Policy Recommendations of the Delaware Healthy Lifestyles Subcommittee

Cancer Risk Reduction Committee

January 2021

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Executive Summary

At the request of Governor John Carney, the Cancer Risk Reduction Committee of the Delaware Cancer Consortium, chaired by Lieutenant Governor Bethany Hall-Long, RNC, PhD and Deborah Brown, Chief Mission Officer of the American Lung Association, took responsibility for developing a strategy for implementing priority initiatives. This request led to the development of a Healthy Lifestyles Subcommittee, which was tasked with studying and recommending policies that could positively influence healthy lifestyles for Delawareans across the life course.

While Delaware has made progress in many health initiatives, the state ranks 30th overall in America's Health Rankings, with a high burden of preventable chronic illness and significant racial, economic, and geographic health inequities that reflect access to resources and opportunities that influence health. The outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes Coronavirus 2019 (COVID-19), amplified these inequities and drastically altered lifestyles and communication. Recovery will require policies and programs that foreground health equity, that support healthy lifestyles in this new reality, and that can be sustained over time.

The Subcommittee held monthly public meetings in-person or virtually between December 2019 and June 2020, as well as a virtual Town Hall in April 2020, and two panel webinars in March to gather input on best practices from national experts. In addition, Health Management Associates surveyed Subcommittee members to prioritize and refine recommendations and develop an implementation timeline, meeting individually with members for clarification if needed. The Subcommittee recommends 14 policies (Table 1).

These recommendations were developed with the intent to support efforts across Delaware to achieve health equity, meaning that everyone has the opportunity to attain their highest level of health.[1] This report details the process, recommendations and rationale for selecting them, and next steps for implementation and evaluation.

[1] "Health Equity," *American Public Health Association*, https://www.apha.org/topics-and-issues/health-equity (accessed June 9, 2020).

Table 1: 14 Policy Recommendations of the Healthy Lifestyles Subcommittee

14 Policy Recommendations of the Healthy Lifestyles Subcommittee	
1. Endorse a “Health in All Policies” approach to focus on social and environmental justice, human rights, and equity in the development, implementation, and evaluation of all policies to ensure policy-oriented strategies for promoting health equity.	Cross-Cutting
2. Expand DELACARE regulations (Regulations for Early Care and Education and School-Age Centers) to family childcare homes and strengthen physical activity requirements across settings.	Birth to age 18
3. Prohibit sugar sweetened beverages (SSBs) in Early Childhood Care and Education Centers.	Birth to age 18
4. Preserve robust school nutrition standards, as defined in the 2010 U.S. Department of Agriculture (USDA) nutrition guidelines for school lunches and maintain flexible, healthy standards relative to consumption of sodium, whole grain, and milk.	Birth to age 18
5. Strengthen the implementation of annual health related fitness assessment, reporting and compliance standards set forth in Delaware Department of Education Regulation 503 Instructional Program Requirements Section 5.0: Physical Education.	Birth to age 18
6. Develop and implement out-of-school nutrition policies (before-school, after-school, sports).	Birth to age 18
7. Propose and implement time requirement standards for elementary, middle and high school physical education and physical activity.	Birth to age 18
8. Strengthen breastfeeding supports in the workplace and other settings, including anti-discrimination protections; strengthen breastfeeding protections at hospitals.	Employee Health
9. Create a formal workplace wellness program infrastructure for state employers. Encourage non-state employers to adopt workplace wellness program infrastructure.	Employee Health
10. Strengthen the corner store intervention model via federal food assistance programs to increase access to and consumption of healthier food options to reduce food insecurity and promote nutritious diets in targeted communities.	Community Wellness
11. Create a financing mechanism to support Healthy Communities Delaware.	Community Wellness
12. Expand SNAP-Ed-like programming to low-income Delawareans.	Community Wellness

13. Explore model policies for reducing consumption of sugar-sweetened beverages (SSBs), including warning labels, counter-marketing, SSB taxes, and/or bans on SSB marketing on/near schools.	Community Wellness
14. Strengthen and enhance Delaware's Complete Streets policy to support the Delaware Department of Transportation's work building active, accessible transportation.	Community Wellness

Source: Delaware Cancer Consortium, Cancer Risk Reduction Committee, Healthy Lifestyles Subcommittee, 2021.

Co-Chairs

The Honorable Bethany Hall-Long, RNC, PhD, Lieutenant Governor, State of Delaware

Karyl T. Rattay, MD, MS, FAAP, Director, Division of Public Health, Delaware Department of Health and Social Services

Members

Joe Bryant	(Ex-Officio Member) Policy Advisor, Office of the Governor
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Steve Groff (represented by Liz Brown)	Director, Division of Medicaid and Medical Assistance, Delaware Department of Health and Social Services (DHSS)
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This policy recommendations report is being submitted to the Delaware Cancer Consortium's Cancer Risk Reduction Committee by the Healthy Lifestyles Subcommittee. The subcommittee represents numerous individuals, and organizations, who devoted their time and effort to the creation of this report.

Additional thanks to Division of Public Health (DPH) staff for supporting the work of the Subcommittee and the production of this report:

Cassandra Codes-Johnson, Associate Deputy Director
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Introduction and Rationale

In October 2019, Governor John Carney requested that the Cancer Risk Reduction Committee of the Delaware Cancer Consortium, chaired by Lieutenant Governor Bethany Hall-Long, PhD and Deborah Brown, Chief Mission Officer of the American Lung Association (ALA), be responsible for developing a strategy for implementing priority initiatives. This request led to the development of a Healthy Lifestyles Subcommittee, which was tasked with studying and recommending policies that could positively influence healthy lifestyles for Delawareans across the life course. The Subcommittee chairs were Lt. Governor Hall-Long, PhD, and Karyl Rattay, MD, Director of the Division of Public Health (DPH), Delaware Department of Health and Social Services. Health Management Associates (HMA) was contracted to facilitate the Subcommittee's work.

While Delaware has made progress in many health initiatives, the state ranks 30th overall in America's Health Rankings, with a high burden of preventable chronic illness and significant racial, economic, and geographic health inequities that reflect access to resources and opportunities that influence health.

Overweight and obesity are associated with increased risk of 13 types of cancer, which together account for about 40 percent of all cancers diagnosed in the United States. Cancers associated with overweight and obesity, excluding colorectal cancer, increased 7 percent between 2005-2014, while the rate of other cancers decreased by 13 percent.[2] In 2012-2016, 28,581 new all-site cancer cases were diagnosed in Delaware, an average of 5,716 per year (Table 2).

Table 2. Number of All-Site Cancer Cases, By Sex and Race/Ethnicity; Delaware Counties, 2012-2016.

	All Races			Non-Hispanic Caucasian			Non-Hispanic African American			Hispanic		
	All	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female
Delaware	28,581	14,619	13,962	22,329	11,504	10,825	4,861	2,441	2,420	805	395	410
Kent	5,251	2,676	2,575	3,939	1,970	1,969	1,060	581	479	162	88	74
New Castle	15,098	7,539	7,559	11,032	5,568	5,464	3,166	1,528	1,638	513	257	256
Sussex	8,221	4,397	3,824	7,349	3,961	3,388	635	332	303	130	50	80

Source: Delaware Health and Social Services, Division of Public Health, Cancer Incidence and Mortality in Delaware, 2012-2016.

[2] "Cancers Associated with Overweight and Obesity Make up 40 percent of Cancers Diagnosed in the United States," Centers for Disease Control and Prevention, October 23, 2017, https://www.cdc.gov/media/releases/2017/p1003-vs-cancer-obesity.html (accessed June 9, 2020).

Lack of opportunity to exercise and access healthy foods are having a significant impact on health, quality of life, and health care costs in our state. For example:

When looking at obesity and overweight combined, Delaware ranks 18 among states (1 being the highest rate).[3]

> "Broader equity issues—like poverty and institutional racism—and community context shape daily life and available choices around healthy food, physical activity, education, jobs, financial security, etc. (together often called "social determinants of health"), which systematically affect people's weight and health. Real change in obesity requires understanding and action on the various drivers of high obesity rates—from addressing historical inequities and underinvestments that result in limited resources in communities to encouraging culturally appropriate, healthy choices at the individual level."
>
> The State of Obesity: Better Policies For A Healthier America. Trust for America's Health, 2019.

- Obesity prevalence among Delawareans has more than doubled from 1990 – 2018 (Figure 1). The prevalence of obesity or overweight among Delawareans increased from 47.1% to 67.8% during that time.[4]
- Among children in Delaware:
  - For high school students, 17.3% of male students and 12.9% of female students are obese.[5]
  - 15% of children ages 10 to 17 are obese.[6]
  - 16.2% of low-income children aged two to four are obese.[7]
- Delaware ranks 17th for prevalence of diabetes and 11th for hypertension.[8]
- In 2017, at least 5,989 Delawareans died from chronic disease, with cardiovascular disease and cancer accounting for 51% of all deaths statewide.[9]
- These conditions (e.g., diabetes, obesity, serious heart conditions including coronary artery disease) are also risk factors for worse outcomes for people with COVID-19.[10]

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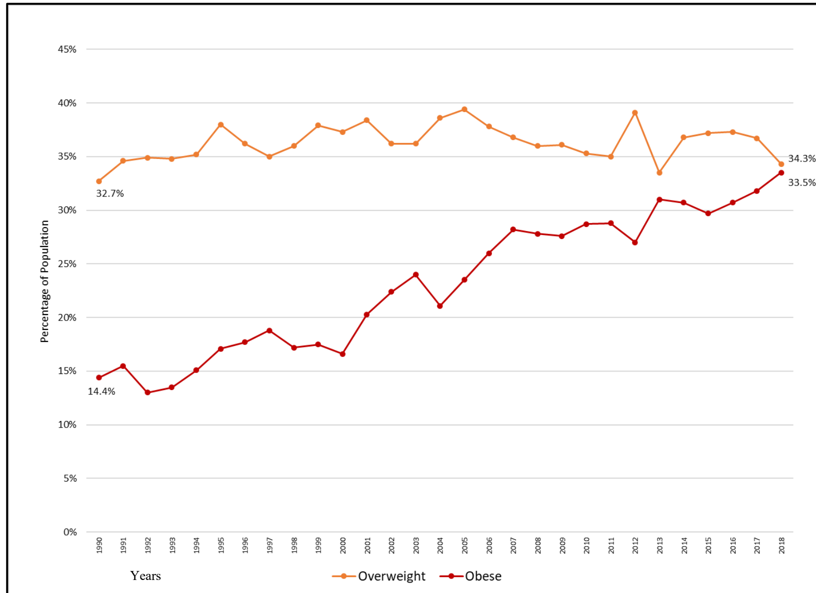
[3] "The State of Obesity in Delaware," Robert Wood Johnson Foundation, https://stateofchildhoodobesity.org/states/de/ (accessed June 9, 2020).
[4] Delaware Department of Health and Social Services, Division of Public Health, Delaware Behavioral Risk Factor Survey (BRFS), 2018.
[5] Youth Risk Behavior Surveillance—2017. MMWR Surveillance Summary 2018;67. Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta.
[6] 2018-19 National Survey of Children's Health (NSCH), Maternal and Child Health Bureau, Health Resources and Services Administration, 2020. Accessed December 4, 2020.
[7] Pan, Liping, Blanck, Heidi, Park, Sohyun, et al. "State-Specific Prevalence of Obesity Among Children Aged 2–4 Years Enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children — United States, 2010–2016." Morbidity and Mortality Weekly Report. 68(46);1057–1061. Accessed December 4, 2020.
[8] "Hypertension in America," Robert Wood Johnson Foundation, September, 2018, https://stateofchildhoodobesity.org/hypertension/ (accessed June 9, 2020).
[9] "Chronic Disease in Delaware: Facts and Figures," Delaware Department of Health and Social Services, Division of Public Health, Health Promotion and Disease Prevention, November 2019 https://www.dhss.delaware.gov/dhss/dph/dpc/files/2019chronicdiseasefactsfigures.pdf
[10] "People Who Are at Higher Risk for Severe Illness," National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, Centers for Disease Control and Prevention. Last Updated May 14, 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

- Only half (50%) of Delaware public middle school students and 43% of high school students reported physical activity that meets recommendations in 2017.[11] Among adults, only 28.5% met CDC recommendations for aerobic physical activity, and only 19% of adults met recommendations for both aerobic and strength-building activity.[12]
- Only 19.3% of children aged six to 17 participated in 60 minutes of physical activity every day.[13]
- 32.9% of youth had parks or playground areas, community centers and sidewalks or walking paths available in their neighborhood in 2016.[12]

Figure 1. Percentage of Overweight and Obesity Prevalence in Delaware, 1990 -2018



Source: Delaware Department of Health and Social Services, Division of Public Health, Delaware Behavioral Risk Factor Survey (BRFS), 2018.

- In 2017, one in six children in Delaware lived in households experiencing food insecurity; while data are not yet available to demonstrate the impact of COVID-19 on food insecurity in the state, the economic impact of COVID-19 is expected to increase it, with the impact falling heavily on lower-income households.[14] By the end of April 2020, one in five households nationwide was estimated to be experiencing food insecurity.[15]
- Racial inequities persist in Delaware across many health conditions, including rates of cancer and chronic illnesses, as well as mortality rates. On some metrics, progress is slow or flat.
  - Incidence of diabetes is higher among Black residents of the state than white residents (15.3 percent vs. 11.8 percent), and death rates are more than twice as high (32.5 percent vs. 16 percent).

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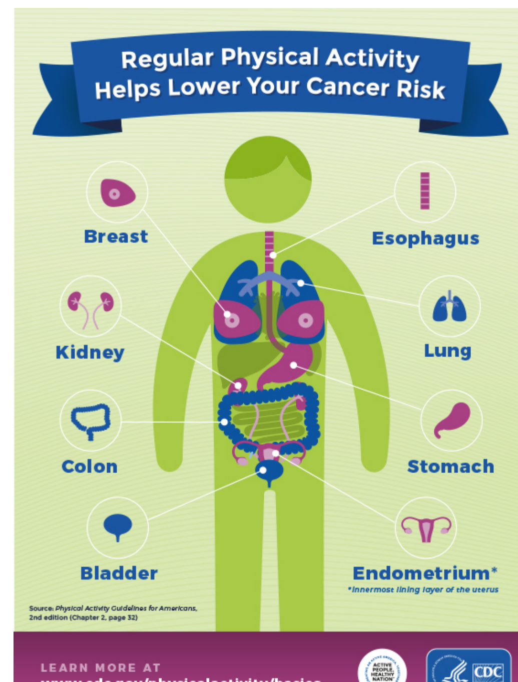
[11] "BRFSS Prevalence & Trends Data," Centers for Disease Control and Prevention, September 13, 2017, https://www.cdc.gov/brfss/brfssprevalence/index.html, accessed June 9, 2020.
[12] "Nutrition, Physical Activity, and Obesity: Data, Trends, and Maps," Centers for Disease Control and Prevention, May 14, 2020 https://www.cdc.gov/nccdphp/dnpao/data-trends-maps/index.html, accessed June 9, 2020.
[13] 2017-2018 National Survey of Children's Health, Maternal and Child Health Bureau, Health Resources and Services Administration, 2019.
[14] "The Impact of Coronavirus on Food Insecurity," Feeding America, April 22, 2020, https://www.feedingamerica.org/sites/default/files/2020-04/Brief_Impact%20of%20Covid%20on%20Food%20Insecurity%204.22%20%28002%29.pdf, accessed June 9, 2020.
[15] Lauren Bauer, "The COVID-19 Crisis Has Already Left Too Many Children Hungry in America," Brookings Institute, May 6, 2020, https://www.brookings.edu/blog/up-front/2020/05/06/the-covid-19-crisis-has-already-left-too-many-children-hungry-in-america/, accessed June 9, 2020.

- Incidence of hypertension is 69.2 percent for Black Delawareans, compared to 62.4 percent for white Delawareans.
- Age-adjusted death rates for breast cancer are 25 percent and 21 percent respectively. For colorectal cancer, they are 15.4 percent compared to 13.3 percent.[16]

Figure 2. Regular Physical Activity Lowers Cancer Risk



Source: U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S.Department of Health and Human Services; 2018.

Numerous initiatives nationwide have improved people's ability to achieve their best potential health. In recent years, more evidence and lessons have emerged from research of policies and programs focused on addressing healthy eating, active living, and obesity at the individual, community, and state levels. Studies demonstrate that states and communities that support multi-sector collaborations and innovative policy approaches over sustained periods can achieve progress. For example, current evidence infers higher levels of physical activity are linked to a lower risk of several types of cancer (Figure 2).

Delaware has adopted a variety of policies to promote healthy lifestyles in recent years, including regulations on physical education and student fitness assessments; changing the beverage choice default option for kids' meals; the revised state vending machine policy/contract; and raising the legal age of tobacco purchase to 21 (T21). Programs include Complete Streets; Healthy Communities Delaware; leading farm-to-school programs; participation in the Women, Infant and Children (WIC) and Senior Farmers Market Nutrition Incentive Programs; Alternative Service Models for School Breakfast Programs to ensure all children can be fed in the classroom or if they are late to school; and innovative approaches to Supplemental Nutrition Assistance Program (SNAP) outreach. In addition, the Department of Education received a federal waiver for the school nutrition program to provide meal options for students during the COVID-19-related school closures. These and numerous other policies and programs have advanced our goal of supporting healthier lifestyles for all; however, more remains to be done.

Health Equity and Social Determinants of Health

These recommendations were developed with the intent to support efforts across Delaware to achieve health equity, meaning that everyone has the opportunity to attain their highest level of health.[17] The Healthy Lifestyles Subcommittee recognizes that our overall health is strongly influenced by where we live, learn, work, play, and pray. It is also heavily influenced by exposure to racism and other forms of

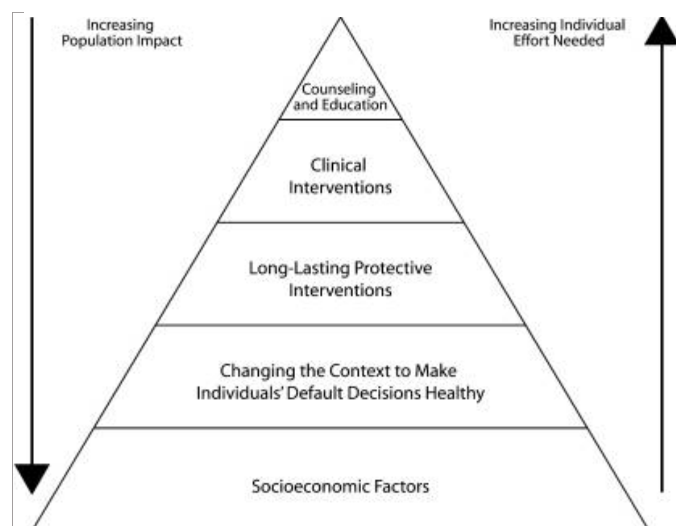
[16] "Disparities Dashboard," Delaware Health Tracker, http://www.delawarehealthtracker.com/index.php?module=indicators&controller=index&action=dashboard&alias=disparities&localeId=10, accessed June 9, 2020.
[17] "Health Equity," American Public Health Association. https://www.apha.org/topics-and-issues/health-equity

systemic injustice, which influence other determinants of health: income, education, housing, exposure to environmental hazards, food security, access to outdoor space, and access to and quality of health care services. Our culture, language, political and religious beliefs, social norms and attitudes, and rates of poverty, crime, and violence affect our health. Delaware can achieve greater health equity by addressing inequities in environmental, social, and economic conditions. While the following recommendations are limited compared to the full scope of change that would be required to eliminate inequities, they were developed with progress toward it in mind. The Subcommittee also recognizes the critical importance of connecting these state-level policy recommendations to the important work being done at all levels across the state, including hyper-local grassroots efforts in communities, in order to support them to effectively address health equity and to meet Delawareans' needs. Discussion of how the recommendations can support equity is in **bold** throughout the recommendations.

An Opportunity to Implement Evidence-Based Approaches from Delaware's Health Equity Guide

DPH, the University of Delaware's School of Public Policy & Administration, and other partners developed a Health Equity Guide (The Guide) for public health practitioners, partners, and other audiences to "help Delawareans better understand tools and strategies that promote health equity and support upstream population health approaches. It is designed to assist all sectors which can include but are not limited to government, education, workplaces, private sector, nonprofit agencies, faith-based institutions, and health care settings address underlying causes of health inequities in communities and promote optimal health for all in Delaware. DPH is working with many community leaders, non-profit organizations, other state agencies, and stakeholders to address health equity issues within our state and improve overall health for Delawareans. By engaging in healthy behaviors and improving environmental and social conditions, there is less risk of disease, disability, and injury. In order for this to occur, we all need to ensure that the healthy choice is not just the easy choice, but that it is also a possible choice within communities."[18] The guide highlights evidence-based practices, tools and resources that can assist Delawareans to reach their full health potential and improve their quality of life. This work is based on an existing data collection of evidenced-based frameworks, including the framework for public health action (Figure 3) and the

Figure 3. The Health Impact Pyramid



Source: Thomas R. Frieden, "A framework for public health action: the health impact pyramid," American Journal of Public Health 100 no. 4 (2010): 590–595.

[18] Erin Knight, Kalyn McDonough, Cassandra Codes-Johnson, "Health Equity Guide for Public Health Practitioners and Partners, Edition 2," Delaware Department of Health and Social Services, Division of Public Health, November 2019. https://www.dhss.delaware.gov/dhss/dph/mh/files/heg2nded.pdf

Racial Justice Framework for Advancing Health Equity. The Guide highlights Health in All Policies and Health Impact Assessments as policy-oriented strategies to address equity.

Health in All Policies (HiAP)

These recommendations are intended to align with population-health focused evidence-based frameworks, such as the internationally recognized Health in All Policies (HiAP) framework.[19] CDC used this approach to create a framework for health departments (state, territorial, and local) – as well as industries that have an important role in the economic, physical, and social environments – to improve health outcomes for all communities and people. HiAP has two main goals. The first is to ensure decision-makers are informed about the health, equity, and sustainability consequences of policy development. The second is to address health equity by incorporating health considerations into decision-making across sectors and policy areas. HiAP uses the social drivers of health tenets, factors beyond traditional public health, to determine how decisions in multiple sectors affect health and how better health can support the goals of various industries. HiAP approaches include five key elements: promoting health and equity, supporting intersectoral collaboration, creating co-benefits for multiple partners, engaging stakeholders, and creating structural or process change.[20] They engage a broad range of stakeholders to use their collective resources for health promotion and sustainability, and simultaneously advance goals such as job creation and economic stability, transportation access and mobility, access to healthy foods, and educational attainment. There is no one "right" way to implement a HiAP approach, and there is substantial flexibility in process, structure, scope, and membership, but the core elements include:

- Promote health, equity, and sustainability
- Support intersectoral collaboration
- Benefit multiple partners
- Engage stakeholders
- Create structural or process change.

The Guide highlights several tools that can be used to promote equity and minimize adverse outcomes when implementing policies. It is critically important that monitoring and evaluation continues to engage and be responsive to the communities affected by policies after they are implemented.

Methodology Summary

The Healthy Lifestyles Subcommittee is comprised of 10 members regardfully selected from Delaware state agencies and key organizations involved in health, food and nutrition, human services, education, children and youth services, workforce and employment, statewide benefits, and planning (see a full list of participants in Appendix A).

[19] "Health in All Policies," Centers for Disease Control and Prevention*,* June 9, 2016, https://www.cdc.gov/policy/hiap/index.html, accessed June 9, 2020.

[20] Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). Health in All Policies: A Guide for State and Local Governments. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute. http://www.phi.org/wp-content/uploads/migration/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf

The Subcommittee was tasked with examining the following priority areas to recommend policy interventions related to each. They represent several major domains in which policies can influence healthy lifestyles, and they align with DPH priorities and these population health strategic focus areas:

- Birth to age 18
- Employee health
- Community wellness.

Our goals were to explore the evidence base on existing programs and examine ongoing efforts in other states to identify best practices and lessons for Delaware, and to develop a report capturing subcommittee recommendations that are actionable, concise, and reflect buy-in of participants and key stakeholders.

The Subcommittee held a series of monthly public meetings from December 2019 to June 2020, including virtual meetings beginning in March 2020.[21] The meetings included presentation and discussion of potential policies, Delaware's existing policies, and research from the evidence base of best practices in Delaware and nationwide. In April, the Subcommittee participated with 60 attendees, including community members, in a virtual town hall meeting to discuss community priorities for supporting healthy lifestyles and to gather input on the potential recommendations (summarized in further detail in the Stakeholder Input section). In addition, Subcommittee Members attended two expert webinars in March 2020, in which national experts, including Kristin Sukys (Harvard Food Law & Policy Center), Christopher Kochtitzky (Division of Nutrition, Physical Activity, and Obesity, Centers for Disease Control and Prevention), William Dietz (The George Washington University Milken Institute School of Public Health), and Sara Benjamin-Neelon (Johns Hopkins Bloomberg School of Public Health) presented evidence and shared their assessments of the potential policies.

In the midst of the Subcommittee's development of these recommendations, the COVID-19 crisis began. It amplified the health inequities that exist nationwide and in Delaware and created new realities and risks to health and economic security for Delawareans. The Subcommittee members and co-chairs have all been involved in the response to the pandemic in their respective roles. The Subcommittee continued its work during this time, including transitioning to virtual meetings and holding a virtual town hall to gather community input to shape the recommendations. The crisis reinforced the need to support equity across the recommendations and motivated creative thinking about opportunities to reimagine what policies could best support healthy lifestyles in Delaware. The recommendations in this report are intended to help to support a stronger, more equitable recovery and future for Delaware.

Stakeholder Input

Throughout the Subcommittee's process in developing and refining their policy recommendations, external stakeholders were invited to share their experience and opinions with the subcommittee to ensure that this final list of recommendations reflects the values and prioritizes of the larger Delaware community. Input was facilitated in two ways.

Stakeholders were encouraged to attend the Subcommittee's meetings. At each of these meetings, several representatives from various Delaware agencies, including the Department of Education, the Office of Management and Budget, and the Department of Transportation (DelDOT), provided insight on

[21] Health Management Associates provided staffing support and meeting facilitation for the Subcommittee.

the current state of policies and data within their agencies as they related to the Subcommittee's three focus areas. Stakeholders suggested improvements to frame potential policy recommendations for aligning with the Subcommittee's vision and effectively address key gaps in state agencies' policy support for healthy lifestyles.

A virtual town hall was organized to further engage Delawareans in shaping the policy recommendations. One hundred sixty individuals registered for the one-hour virtual town hall and 60 individuals attended. Town hall attendees represented a diverse cross-section of entities, including members of the public, local hospital systems, and professional associations. During the virtual town hall, the Subcommittee chairs introduced the group's context and purpose and explained each policy recommendation, highlighting the state of current related policies in Delaware and potential policies to address them. After the virtual town hall, all registrants were sent a post-survey and were asked to mark their level of support for each policy using the following scale:

- Strongly do not support
- Do not support
- Neutral
- Support
- Strongly Support.

The post-survey also allowed participants to provide further comment on any of the recommendations. Fifty-two individuals participated in the post-survey and prioritized the recommendations as follows:

1. Strengthen breastfeeding supports in the workplace and other settings, including anti-discrimination protections; strengthen breastfeeding protections at hospitals.
2. Prohibit sugar-sweetened beverages in Early Childhood Care and Education Centers.
3. Strengthen and enhance Delaware's Complete Streets policy to support DelDOT's work building active, accessible transportation.
4. Enhance physical activity requirements in schools.
5. Preserve 2010 U.S. Department of Agriculture Regulations for School Meals.
6. Enhance support for corner stores.
7. Create comprehensive State of Delaware Workplace Wellness Policy.
8. Enhance DELACARE Regulations across childcare and education settings.
9. Create Sugar-sweetened Beverage Tax/Related policies.
10. Create financial mechanism to support Healthy Communities Delaware.
11. Make Supplemental Nutrition Assistance Program Education (SNAP-Ed)-like programming available to all.
12. Women, Infant and Children (WIC) supports for corner stores.

13. Strengthen the implementation of annual health-related fitness assessment, reporting, and compliance standards.

14. Out-of-School nutrition regulations.

Each of the following policy recommendations includes a summary of town hall participants' input and a chart showing their level of support. The recommendations are the result of extensive feedback and input from Subcommittee members, gathered in a variety of ways over the course of the process. To the extent possible, they reflect general consensus and balance of input provided.

Implementation Timeframe:
Immediately

1

Health in All Policies

Endorse a Health in All Policies approach to focus on social and environmental justice, human rights and equity in the development, implementation, and evaluation of all policies to ensure policy-oriented strategies for promoting health equity.

BEST PRACTICES

Delaware's Health Equity Guide[22] for public health practitioners, partners, and many other audiences highlights evidence-based practices, tools, and resources that can assist Delawareans to reach their full health potential and improve their quality of life. It recommends strategies to be used by government, education, workplaces, private sector, nonprofit agencies, faith-based institutions, and health care settings in order to address underlying causes of health inequities in communities and promote optimal health for all in Delaware. The Guide highlights Health in All Policies as a policy-oriented strategy to address equity.

RATIONALE FOR POLICY RECOMMENDATION

This overarching recommendation expresses the Subcommittee's intention to support efforts across Delaware to achieve health equity, meaning that everyone has the opportunity to attain their highest level of health. The Healthy Lifestyles Subcommittee recognizes that our overall health is strongly influenced by where we live, learn, work, play, and pray. It is also heavily influenced by exposure to racism and other forms of systemic injustice, which influence other determinants of health including income, education, housing, exposure to environmental hazards, food security, access to outdoor space, and access to and quality of health care services. Our culture, language, political and religious beliefs, social norms and attitudes, and rates of poverty, crime, and violence affect our health. Delaware can achieve greater health equity by addressing inequities in environmental, social, and economic conditions. This is particularly critical to address the disparate impact of COVID-19 on Delawareans and to support a more equitable recovery and future. Health equity must be the foundation for the development and implementation of the policies recommended in this report.

[22] Erin Knight, Kalyn McDonough, Cassandra Codes-Johnson, "Health Equity Guide for Public Health Practitioners and Partners, Edition 2," Delaware Division of Public Health, November 2019.

Policy Area 1: Ages 0-18

Childhood, from infancy through the school years, plays a critical role in our health over the life course, especially regarding physical activity and nutrition. Critical to supporting health equity are opportunities to support young people to access the resources needed to support healthy lifestyles and to gain knowledge and develop habits that shape their lives. The COVID-19 crisis has deeply affected every area of life for young people, from childcare to school, out-of-school activities, and other recreation. It has upended the childcare and education systems and has profoundly challenged families, deepening economic and social inequities. The policy response to COVID-19 must strongly support physical activity and nutrition for children aged 0 to 18 as part of addressing these inequities. It is an opportunity to rethink how systems do so.

Alignment with the Whole School, Whole Community, Whole Child Model

Whole School, Whole Community, Whole Child (WSCC)[23] is an evidence-based model developed by the Centers for Disease Control and Prevention (CDC) and the Association for Supervision and Curriculum (ASCD) to address health and wellness in schools for students between the ages of 13-18. The framework calls for alignment, integration, and collaboration between 10 correlated school health components to ensure students are healthy, safe, supported, engaged, and challenged. This student-centered approach emphasizes the roles and connections between schools, families, and communities, as well as school policies needed to support student success. By engaging these natural support systems, healthy behaviors are reinforced in multiple settings for the child, and students are engaged as active participants in their learning and health. The 10 components of the model are:

1. physical education and physical activity
2. nutrition environment and services
3. health education
4. social and emotional school climate
5. physical environment
6. health services
7. counseling, psychological and social services
8. employee wellness
9. community involvement
10. family engagement.

The following recommendations focus on early childhood care and education and kindergarten through grade 12 educational settings and align with the priorities of the WSCC model and its emphasis on the connections between schools, families, and communities in promoting children's health.

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[23] "Whole School, Whole Community, Whole Child (WSCC)," Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Accessed 7/8/2020.
https://www.cdc.gov/healthyschools/wscc/index.htm#:~:text=The%20Whole%20School%20Whole%20Community,for%20addressing%20health%20in%20schools.

Implementation Timeframe: 1-2 years

2 Early Childhood Care and Education

Expand DELACARE regulations to family childcare homes and strengthen physical activity requirements across settings.

BEST PRACTICES

Nationally, best practices for early childhood care and education related to physical activity include[24]:

- Encourage daily physical activity among children in childcare.
- Facilitate age-appropriate activity in short, regular bursts throughout the day.
  - Give infants supervised time in the prone position ("tummy time") every day.
  - Limit the time that infants spend in restricted seating.
  - Give toddlers 60 to 90 minutes per 8-hour day for vigorous physical activities *(activities that get them breathing deeper and faster than typical activities)*, spread out in short, regular bursts throughout the day.
  - Give preschool-age children 90 to 120 minutes per 8-hour day for vigorous physical activities *(activities that get them breathing deeper and faster than typical activities)*, spread out in short, regular bursts throughout the day.
- Model active play.
- Minimize television/screen time and sedentary time.
- Support healthy sleeping habits.

RATIONALE FOR POLICY RECOMMENDATION

Two sets of childcare regulations exist in Delaware: one for childcare centers and school-age programs and one for family and large family childcare homes. The DELACARE regulations were updated most recently in 2019. Across settings, they share a requirement that "A licensee shall provide chances for physical activity for each child according to the child's ability. For every four hours the child is in care between 7 a.m. and 7 p.m., 30 or more minutes of physical activity must be provided. Daily active play may be divided into one or more blocks of time. It may be indoors or outdoors." However, there is variation in the level of detail and specific requirements across these settings with respect to physical activity.

Standardizing requirements and strengthening physical activity standards across settings supports the health of infants and young children and supports health equity by ensuring that children receive these services regardless of the resources available at home, and across childcare settings that vary in their size and capacity. Every young Delawarean should be provided the same care regardless of the facility's size. Childcare capacity has been deeply affected by the COVID-19 crisis, and the sector will need to adapt to changing conditions. Physical activity policies and practices are among the areas that will likely need to be revisited.

Community Support from Town Hall Survey

Percentage	Response
41%	STRONGLY SUPPORT
33%	SOMEWHAT SUPPORT
12%	NEUTRAL
8%	SOMEWHAT DO NOT SUPPORT
6%	STRONGLY DO NOT SUPPORT

[24] Harvard School of Public Health summary of obesity prevention recommendations for early child care providers based on a review of expert guidance from the Institute of Medicine, the National Resource Center for Health and Safety in Child Care and Early Education, the American Academy of Pediatrics, and others. https://www.hsph.harvard.edu/obesity-prevention-source/obesity-prevention/early-child-care/early-child-care-obesity-prevention-recommendation-complete-list/

Implementation Timeframe: 1-2 years

3 Early Childhood Care and Education

Prohibit Sugar Sweetened Beverages (SSBs) in Early Childhood Care and Education Centers

BEST PRACTICES

Nationally, best practices for food and nutrition in early childhood care and education centers include[25]:

- Serve age-appropriate and healthy beverages.
- Offer safe drinking water regularly and in place of fruit drinks, soda, or other sweetened beverages.
- Provide a varied and balanced diet that emphasizes minimally processed foods.
- Encourage healthy growth in children by keeping high-calorie, low-nutrient foods out of childcare.
- Encourage family involvement in healthy eating at the child-care facility.
- Promote ideal and age-appropriate fluid intake among infants.
- Practice responsive feeding.
- Introduce complementary foods at the appropriate age.
- Encourage children to enjoy meals and regulate their own food intake.
- Model healthy mealtime behaviors to children.

RATIONALE FOR POLICY RECOMMENDATION

There are two sets of childcare regulations: one for childcare centers and school aged programs and one for family and large family childcare homes. For each set of DELACARE regulations, meals must follow the meal pattern requirements found in the Appendices. These meal pattern requirements say that water, milk, or 100% unsweetened juice are the beverages that may be served. Additionally, both sets of regulations say explicitly that "A licensee shall ensure meals and snacks provided by the childcare home: 2. May include 100% unsweetened juice, not a juice drink or cocktail..."[26]

Community Support from Town Hall Survey

69% STRONGLY SUPPORT

16% SOMEWHAT SUPPORT

6% NEUTRAL

2% SOMEWHAT DO NOT SUPPORT

[25] Harvard School of Public Health summary of obesity prevention recommendations for early child care providers based on a review of expert guidance from the Institute of Medicine, the National Resource Center for Health and Safety in Child Care and Early Education, the American Academy of Pediatrics, and others. https://www.hsph.harvard.edu/obesity-prevention-source/obesity-prevention/early-child-care/early-child-care-obesity-prevention-recommendation-complete-list/

[26] Delaware Department of Services for Children, Youth, and Family, Office of Childcare Licensing, DelaCare Regulations for Early Care and Education and School-Age Centers, May 2019, Dover, DE: 75.

This recommendation is intended to strongly state that no sugar-sweetened or non-caloric sweetened beverages are permitted to be provided in early childhood care and education settings. Non-caloric "diet" sweeteners are not intended for consumption by young children and this should be explicitly clarified in this policy. **The policy will help to reduce inequities in consumption of sugar-sweetened beverages among children in various childcare settings. Equity across childcare settings will be a key consideration during COVID-19 recovery.**

In addition, in Fall 2020 Early Childhood Education (ECE) licensing will move to the Department of Education, creating an opportunity to align early childhood education with K-12 requirements.

8%

STRONGLY DO NOT SUPPORT

Implementation Timeframe: Immediately

4 K-12 Education

Preserve robust school nutrition standards, as defined in the 2010 USDA nutrition guidelines for school lunches and maintain flexible, healthy standards relative to consumption of sodium, whole grain and milk.

BEST PRACTICES

Nationally, the Community Preventive Services Task Force (CPSTF) recommends a broad range of nutrition and exercise-related policies and programs, including:[27]

- Meal or fruit and vegetable interventions to increase healthier foods and beverages provided by schools
- Multicomponent interventions to increase availability of healthier foods and beverages in schools
- Meal or fruit and vegetable snack interventions combined with physical activity interventions in schools
- Enhanced school-based physical education
- Interventions to increase active travel to school.

Community Support from Town Hall Survey

61%

STRONGLY SUPPORT

18%

SOMEWHAT SUPPORT

[27] "Obesity Prevention and Control: Multicomponent Interventions (Meal or Fruit and Vegetable Snack Interventions + Healthier Snack Foods and Beverages) Combined with a Physical Activity Intervention in Schools: Community Preventive Services Task Force Finding and Rationale Statement. Community Preventive Services Task Force, October 2018. https://www.thecommunityguide.org/content/tffrs-obesity-prevention-control-multicomponent-interventions-combined-physical-activity-intervention-schools

RATIONALE FOR POLICY RECOMMENDATION

The Subcommittee recommends that Delaware preserve the strongest Federal policies for school meals to promote health and make healthier food options and benefits available to low-income Delawareans. These can be codified into a variety of State regulations and, in some cases, procurement policies. **This is critical to increasing health equity. Increased food insecurity as a result of the COVID-19 crisis makes school nutrition even more important, as families may be relying on school meal programs even more than before.**

The Healthy, Hunger-Free Kids Act (HHFKA), passed in 2010, sought to modify the National School Lunch Program (NSLP) to address childhood obesity, and included a requirement for the USDA to establish science-based national nutrition standards. Rollback began in May 2017 when USDA formally altered these nutrition standards, and culminated in the 2019 Final Rule rolling back the nutrition standards even further, despite opposition from over 98 percent of commenters, including the American Heart Association, the Academy of Nutrition and Dietetics, and the National Association of Pediatric Nurse Practitioners, among others. The new rule gives school lunchrooms flexibility to provide flavored milk, higher sodium foods, and fewer whole grains. An evaluation of seven high-profile obesity policies estimated that the original nutrition standards would prevent 1,816,000 cases of childhood obesity and found that the standards had the "largest impact on reducing childhood obesity of any of the interventions evaluated in [the] study." Healthier menus have also been linked to improved academic achievement.[28] Delaware should maintain healthy standards relative to consumption of sodium, whole grains and milk while allowing reasonable flexibilities through waivers where necessary.
The State should take steps to support robust nutrition standards, as well as food assistance policies, and remove barriers to access.

6%
NEUTRAL

8%
SOMEWHAT DO NOT SUPPORT

8%
STRONGLY DO NOT SUPPORT

[28] "Rollback Of Nutrition Standards Not Supported By Evidence, " Health Affairs Blog, March 13, 2019.DOI: 10.1377/hblog20190312.130704

Implementation Timeframe: 1-2 years

5 K-12 Education

Strengthen the implementation of annual health-related fitness assessment, reporting, and compliance standards set forth in Delaware Department of Education Regulation 503 Instructional Program Requirements Section 5.0 Physical Education.

BEST PRACTICES

CDC recommends a coordinated approach to develop, implement, and evaluate healthy eating and physical activity policies and practices, including robust measurement and evaluation. Across school and community sectors, schools, parents and students should work together to maximize healthy eating and physical activity opportunities for students.[29] Strategies include:

- Coordinate healthy eating and physical activity policies and practices through a school health council and school health coordinator. The Whole School, Whole Whole Community, Whole Child (WSCC) model suggests that these councils benefit from the participation of the broader community of health advocacy and nonprofit agencies, parents, local support organizations, parents, and the wider community, going beyond current students, staff, parents, and administration.
- Assess healthy eating and physical activity policies and practices.
- Use a systematic approach to develop, implement, and monitor healthy eating and physical activity policies.
- Evaluate healthy eating and physical activity policies and practices.

Delaware's preferred assessment method is FitnessGram®. FitnessGram® is an evidence-based national fitness assessment and reporting program for youth developed by The Cooper Institute. It evaluates five components of health-related fitness: aerobic capacity, muscular strength, muscular endurance, flexibility, and body composition, using objective criteria. The FitnessGram® platform generates confidential individual reports that are provided to parents, aggregate school-level reports that are provided to each school, and aggregate state-level data that are reported annually. In conjunction with other programs that create opportunities for physical activity and other resources for healthy lifestyles, it can be an effective tool to support population-level health.

For example, in a successful FitnessGram® implementation effort in Georgia as part of the Society of Health And Physical Educators (SHAPE) program, after five years of implementation, the rate of reporting was 98.3% among school districts, and more than 70% of students were assessed. In addition to the data collection component, parents of almost one million students received individualized student health-related fitness information. The state saw positive trends on a number of indicators, including an increase in the percent of students with healthy weight from 57.9% for boys and 58.4% for girls in 2012 to more than 60% from 2015-17.[30]

Community Support from Town Hall Survey

31%
STRONGLY SUPPORT

35%
SOMEWHAT SUPPORT

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[29] "School Health Guidelines," Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Accessed 7/8/2020. https://www.cdc.gov/healthyschools/npao/strategies.htm

[30] Georgia Department of Education Annual Fitness Assessment Program Report, 2017. https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-Instruction/Documents/HPE/Governor%27s%20Report%202017%20%20Complete.pdf

RATIONALE FOR POLICY RECOMMENDATION

This policy recommendation aims to develop and implement an aligned and coordinated school health infrastructure and approaches that will increase harmonization of behavioral and physical health policies, programs, and practices to improve learning environments. Using an evidence-based framework that focuses on and supports the needs of the whole child helps districts and schools identify specific needs and target interventions to implement a school-wide approach which acknowledges that learning, health, and the school are integral components to support Delaware's youth in schools.

While Delaware has implemented FitnessGram® via the Delaware Department of Education Regulation 503 Instructional Program Requirements Section 5.0 Physical Education, data is not consistently reported or used to its greatest potential. There are some barriers to efficient and consistent district and school-level data entry into the required portal. Delaware's implementation of FitnessGram® must be strengthened to ensure that it is an effective tool to identify needs and progress on children's health across the state.

Promoting and providing technical assistance to support appropriate implementation of FitnessGram® and its evaluation standards allow for the consistent gathering of state-level quantitative and qualitative data on childhood obesity to use for public health surveillance. This data will facilitate the identification of health inequities in communities and will justify the need for public health investments in those communities. This policy is also an opportunity to promote and improve school health through professional development and training on the WSCC model, which supports connections between health and academic achievement, school nutrition environment, physical education and physical activity, quality health education curriculum, out of school time programs, and employee wellness approaches.

18%

NEUTRAL

8%

SOMEWHAT
DO NOT SUPPORT

8%

STRONGLY
DO NOT SUPPORT

Implementation Timeframe: 1-2 years

6 K-12 Education

Develop and implement out-of-school nutrition policies (before-school, after-school, sports).

BEST PRACTICES

A variety of nutrition standards could be applied to out-of-school meals and snacks. School nutrition programs already provide meals that meet federal nutrition standards for the National School Lunch and Breakfast Programs and help ensure that foods and beverages sold outside of the school meal programs (i.e., competitive foods) meet Smart Snacks in School nutrition standards.

CDC synthesized research and best practices promoting healthy eating to develop its School Health Guidelines, which serve as a foundation for developing, implementing, and evaluating school-based healthy eating policies and practices for students. Their recommendations use the 2015-2020 Dietary Guidelines for Americans and aim to ensure that all foods and beverages sold or served outside of school meal programs are nutritious and appealing.[31]

RATIONALE FOR POLICY RECOMMENDATION

Delaware's current regulations governing school nutrition standards include a variety of requirements for food provided in schools, including:

- For School Nutrition Programs:
  - Age/grade groups for breakfast and lunch
    - Calorie ranges
    - Saturated fat limits
    - Sodium restrictions
    - Whole grain rich requirements.
  - A la carte, vending, fundraisers
    - Smart Snack standards.
- Child and Adult Care Food Program (CACFP):
  - Age groups
  - Food components
  - Portion sizes
  - Sugar limits on cereals and yogurt
  - No sweet grains allowed.

However, Department of Education rules do not apply to after-school activities more than 30 minutes after the school day ends. School districts would have oversight over this and put it into their wellness policies. It also does not fall under

Community Support from Town Hall Survey

33% STRONGLY SUPPORT

31% SOMEWHAT SUPPORT

12% NEUTRAL

12% SOMEWHAT DO NOT SUPPORT

12% STRONGLY DO NOT SUPPORT

[31] U.S. Department of Health and Human Services and U.S. Department of Agriculture. 2015-2020 Dietary Guidelines for Americans. 8th Edition. December 2015. Available at https://health.gov/our-work/food-and-nutrition/2015-2020-dietary-guidelines/.

USDA regulations. Delaware could establish standards for out-of-school activities for before-school, after-school, and sports programs affiliated with schools to support provision of nutritious snacks and meals during activities that are not already covered by robust requirements. **These nutrition standards can help address inequities in which foods are available to young people as part of activities outside school.**

Implementation Timeframe: 1-2 years

7 K-12 Education

Propose and implement time requirement standards for elementary, middle, and high school physical education and physical activity.

BEST PRACTICES

Physical activity for school-aged children can be improved significantly through approaches such as providing a variety of school-based physical activities to enable all students to participate in 60 minutes of moderate-to-vigorous physical activity each day. The Comprehensive School Physical Activity Program (CSPAP) is a framework for planning and organizing these activities as part of the Whole School, Whole Community, Whole Child (WSCC) model, under which schools can provide many opportunities for students to be physically active, including physical education and physical activity. Physical education, the foundation of the CSPAP approach, "provides students with a planned sequential K-12 standards-based program of curricula and instruction designed to develop motor skills, knowledge, and behaviors for healthy active living, physical fitness, sportsmanship, self-efficacy, and emotional intelligence. The essential components of a physical education program include policies and environment, curriculum, appropriate instruction and student assessment."[32]

RATIONALE FOR POLICY RECOMMENDATION

While Delaware requires students to take physical education in grades K-8, the State does not specify a minimum number of minutes per week. High schools are required to provide students with physical education, and students must complete physical education credits for graduation.[33] However, some other states have time requirements, either for physical activity or physical education class. Setting a time

Community Support from Town Hall Survey

55% STRONGLY SUPPORT

27% SOMEWHAT SUPPORT

10% NEUTRAL

[32] "What is CSPAP?" SHAPE America, undated. Accessed 7/8/2020. https://www.shapeamerica.org/cspap/what.aspx

[33] "2016 Shape of the Nation State Profile: Delaware," SHAPE America, 2016. Accessed 7/8/2020/ https://www.shapeamerica.org/advocacy/son/2016/upload/SON_-Delaware_-2016.pdf

requirement for physical activity provides flexibility to schools, whose space and staffing are limited, while setting a standard to support students to get exercise. Delaware should ensure that any policy changes do not weaken existing physical education programs at schools, but strengthen them and support schools to offer an evidence-based level of physical activity with age-appropriate physical education as the cornerstone. Policies could start with physical activity requirements and incorporate physical education requirements over time. **This policy will require oversight and likely technical assistance to ensure that it is implemented equitably and that differing access to resources among schools and districts does not exacerbate inequities in students' access to physical activity. The COVID-19 crisis upended school as it previously existed, and the future of in-person learning and physical activity is not yet clear, but evidence-based standards for physical activity and physical education will be important to consider as the educational system adapts to new realities. Planning for the reopening of schools should be done with these policy change goals taken into consideration.**

2%

SOMEWHAT DO NOT SUPPORT

6%

STRONGLY DO NOT SUPPORT

Policy Area 2: Worksite Wellness

Workplace conditions are an important determinant of health on many levels, and worksite policies can shape healthy lifestyles in numerous ways.[34] They must address, physical, mental, and emotional health. Worksite wellness programs remain an area of policy with an evolving evidence base and ongoing debate about the impact of a variety of strategies. Many state programs have not yet been rigorously evaluated, and the effectiveness of a number of private-sector programs is mixed. There is also debate over whether observational evidence is strong enough to support some wellness programs; meanwhile, randomized controlled trials are not necessarily feasible and wellness programs need not be held to a higher standard than many other health interventions. However, CDC's Worksite Wellness Scorecard identifies numerous focus areas where evidence merits intervention:

- Organizational supports
- Tobacco use
- Nutrition
- Physical activity
- Weight management
- Stress management
- Depression
- High blood pressure
- High cholesterol
- Prediabetes and diabetes
- Heart attack and stroke
- Maternal health and lactation support
- Vaccine-preventable diseases
- Occupational health and safety
- Cancer
- Alcohol and Other Substance Use
- Sleep and Fatigue
- Musculoskeletal Disorder.

Workplace health promotion programs, which may or may not include incentive programs, need to be designed with equity in the foreground and in ways that truly support improved health, rather than simply selecting healthier or higher-income employees who may be more able to participate. "Smart" incentives can be part of a well-designed program, but such programs need to be embedded in a

[34] CDC Worksite Wellness Scorecard, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion.

"culture of health" and avoid penalizing people who already experience higher costs and burdens of health risks or conditions. As noted by Johns Hopkins Bloomberg School of Public Health expert on workplace wellness Ron Goetzel, "Paying people to improve their health in an unhealthy work environment is a futile strategy."[35] Screening should not go beyond guidelines recommended by the U.S. Preventive Services Task Force (USPSTF). These include high blood pressure, obesity, cholesterol, glucose, triglycerides, cervical cancer, colon cancer, and breast cancer, among others. The CDC framework includes mental health conditions and substance use disorders, which should be addressed as part of a comprehensive approach. Return on investment should not be the only metric for health promotion, because programs can still be cost-effective. Many preventive services may not have a demonstrable return on investment but are still valuable for employees, employers, population health, and society.[36] These programs can play important roles in supporting workplaces' adaptation to protect employees from COVID-19, while supporting physical activity and nutrition across a wide variety of settings.

Implementation Timeframe: Immediately

8 Worksite Wellness

Strengthen breastfeeding supports in the workplace and other settings, including anti-discrimination protections; strengthen breastfeeding protections at hospitals.

BEST PRACTICES

Evidence supports multiple positive impacts of breastfeeding on infant and maternal health, and robust breastfeeding policies and protections in the workplace are key to making it possible. Two of the national Healthy People 2020 initiative goals are focused on breastfeeding: increasing the proportion of infants who are breastfed at six months and infants who are breastfed exclusively through six months.[37]

While all states have laws specifically allowing women to breastfeed in any public or private location[38], there is substantial variation in protections offered in different settings, as well as variation in hospital practices and access to lactation support services, all of which influence

Community Support from Town Hall Survey

Workplace protections	Hospital and broader protections
73% STRONGLY SUPPORT	**71%** STRONGLY SUPPORT

[35, 36] Ron Goetzel, The Value of Workplace Health Promotion (Wellness) Programs, Health Affairs Blog, December 22, 2014

[37] "Breastfeeding State Laws," National Conference of State Legislatures, July 7, 2020. https://www.ncsl.org/research/health/breastfeeding-state-laws.aspx

[38] Del. Code Ann. tit. 31 § 310 (1997) entitles a mother to breastfeed her child in any location of a place of public accommodation wherein the mother is otherwise permitted.

breastfeeding rates. For example, New York created a Breastfeeding Mothers Bill of Rights to be posted in health care facilities. At least three states have specific requirements for childcare facilities: "Louisiana prohibits facilities from discriminating against breastfed babies. Mississippi requires licensed child care facilities to provide breastfeeding mothers with a sanitary place that is not a toilet stall to breastfeed their children or express milk, to provide a refrigerator to store expressed milk, to train staff in the safe and proper storage and handling of human milk, and to display breastfeeding promotion information to the clients of the facility. Maryland requires childcare centers to promote proper nutrition and developmentally appropriate practices by establishing training and policies promoting breastfeeding."[39]

Despite existing protections, parents who want to breastfeed may still face lack of accommodations in in the workplace or outright discrimination. Strengthening state-level protections is a first step to ensuring that barriers to breastfeeding are addressed. Newer state laws require more specificity from employers about their accommodations, including written policies and, for example, details of how lactation rooms must be equipped.

22% SOMEWHAT SUPPORT	18% SOMEWHAT SUPPORT

RATIONALE FOR POLICY RECOMMENDATION

Delaware has existing anti-discrimination protections but could examine opportunities to strengthen policies that influence breastfeeding initiation and continuation. The State should take further steps to understand the historical, structural, and societal barriers to breastfeeding that women face to better address them through policy. These range from workplace policies, to barriers in health care programs and settings, to historical trauma and structural racism.[40]

Many hospitals in Delaware have achieved Baby Friendly designation, but some may find it challenging to maintain high levels of compliance. **In addition, Delaware's peer and professional support pool has been found to lack diversity, hindering equity efforts.[41] Robust**

0% NEUTRAL	6% NEUTRAL

[39] "Breastfeeding State Laws," National Conference of State Legislatures, July 7, 2020. https://www.ncsl.org/research/health/breastfeeding-state-laws.aspx

[40] "Special Report: Applying a Racial Equity Lens to End Hunger," Bread for the World. Accessed 7/8/2020. https://www.bread.org/library/applying-racial-equity-lens-end-hunger

[41] "Improving Breastfeeding in Delaware: Creating Breastfeeding-Friendly Communities," Association of State and Territorial Health Officials, 2018. https://www.astho.org/Programs/Maternal-and-Child-Health/Documents/Improving-Breastfeeding-in-Delaware-Creating-Breastfeeding-Friendly-Communities/

requirements that cover all aspects of breastfeeding promotion and support with culturally and linguistically competent services are important to establish and maintain. Delaware's Pregnant Workers Fairness Act details the State's policy regarding workplace protections for breastfeeding.[42] "Employers must make reasonable accommodations for an employee's known limitations related to pregnancy, childbirth or related conditions, including the need to express breast milk, unless doing so would impose an undue hardship on the employer. Employers may not deny employment opportunities to a pregnant employee because of the need to provide a reasonable accommodation, require a pregnant employee to accept an accommodation, or force a pregnant employee to take leave if another reasonable accommodation can be provided. Employers must provide written notice of these rights to new and existing employees and to any employee who notifies the employer of a pregnancy. Employers must also conspicuously post notice of these rights in their place of business in an area accessible to employees. The law applies to employers with four or more employees and protects workers regardless of tenure and number of hours worked."[43] These protections could be strengthened with greater detail on how accommodations such as lactation rooms must be provided and equipped, and could include elements such as flexible work scheduling to accommodate breastfeeding, accommodations for pumping, and storage options for breastmilk. The Delaware Department of Health and Social Services has developed policies that could be considered for broader use. **Workplace circumstances and policies will likely continue to adapt to COVID-19, and breastfeeding accommodations should be carefully considered in the process because of their importance for mother and infant health, women's economic opportunities, and equitable workplaces.**	**0%** SOMEWHAT DO NOT SUPPORT **6%** STRONGLY DO NOT SUPPORT	**0%** SOMEWHAT DO NOT SUPPORT **6%** STRONGLY DO NOT SUPPORT

[42] Pregnant Workers Fairness Act (Senate Bill 212, enacted September 9, 2014).
[43] Summary of Delaware's Pregnant Workers Fairness Act, National Partnership for Women and Families. https://www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/reasonable-accommodations-for-pregnant-workers-state-laws.pdf

Implementation Timeframe: 1-2 years

9 Worksite Wellness

Create a formal workplace wellness program infrastructure for state employers. Encourage non-state employers to adopt workplace wellness program infrastructure.

BEST PRACTICES

According to Healthy People 2010, a comprehensive workplace health promotion program includes the following five elements:

1. Health education focused on skill development and lifestyle behavior change along with information dissemination and awareness building.
2. Supportive social and physical environments, reflecting the organization's expectations regarding healthy behaviors and implementing policies promoting healthy behaviors.
3. Integration of the worksite program into the organization's benefits, human resources infrastructure, and environmental health and safety initiatives.
4. Links between health promotion and related programs like employee assistance.
5. Screenings followed by counseling and education on how to best use medical services for necessary follow-up."

"Comprehensive health promotion programs are built on a culture of health that supports individuals' efforts at changing lifelong health habits by putting in place policies, programs, benefits, management, and environmental practices that intentionally motivate and sustain health improvement."[44]

RATIONALE FOR POLICY RECOMMENDATION

The impact of COVID-19 on workplaces has been profound, and worksite policies of all kinds will need to continue to adapt on an ongoing basis to support healthy lifestyles in post-COVID-19 world. Among them, an effectively designed worksite wellness policy can support health in many ways. The State is the largest public employer in Delaware. The State Employee Benefits Committee (SEBC) is the governing body that manages employee benefit coverage. The SEBC upholds the mission of the State Group Health Insurance Plan (GHIP) which is to "offer State of Delaware employees, retirees and their dependents adequate access to high quality health care that produces good

Community Support from Town Hall Survey

52%
STRONGLY SUPPORT

22%
SOMEWHAT SUPPORT

8%
NEUTRAL

8%
SOMEWHAT DO NOT SUPPORT

[44] Do Workplace Health Promotion (Wellness) Programs Work? Goetzel et al, Journal of Occupational and Environmental Medicine, August 2014. https://www.researchgate.net/profile/Ron_Goetzel/publication/265018065_Do_Workplace_Health_Promotion_Wellness_Programs_Work/links/5a31a589aca2727144a8dda5/Do-Workplace-Health-Promotion-Wellness-Programs-Work.pdf?origin=publication_detail

outcomes at an affordable cost, **promotes healthy lifestyles**, and helps them be engaged consumers." The State of Delaware Statewide Benefits Office (SBO), Department of Human Resources (DHR) is the "administrative arm" of the SEBC. Over time, the SBO has offered a variety of programs under the DelaWELL umbrella (2006 – 2020), which have involved various program designs, onsite screenings and events, incentive structures and requirements, cash incentives ($100 and $200), and health resources and tools, based on the feedback received from vendors and members. In the past, these efforts had relatively low participation and engagement, though they have grown. They have also seen positive results over the years (e.g., reduction in medical and lifestyle risk factors, disease management program savings, reduction in hospital admissions, etc.). SBO/DHR shared with the Subcommittee a draft of a comprehensive State of Delaware Workplace Wellness Policy for Executive Branch agencies. The policy recommendation is to build upon the existing draft by working with key stakeholders (i.e., Subcommittee members, leadership, organization Human Resource leads, DPH, State employees, etc.) to continue the development and implementation of the State of Delaware Workplace Wellness Policy. This policy could strengthen Delaware's worksite wellness offerings and provide a basis for public and private employers across the state to establish policies and programs. It should include: wellness policy for the state workforce; **language on equity to protect workers from inequitable impact**; reflect the CDC Worksite Wellness Toolkit; memorialize Delaware's recent healthy vending policies, healthier food and snack guidelines; and address behavioral health. State agencies could adopt the policy first, then expand by working with school districts, charter schools, and higher education (Delaware Technical Community College and Delaware State University) to adopt similar policies for their employees.

10%

STRONGLY
DO NOT SUPPORT

Policy Area 3: Community-Level Policies

The communities where people live, work, and play are among the most powerful drivers of health. These include access to healthy foods and physical activity. Research has found a link between built environments — all the human-made physical aspects of a community — and both physical activity and obesity. The odds of a child having obesity or being overweight increase by 20 to 60 percent if he or she lives in a neighborhood with unfavorable environmental aspects, such as poor housing, unsafe conditions, and no access to sidewalks, parks, or recreation centers.[45] Thoughtful community design and land use can encourage physical activity by providing safe and accessible sidewalks; investing in biking infrastructure, parks, and public transportation; and breaking down barriers to active commuting. Many aspects of communities and transit systems also play key roles in influencing access to healthy foods and eating habits.

Community-level policies must focus on health equity to effectively address discrimination against people due to race, ethnicity, income, ability, gender, sexual identity, and other attributes as well as all their impacts. Low-income communities and communities of color must be full partners in policy development and implementation.

The Trust for America's Health 2019 Community Policies and Programs recommendations highlight these key areas to support community health:[46]

- Street connectivity
- Sidewalk, bicycle, and trail infrastructure
- Transit access
- Mixed residential and commercial land use
- Park and recreational areas
- Safe routes to school
- Access to healthy foods.

Many state and local efforts exist in Delaware to increase access to healthy food and nutrition, as well as to make the built environment more supportive of health. Examples include:

- Mixed use development
- Increasing walkability, such as by improved sidewalks and crosswalks
- Improved access to public transportation
- Complete Streets
- Land Bank support to redistribute land that was unable to be sold, supporting basic clean-up of vacant lots in areas where there is high poverty, helping to beautify neighborhoods, create opportunities for community engagement, reduce crime, and enable access to those properties for urban gardening by small non-profits.

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[45] Gopal K. Singh, Mohammad Siahpush, and Michael D. Kogan. Neighborhood Socioeconomic Conditions, Built Environments, And Childhood Obesity. Health Affairs 2010 29:3, 503-512. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2009.0730

[46] Molly Warren, Stacy Beck, and Daphne Delgado. The State of Obesity: Better Policies for a Healthier America 2019. Trust for America's Health, September 2019. https://www.tfah.org/wp-content/uploads/2019/09/2019ObesityReportFINAL-1.pdf

In addition, Healthy Communities Delaware (HCD) is a new initiative to help coordinate activities and resources throughout Delaware to address the social determinants of health, including food, housing, income, and social justice and equity. It is critically important that funding that flows through these initiatives include mechanisms that enable less sophisticated grassroots organizations doing important work that addresses equity to garner resources or share needs even when they may not typically be able to tap into high-level government systems or funding opportunities. The following recommendations are intended to align with and build on Delaware's existing successful and promising policies and programs. **Community-level policies are particularly critical as part of the response to COVID-19 because they can help to address inequities deepened by the crisis, and promote community health, adaptation, and resilience.**

Implementation Timeframe: Immediately to 1 Year

10 Community Wellness

Strengthen the corner store intervention model via federal food assistance programs to increase access to and consumption of healthier food options, reduce food insecurity, and promote nutritious diets in targeted communities.

BEST PRACTICES

The Subcommittee identified a variety of strategies to increase access to affordable, healthy foods in corner stores. Maximizing access to and the positive health impact of the WIC food package and SNAP in corner stores is a nationally recognized best practice for corner store interventions, in addition to broader efforts to support corner stores to offer healthier foods without creating excessive burdens on small businesses that are important in their communities. [47]

The 2009 redesign of WIC food packages to better align with the U.S. Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics, led to increased availability of healthier foods and beverages in authorized WIC stores and improved dietary quality among families who enrolled in WIC. A 2019 CDC study found 41 U.S. states and territories show significant declines in obesity among children aged 2-4 years from low-income families enrolled in WIC between 2010-2016.[48]

Community Support from Town Hall Survey
(Strengthen corner store model via federal food assistance programs)

49%
STRONGLY SUPPORT

Community Support from Town Hall Survey
(Support infrastructure requirements to increase healthy food options in corner stores.)

43%
STRONGLY SUPPORT

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[47] Healthy Corner Stores: The State of the Movement. Public Health Law and Policy, ChangeLab Solutions, 2009. https://changelabsolutions.org/sites/default/files/documents/HCSReport.pdf

[48] Decline in Early Childhood Obesity in WIC Families, CDC, November 2019. https://www.cdc.gov/media/releases/2019/p1121-decline-childhood-obesity-wic-families.html

Many corner stores typically do not supply the full range of foods and beverages necessary to build a healthy diet.[49] Encouraging and supporting the infrastructure of corner stores to stock and sell healthier foods and beverages is another effective strategy to improve health and help prevent childhood obesity. According to the United States Department of Agriculture (USDA), the most successful programs are multi-dimensional and comprehensive and involve approaches that target the internal, in-store environment and the external community environment. Some common elements of successful healthy corner store programs include:

- Partnerships
- Incentives
- Educating Consumers
- Inventory Improvements
- Training and Technical Assistance
- Marketing
- Funding.

An example of a healthy corner store program is the national Healthy Corner Stores Network, originally founded by The Food Trust in partnership with ChangeLab Solutions and Urbane Development. This initiative supports efforts to increase the availability of healthy, affordable foods through small-scale stores in underserved communities across the country. Evaluation by The Food Trust and Econsult Corporation has shown that corner stores in Philadelphia that introduced healthier produce to store shelves have resulted in healthier choices, healthier businesses, and healthier communities.[50] Among other examples, the Baltimore Healthy Stores project developed strategies to increase access to a nutritionally adequate diet, improve food security, and reduce the risk of diet-related chronic diseases. It includes five phases introducing and promoting foods in stores: healthy eating for kids, healthy cooking habits, healthy snacks, carry-out foods, and low-calorie drinks. Incentives for store owners included shelf labels, posters, in-store nutrition and cooking workshops, customer coupons, and a voucher for wholesale orders of healthy food items.[51] It is led by a research team from the Johns Hopkins Bloomberg School of Public Health in partnership with the Baltimore City Health Department and interested community organizations.[52]

24% SOMEWHAT SUPPORT	**39%** SOMEWHAT SUPPORT
0% NEUTRAL	**4%** NEUTRAL
16% SOMEWHAT DO NOT SUPPORT	**4%** SOMEWHAT DO NOT SUPPORT
12% STRONGLY DO NOT SUPPORT	**10%** STRONGLY DO NOT SUPPORT

[49] Healthy Corner Stores, Making Corner Stores Healthier Places to Shop, United States Department of Agriculture, June 2016, https://snaped.fns.usda.gov/sites/default/files/resourcefinder/Healthy-Corners-Stores-Guide.pdf
[50] "The National Healthy Corner Stores Network," The Food Trust. Accessed 7/8/2020. http://thefoodtrust.org/administrative/healthy-corner-stores-network
[51] Healthy Corner Stores: Making Corner Stores Healthier Places to Shop. United States Department of Agriculture's (USDA) Food and Nutrition Service's (FNS) Supplemental Nutrition Assistance Program (SNAP), June 2016. https://snaped.fns.usda.gov/sites/default/files/resourcefinder/Healthy-Corners-Stores-Guide.pdf
[52] "Baltimore Healthy Stores," Healthy Food Systems. Accessed 7/8/2020. https://healthyfoodsystems.net/previous-projects/baltimore-healthy-stores/

RATIONALE FOR POLICY RECOMMENDATION

Corner stores are more prevalent in low income communities and are less likely to offer fresh produce, whole grains, and low-fat dairy products than grocery stores. Delaware has a wide variety of corner store-related efforts, including local pilots to support infrastructure development. These could be strengthened in a variety of ways, including:

- Infrastructure improvements, including façade, refrigeration (energy efficiency) and signage
- Expand upon local pilots to support infrastructure development for distribution of produce, local food, especially in season
- Establishing local, community infrastructure for the work
- Coordinating and expanding efforts beyond the Department of Agriculture into Health, Community Economic Development, and potentially in partnership with health care providers.
- Focus on Healthy Community Economic Development.

Initially, the Subcommittee developed two separate recommendations addressing corner store requirements and the use of federal programs to strengthen them. This recommendation consolidates them under the broader umbrella of enhanced support for corner stores.

Federal food assistance programs like WIC and SNAP are important parts of such an approach. WIC helps to establish successful long-term breastfeeding, provides participants with a wider variety of food, and offers WIC state agencies greater flexibility in prescribing food packages to adapt to participants with cultural food preferences. Corner stores already accept SNAP, but further efforts to help corner stores make more healthy food options available to users of SNAP would be valuable.

Nutrition initiatives such as targeted projects for SNAP authorized-retailer incentive programs for SNAP benefits when used on fruits and vegetables offer a full or partial financial match of SNAP benefits spent on purchasing eligible fruits and vegetables, helping to make them more affordable.

Support for corner stores to expand access to WIC food packages and otherwise offer healthier food options that are affordable supports health equity by expanding the range of foods available to people with limited other options for grocery shopping, supports local retail capacity, and can help strengthen community development efforts. Corner stores tend to have higher prices than some other retail options, making policies that increase affordability through WIC and SNAP particularly critical. These efforts support greater food security in a time when it is threatened by the economic impact of the COVID-19 crisis.

Implementation Timeframe: 3+ years

11 Community Wellness

Create a financing mechanism to support Healthy Communities Delaware.

BEST PRACTICES

Healthy Communities Delaware (HCD) is an initiative to help coordinate activities and resources throughout Delaware to address the social determinants of health, including food, housing, income, and social justice and equity. HCD includes representatives of 30 Delaware organizations addressing health issues and received an initial investment of $500,000 from the state.[53] As HCD details in its guiding principles, "the roots of poor health and poverty are complex. A siloed approach is inefficient and ineffective. To be successful, work must intentionally engage multiple sectors to improve the health and well-being of individuals, families, and communities."[54] Numerous financing mechanisms to support multi-sectoral, community priority-driven health consortia exist across the country.

RATIONALE FOR POLICY RECOMMENDATION

Creating a financing mechanism for HCD would be a valuable opportunity to contribute to multisectoral efforts to support healthy lifestyles. **If policy recommendations such as a sugar-sweetened beverage tax (Recommendation 14) are implemented, the resulting revenue would likely be very substantial and could be directed into HCD through a variety of mechanisms in order to support community-based efforts to address the social determinants of health and promote equity in ongoing, sustainable ways. This would also be an opportunity for state-level policy changes to result in concrete support of programs and organizations working at the most local levels, helping to address inequities that are worsened by the COVID-19 crisis and that require long-term support to close.**

Community Support from Town Hall Survey

53%
STRONGLY SUPPORT

14%
SOMEWHAT SUPPORT

14%
NEUTRAL

8%
SOMEWHAT DO NOT SUPPORT

12%
STRONGLY DO NOT SUPPORT

[53] Healthy Communities Delaware, Delaware Community Foundation. https://www.delcf.org/community/hcd/#:~:text=HCD%20is%20an%20initiative%20to,and%20social%20justice%20and%20equity.

[54] Healthy Communities Delaware, Delaware Community Foundation. https://healthycommunitiesde.org/about-us

Implementation Timeframe: 1-2 years

12 Community Wellness
Expand reach of SNAP-Ed-like programming to low-income Delawareans.

BEST PRACTICES

States have the option to provide nutrition education to SNAP recipients through SNAP-Ed activities that occur within a state as outlined in an approved SNAP-Ed Plan. SNAP-Ed is an important opportunity for nutrition education that can shape the health of families and communities, providing information, strategies, and support for healthy lifestyles.

Implementing agencies contract with state agencies to provide SNAP-Ed and include Cooperative Extension offices, universities, state departments of health or education, state-level nutrition networks, food banks, and other organizations. The Delaware Department of Health and Social Services administers SNAP-Ed through the University of Delaware Cooperative Extension. Delaware's SNAP-Ed plan for 2020 stated that the program "will strive to use evidence-based nutrition education and PSE interventions to improve the health behaviors of low-income Delawareans that affect priority issues including obesity, mental health, and chronic disease."[55]

RATIONALE FOR POLICY RECOMMENDATION

Like other policies supporting access to nutritious food, these efforts can be part of State efforts to support low-income families in a time when food insecurity has rapidly increased, while acknowledging that individual-level interventions have limited potential to address structural drivers of food insecurity. Expanding access to SNAP-Ed and similar programming to broaden its reach, enable interactions across sectors, and reduce administrative burden would help support more equitable access to information about food and nutrition, in turn supporting health equity. Potential policies could include options for a public/private fund to support nutrition education and related experiential programming, targeted toward areas of greatest need.

Community Support from Town Hall Survey

39%
STRONGLY SUPPORT

33%
SOMEWHAT SUPPORT

12%
NEUTRAL

8%
SOMEWHAT DO NOT SUPPORT

8%
STRONGLY DO NOT SUPPORT

[55] Fiscal Year 2020 Delaware Supplemental Nutrition Assistance Program Education (SNAP-Ed) Needs Assessment. University of Delaware. https://www.udel.edu/content/dam/udelImages/canr/pdfs/extension/nutrition-wellness/delaware-snap/FY2020-SNAP-Ed-Needs-Assessment.pdf

Implementation Timeframe: 1-3+ years

13

Community Wellness

Explore model policies for reducing consumption of sugar-sweetened beverages (SSBs), including warning labels, counter-marketing, SSB taxes, and/or bans on SSB marketing on/near schools.

BEST PRACTICES

SSBs, the single largest source of added dietary sugars nationwide, are associated with increased rates of early mortality, cardiovascular disease, diabetes, and obesity.[56] Well-designed SSB taxes and other policies with similar goals, particularly when used together, can lead to reduced sugar consumption.[57]

While no state currently taxes sweetened beverages, seven localities do: Albany, Berkeley, Boulder, Oakland, San Francisco, Seattle, and Philadelphia.[58] These are excise taxes that target the manufacturers and distributors of SSBs, with the expectation that much or all of the tax is passed on to customers. Sales taxes are typically smaller, are added at the point of purchase, and are likely to have smaller effects on consumer behavior. SNAP enrollees are exempt from sales tax on food and beverages, limiting their impact. Most cities direct their revenue from SSBs to a general fund and subsequently into public health initiatives. **It is critical that development and implementation of any SSB policy or regressive consumption tax include the consumers who would be most impacted by it so its impact can be measured on equity.** Options to address this include allocating revenue from an SSB tax to a funding mechanism or governance body that supports equity and social, environmental, and health justice (e.g. through Healthy Communities Delaware).

Separately, health warning labels have proven effective in influencing tobacco and alcohol consumption, and a number of states have introduced legislation to establish them for SSBs.[59] Counter-marketing on the health effects of SSBs, banning SSB marketing in or near schools, and other steps can help address the inequitable impact of SSB advertising, which is disproportionately targeted to lower-income communities and communities of color.[60]

Community Support from Town Hall Survey

51%

STRONGLY SUPPORT

24%

SOMEWHAT SUPPORT

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[56] Madsen KA, Krieger J, Morales X. Sugar-Sweetened Beverage Taxes: Emerging Evidence on a New Public Health Policy. JAMA. 2019;321(18):1777-1779. doi:10.1001/jama.2019.5344 and Malik VS, Li Y, Pan A, et al. Long-Term Consumption of Sugar-Sweetened and Artificially Sweetened Beverages and Risk of Mortality in US Adults. Circulation. 2019.

[57] Madsen KA, Krieger J, Morales X. Sugar-Sweetened Beverage Taxes: Emerging Evidence on a New Public Health Policy. JAMA. 2019;321(18):1777-1779. doi:10.1001/jama.2019.5344

[58] Kristin Sukys, Policy Analyst, CHLPI Healthy Lifestyles Subcommittee Webinar March 24th, 2020.

[59] States include California, New York, Baltimore, Washington and Hawaii. ChangeLab Solutions has model legislation for requiring safety warnings for sugary drinks and other resources.

[60] Madsen KA, Krieger J, Morales X. Sugar-Sweetened Beverage Taxes: Emerging Evidence on a New Public Health Policy. JAMA. 2019;321(18):1777–1779. doi:10.1001/jama.2019.5344 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6822675/

In addition, schools that participate in the National School Lunch and Breakfast Program can only market foods on school property that meet USDA Smart Snacks nutrition standards, which states can strengthen by applying them to all schools or expanding the scope of the restrictions. Delaware could emulate other states such as Rhode Island by expanding the policy to all schools. Additionally, Delaware could examine strengthening the Federal standards.

RATIONALE FOR POLICY RECOMMENDATION

Almost a third of Delaware children age 10-17 are at an unhealthy weight—either overweight or obese. According to the Centers for Medicare and Medicaid Services, health care costs in Delaware-per capita are more than 27 percent above the U.S. average, ranking the state third highest in the country behind only Alaska and Massachusetts. Research supports that overweight and obesity are risk factors for at least 13 types of cancer, including breast, colorectal, liver, gallbladder, pancreatic, stomach, kidney, thyroid and ovarian cancer. Exploring these types of policies would address the parallel challenges of chronic disease and growing health care costs. Delaware is ranked 3rd in health care spending, yet 31st in overall health outcomes, much of which are driven by the impact of diet, nutrition, and physical inactivity.

The Public Health Law Center notes that "Several policy and legal strategies are available to reduce the consumption of sugary drinks, including healthy food purchasing and vending policies in schools and workplaces, government ordinances that restrict the sale of unhealthy beverages on public property, restrictions on the sale of these beverages in schools, and increasing the price of these unhealthy beverages through taxes or other pricing policies."[61] Delaware should consider steps to implement a variety of policies that discourage excessive sugar consumption and address the inequitable impact of SSB advertising. The combination of a decline in sugary drink consumption from an SSB tax or other SSB policy and the use of the tax revenue to fund programs aimed at reducing nutrition related chronic health conditions could result in a substantial improvement in the health of Delawareans.

6%

NEUTRAL

6%

SOMEWHAT
DO NOT SUPPORT

14%

STRONGLY
DO NOT SUPPORT

[61] "Sugar Sweetened Beverages," Public Health Law Center. Accessed 7/8/2020. https://www.publichealthlawcenter.org/topics/healthy-eating/sugar-sweetened-beverages

Implementation Timeframe: 1-2 years

14 Community Wellness

Strengthen and enhance Delaware's Complete Streets policy to support DelDOT's work building active, accessible transportation.

BEST PRACTICES

Complete Streets policies "promote mobility and physical activity for people of all ages, abilities, and income levels. Complete Streets facilitate many forms of transportation, including walking, bicycling, taking public transit, and driving. Over 1,400 U.S. cities, regions, and states have implemented Complete Streets policies," including Delaware. Complete Streets is an evidence-based approach to supporting healthier, more equitable communities. Benefits include "reduced traffic and fewer traffic collisions, more active living and exercise opportunities, and better air quality for surrounding neighborhoods. Complete Streets also increase economic opportunity by improving access to local institutions and businesses through alternate modes of transportation. And Complete Streets policies can help address infrastructure and investment disparities in underserved communities."[62]

RATIONALE FOR POLICY RECOMMENDATION

Delaware has a solid planning framework and track record of success in addressing many of these issues, including through a Complete Streets policy. Delaware is unique in that State government provides many services and infrastructure needs throughout the state. The statewide plan guides policies and spending, including on priorities such as Complete Streets. Its core principles include compact development, and healthy communities are a policy focus. This framework has been built over the past 20 years, with a great deal of intergovernmental coordination. This framework can be used as a springboard for new programs and healthy community planning strategies. Many planning strategies for healthy communities work best in denser urban, suburban, and small town areas. However, most of Delaware's population (70% +/-) lives in lower density suburban or rural areas. Some different and innovative approaches will be needed to address healthy community development in these areas.

While Delaware's implementation of Complete Streets has been strong, areas to examine for further potential enhancements include expansion of active transportation options:

- Encourage local municipalities to adopt bicycle parking requirement in their local land use ordinance/development review guideline.
- Encourage local municipalities to adopt bicycle/pedestrian facilities related provision in their local land use ordinance/development review guideline.

Community Support from Town Hall Survey

67% STRONGLY SUPPORT

14% SOMEWHAT SUPPORT

10% NEUTRAL

2% SOMEWHAT DO NOT SUPPORT

8% STRONGLY DO NOT SUPPORT

[62] "Complete Streets Policies at the Local Level," ChangeLab Solutions. Accessed 7/8/2020. https://www.changelabsolutions.org/product/complete-streets-policies-local-level

- Encourage local municipalities to assess their bicycle and pedestrian facilities as a part of their Comprehensive Plan development process.

As part of the recovery from COVID-19, there will be significant need for creativity and innovation around transportation and the built environment, to protect health and ensure that people can safely carry out their daily lives. **This will be a critical area for promoting health equity by making transit, safe outdoor recreation, and active transportation accessible, including consideration for any ongoing COVID-19 restrictions.**

Future Considerations

In the course of Subcommittee discussions, a variety of considerations and ideas for future consideration emerged. These included:

Policy Area 1: Ages 0-18

- Expanding access to high quality Pre-K/Head Start/Early Head Start focusing particularly on these aspects:
    - Resources that support Quality Rating and Improvement Systems as a tool to monitor and implement healthy eating and physical activity (HEPA) standards.
- Prioritizing funding for dedicated technical assistance and grant opportunities for early childhood care and education providers and schools operating in or serving socially or economically disadvantaged communities to adopt and implement nutrition, active play, and screen time standards.
- Requiring early childhood care and education settings to provide foods appropriate to children's cultural and religious backgrounds, which might be best supported through technical assistance and resources rather than an overall recommendation.
- Ensuring availability and accessibility of water in schools.
- Extending Purchase of Care past age 13 (e.g., for 13-16 year-olds if possible) to allow younger teens to be in out-of-school programming such as Boys and Girls Clubs.

Policy Area 2: Worksite Wellness

- Establishing paid sick leave and other family-friendly policies (e.g., telecommuting, paid parental leave). For example, State and Federal policies have been implemented to provide emergency sick leave during the COVID-19 crisis; these could be made permanent.

Policy Area 3: Community Wellness

- Raising the minimum wage to decrease inequality, a driver of health inequities.
- Pursuing bike and pedestrian capital projects and bond bill appropriations.
- Pursuing Safe Routes to Schools funding (state level support and focus).

Implementation and Sustainability Approach

DPH, like the rest of the nation, is concerned with Delaware's most vulnerable populations such as older adults, people of color and those with complex medical, behavioral health and social needs, and is working on emerging policies, systems and environmental change strategies to improve health outcomes in the midst of the COVID-19 pandemic. As staff support to the Delaware Cancer Consortium, DPH will remain committed to supporting the implementation and sustainability of the work of the Healthy Lifestyles Subcommittee under the guidance of the Cancer Risk Reduction Committee. This work is directly aligned with the foundational pillars of our strategic priorities. We recognize the synergy between this effort and Healthy Communities Delaware, which promotes evidence-based implementation of strategies to support addressing social determinants of health. These efforts can also be aligned with the Culture of Health framework developed by the Robert Wood Johnson Foundation, on which DPH already relies. A Culture of Health is defined as "one in which good health and well-being flourish across geographic, demographic, and social sectors; fostering healthy equitable communities guides public and private decision making; and everyone has the opportunity to make choices that lead to healthy lifestyles."[63] Delaware's *Health Equity Guide for Public Health Practitioners and Partners* offers approaches and tools to support equitable policy implementation and realize the goals of a Culture of Health. Key steps and considerations include:

- Developing a comprehensive approach across all branches of government to ensure successful implementation and sustainability of this effort
- Identifying and assigning potential roles in state government, including in the Executive Branch, Legislature, and partner organizations
- Analyzing the fiscal implications of these policy recommendations, as well as how they could fit into Delaware's COVID-19 response in the short and long term
- Ensuring considerations for statewide management of COVID-19.

Evidence-based policymaking frameworks such as the one defined by the Pew Charitable Trusts (Figure 4) can offer a framework to guide these efforts, using the following steps and key questions that flow from them[64]:

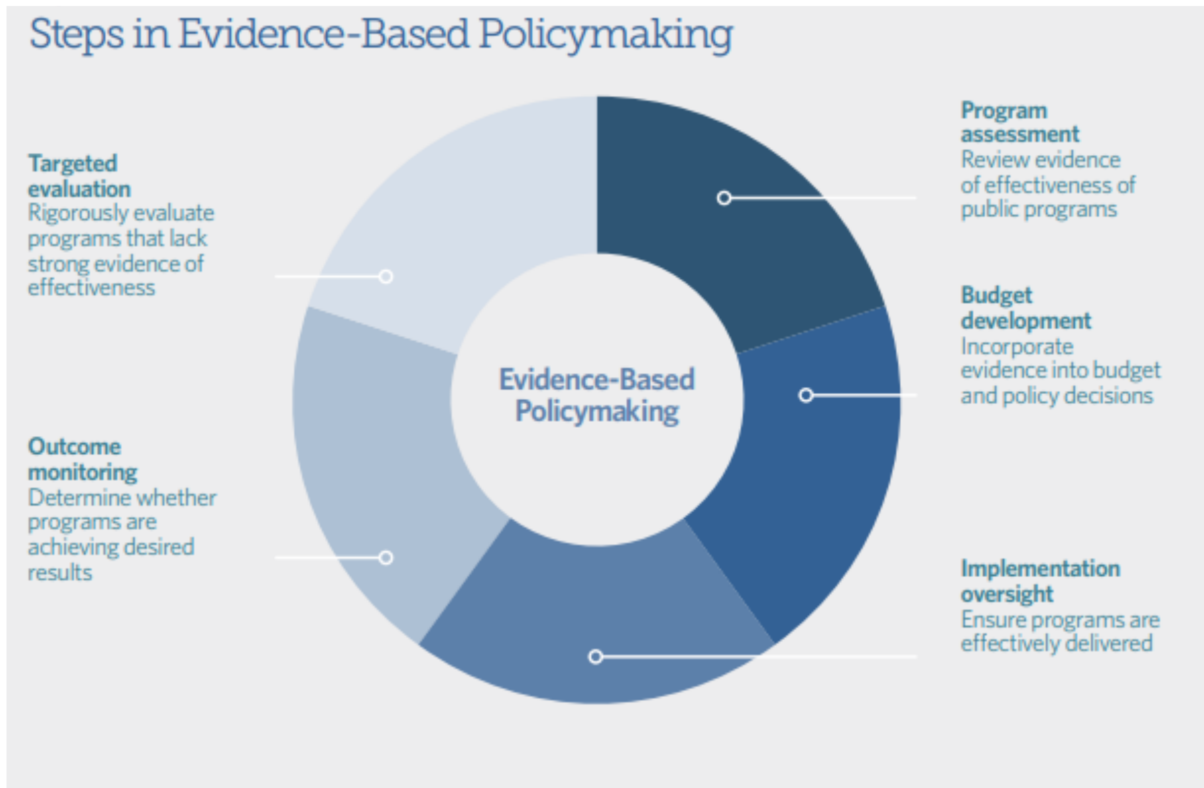
1. Program/Policy assessment (Do we need a cost-benefit analysis to understand return on investment of the policies? What do the evidence base and state experiences suggest about outcomes? How effective has a given policy been in achieving intended goals?)
2. Budget development (Is the current policy/program working? Do the benefits outweigh the costs? How does the policy/program compare to alternative programs?)

[63] "What is a Culture of Health?" Evidence for Action, a program of the Robert Wood Johnson Foundation administered by the University of California, San Francisco. Accessed 7/8/2020. https://www.evidenceforaction.org/what-culture-health#:~:text=A%20Culture%20of%20Health%20is,that%20lead%20to%20healthy%20lifestyles.

[64] The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, *Evidence-Based Policymaking: A guide for effective government*. Washington, DC and Chicago, IL, November 2014. Accessed December 4, 2020. https://www.pewtrusts.org/~/media/assets/2014/11/evidencebasedpolicymakingaguideforeffectivegovernment.pdf

3. Implementation oversight (Is the program operating with fidelity? Are we conducting data-driven performance management to refine performance objectives, promote innovative strategies and foster cross-sector collaboration? Are success indicators needed to ensure performance?)
4. Outcome monitoring (Do we have meaningful/desired outcome measures defined? How are we messaging this to partners and key decision makers?)

Figure 4. Steps in Evidence-Based Policymaking



Source: The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, Evidence-Based Policymaking: A guide for effective government, 2014.

5. Targeted evaluation (How do we leverage available resources for evaluation? Should we identify high-priority programs for evaluation based on administrations top priorities? Can evaluations be linked to requirements for future funding? What is the most appropriate central repository for these evaluations?)

Ensuring Robust Evaluation

As noted above, robust evaluation is critical to understanding the impact of policies resulting from these recommendations, including policies on equity. The Subcommittee has discussed potential collaboration with national experts to evaluate implementation of these policies. This research should be community-engaged and focused on the needs of Delawareans. The impact of COVID-19 and recovery from it will be the context for implementation and evaluation of these efforts, which will need to respond and adapt to changing circumstances across the State. A Plan, Do, See, Act approach that is responsive to these changing needs and realities will be necessary to guide policies influencing healthy lifestyles in the months and years ahead.

Strategic and Implementation Planning Process

Potential next steps to structure the strategic and implementation planning process include:

Strategic and Implementation Plan Development

The strategic plan will provide more details about the specifics of what will be done and how it will be done. Its development may include:

- Conversations with small groups of experts from the Subcommittee and elsewhere to identify any specifics that are not already outlined, including political considerations
- For each policy, strategic questions include:
    - What policy or agency(ies) govern this policy?
    - Does it require legislation?
    - Are there additional entities/organizations/people that need to be involved, weigh in, provide support?
    - Do we need cost analyses?
    - What strategic considerations are most important for making this reality? What barriers will need to be overcome?

This stage of the process will draw from previous research on best practices for implementation of similar policies and identify additional evidence as appropriate. The strategic plan will still be relatively high-level but will include more detail than the recommendations document about the strategy for implementation.

As a separate document or part of the strategic plan, the implementation plan will specifically detail:

- Resources needed (staff time, leadership support, money, facilities, legislation)
- Where: specific locations, county wide, statewide?
- When: what will the specific prep and roll out look like?
- Who: what agencies, organizations, and/or individuals will lead and participate in implementation?
- How: what are the specific steps, timelines, and milestones?

Information will be gathered via:

- Conversations with experts from the Subcommittee and personnel who might be responsible for implementing to start to flesh out steps, costs, resource needs, and timelines
- Possible fiscal note/financial analyses using review existing studies on similar programs (i.e., return on investment or cost benefit studies) to estimate costs and possible scope, possible revenue or savings that could result.

The timing and specific process of developing these plans will be determined by the participating agencies. See Table 3.

Implementation Roadmap – Subcommittee Recommendations

Table 3

<table>
<tr><th>IMMEDIATELY</th><th>YEAR 1</th><th>YEAR 2</th><th>YEAR 3</th><th>YEAR 4</th><th>YEAR 5+</th></tr>
<tr><td colspan="6">Endorse a health equity lens across all policies; implement using Health in All Policies approach</td></tr>
<tr><td>Preserve robust school nutrition standards, as defined in the 2010 USDA nutrition guidelines for school lunches and maintain flexible, healthy standards for sodium, whole grains and milk.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Strengthen breastfeeding supports, including anti-discrimination protections.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Enhance DELACARE Regulations across childcare and education settings.</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Prohibit sugar-sweetened beverages in Early Childhood Care and Education Centers.</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Enhanced fitness assessment implementation, reporting and compliance in schools.</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Develop out-of-school nutrition regulations (before-school, after-school, sports).</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Establish physical activity/education time requirements in schools.</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Strengthen the corner store intervention model via federal food assistance programs; enhance infrastructure support for corner stores</td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Create comprehensive State of Delaware Workplace Wellness policy.</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">Expand SNAP-Ed-like programming to reach more low-income Delawareans.</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td colspan="3">Create additional financing mechanism to support Healthy Communities Delaware if other policies generate revenue.</td></tr>
<tr><td></td><td></td><td colspan="3">Explore sugar-sweetened beverage tax/related policies.</td><td></td></tr>
<tr><td></td><td colspan="2">Enhance Delaware's Complete Streets policy to support DelDOT's work building active, accessible transportation.</td><td></td><td></td><td></td></tr>
</table>

Appendix A. Healthy Lifestyles Subcommittee Members

Healthy Lifestyles Subcommittee of the Cancer Risk Reduction Committee

Co-Chairs

The Honorable Bethany Hall-Long, RNC, PhD, Lieutenant Governor, State of Delaware

Karyl T. Rattay, MD, MS, FAAP, Director, Division of Public Health, Delaware Department of Health and Social Services

Members

Joe Bryant	(Ex-Officio Member) Policy Advisor, Office of the Governor
Christine Alois	Deputy Secretary, Delaware Department of Education
Faith Rentz (represented by Aaron Schrader)	Director of Statewide Benefits and Insurance Coverage, Delaware Department of Human Resources
Jonathan Kirch	Director, Government Relations, American Heart Association
Jeanne Chiquoine	Director, Delaware Government Relations, American Cancer Society Action Network (ACS CAN)
Deborah P. Brown	Chief Mission Officer, American Lung Association
Steve Groff (represented by Liz Brown)	Director, Division of Medicaid and Medical Assistance, Delaware Health and Social Services (DHSS)
David Edgell	Chair, Delaware Council on Farm and Food Policy; and Principal Planner, Delaware Office of State Planning Coordination, Office of Management and Budget
Elizabeth Romero (represented by Dana Carr)	Director, Division of Substance Abuse and Mental Health, DHSS
Allison Karpyn	Acting Director, University of Delaware, Center for Research in Education & Social Policy; and Associate Professor of Human Development and Family Studies
Josette DelleDonne Manning (represented by Meredith Seitz)	Secretary, Delaware Department of Services for Children, Youth and Their Families