GOALS STRATEGIES & OBJECTIVES

The goals, strategies and objectives in this section were selected as a means to achieve a positive impact on key health behaviors. Movement on those key behaviors will be tracked by a set of high-level indicators that measure the behaviors as well as the overall goal of decreasing the number of overweight and obese people in Wisconsin. The indicators below were selected based on their relevance to the measured behavior and the availability of data that can be tracked over the next several years. The targets were set using a 10% improvement methodology, similar to Healthy People 2020.

State Plan 2020 outcome indicators

- By 2020, decrease the percentage of adults who are obese from 27.7% to 24.9%.[1]
- By 2020, increase the percentage of adults who are at a healthy weight (neither overweight nor obese) from 36.0% to 39.6%.[1]
- By 2020, decrease the percentage of high school youth who are overweight or obese from 25.3% to 22.8%.[2]
- By 2020, decrease the percentage of children 2-4 years old participating in the WIC Program who are overweight or obese from 30.6% to 27.5%.[3]

State Plan outcome indicators for behavioral factors

Breastfeeding

- By 2020, increase the percentage of infants ever breastfed from 81.3% to 89.4%.[4]
- By 2020, increase the percentage of infants exclusively breastfed for at least 3 months from 31.4% to 34.5%.[4]
- By 2020, increase the percentage of infants breastfed at least 6 months from 48.7% to 53.6%.[4]
- By 2020, increase the percentage of infants breastfed at least 12 months from 21.9% to 24.1%.[4]

Fruit and Vegetable Consumption

- By 2020, increase the percentage of adults who consume fruits 2 or more times per day from 35% to 38.5% and the percentage of adults who consume vegetables 3 or more times per day from 23.3% to 26.6%.[5]
- By 2020, increase the percentage of adults who consume fruits and vegetables 5 or more times per day from 22.7% to 25%.[5]
- By 2020, increase the percentage of high school youth who consume fruits 2 or more times per day from 32.9% to 36.2% and the percentage of high school youth who consume vegetables 3 or more times per day from 12.7% to 14.0%.[2]

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[1] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011

[2] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System, 2011

[3] Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System, 2011

[4] Centers for Disease Control and Prevention, Breastfeeding Report Card, 2012

[5] Centers for Disease Control and Prevention, State Indicator Report on Fruits and Vegetables, 2009

Physical Activity

- By 2020, increase the percentage of adults who are moderately-vigorously active for at least 150 minutes each week from 57.4% to 63.1%.[1]
- By 2020, increase the percentage of adults who participated in physical activity in the past month from 77.3% to 85.0%.[1]
- By 2020, increase the percentage of high school youth who are moderately-vigorously active for at least 60 minutes, all 7 days per week from 27.7% to 29.4%.[2]
- By 2020, increase the percentage of high school youth who are moderately-vigorously active for at least 60 minutes, at least 5 days per week from 51.6% to 56.8%.[2]
- By 2020, decrease the percentage of high school youth not participating in at least 60 minutes of physical activity on any day in the past week from 11.8% to 10.6%.[2]

Television Viewing

- By 2020, decrease the percentage of high school youth who watched 3 or more hours of television per day from 24.0% to 21.6%.[2]
- By 2020, decrease the percentage of high school youth who play video or computer games for 3 or more hours per day from 23.3% to 21.0%.[2]
- By 2020, decrease the percentage of children 2-4 years participating in the WIC Program who watch more than 2 hours of television or video per day from 17.0% to 15.3%.[3]

Data will also be analyzed by sub-populations as available to identify potential disparities and monitor progress on targeted interventions.

implementation period

The overarching goals of this plan align with the Healthiest Wisconsin 2020 plan. However, because it is difficult to project out more than five years, the specific strategies and objectives that make up the majority of the plan have a five-year window out through 2018. Progress on the State Plan objectives will be regularly monitored and adjustments made, as needed, through the 2013-2018 implementation window. In 2018, the State Plan will be revised to reflect the current evidence and landscape and new strategies and objectives will be developed for the remaining years to 2020.

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[1] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011

[2] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System, 2011

[3] Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System, 2011

[4] Centers for Disease Control and Prevention, Breastfeeding Report Card, 2012

[5] Centers for Disease Control and Prevention, State Indicator Report on Fruits and Vegetables, 2009

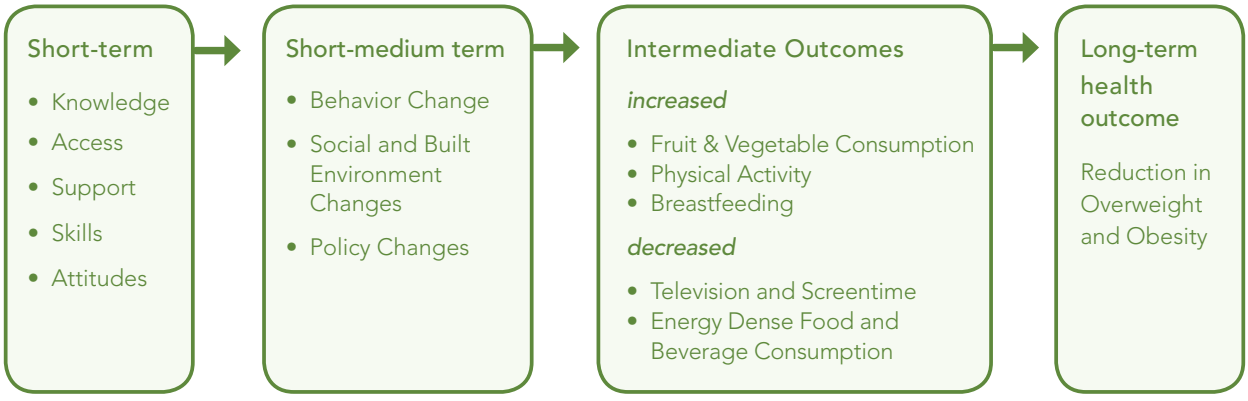
strength of evidence

Determining the Strength of Evidence for State Plan Strategies

The target audience for the State Plan is partners throughout the state working on improving nutrition, increasing physical activity and preventing and reducing overweight and obesity. The State Plan encourages partners to assess the needs in their community, organization or group as an initial planning step. After the assessment is completed, the results should be shared widely and the stakeholders engaged in prioritizing a strategy or multiple strategies for implementation. The strategy selection process should include criteria such as feasibility, reach and impact, available resources, public and leadership support, ability to reduce disparities and strength of evidence.

During the development of the Nutrition, Physical Activity and Obesity State Plan, goals, strategies and objectives were selected based on the above criteria. For each strategy in the plan, the strength of evidence was determined for its ability to either increase breastfeeding, improve nutrition or increase physical activity, and its ability to reduce obesity. This information has been provided for each intervention strategy listed in the following sections for the user of the State Plan to assist with selecting priority strategies for local implementation. The full evidence table is in the Appendix and will be periodically updated, as new evidence is available. However, it is important to recognize that obesity prevention is still relatively new, and in many cases, the scientific literature is lagging. Also, the review focused primarily on statistical significance and not clinical significance. Strategies that have some evidence or have limited evidence supported by expert opinion may still merit consideration. and by doing so can contribute to the field through practice-based evidence.

While decreasing obesity is the ultimate goal, it is also important to effectively impact the target behaviors (increase breastfeeding, fruit and vegetable consumption and physical activity and decrease energy dense food and beverage consumption). The underlying theory is that the short-term outcomes are more process oriented and will affect access, knowledge, attitudes, skills and support, which in turn will lead to sustainable behavioral, and environmental and policy changes, leading to improvements in healthful eating and increased physical activity, which will lead to stabilization and reduction of overweight and obesity. The strategies were selected to flow along this path. Implementation of multiple strategies in multiple settings is needed to have the population level impact on rates of obesity.



Strength of Evidence Rating Scale and Criteria

The University of Wisconsin Population Health Institute recently released a revised, online version of What Works for Health, www.countyhealthrankings.org/programs as part of the County Health Rankings & Roadmaps project. The strength of evidence rating and criteria used for the Nutrition, Physical Activity and Obesity Program was adapted from this resource and is noted below.

RATING	EVIDENCE CRITERIA	QUALITY OF EVIDENCE
Scientifically Supported	1 or more systematic review(s), or 3 experimental or quasi-experimental studies, or 6 descriptive studies	Studies have strong design, statistically significant positive finding(s), large magnitude of effect(s).
Some Evidence	1 or more review(s), or 2 experimental or quasi-experimental studies, or 3-5 descriptive studies	Compared to "scientifically supported," studies have less rigorous design, smaller magnitude of effect(s), effects may fade over time, statistically significant positive finding(s), overall evidence trends positive.
Limited Evidence, Supported by Expert Opinion	Varies, generally less than 3 studies of any type	Body of evidence less than "some evidence," recommendation supported by logic, limited study, methods supporting recommendation unclear. Expert Opinion: Recommended by credible groups; research evidence limited. Credible groups are recognized for their impartial expertise in an area of interest. Further study may be warranted.
Insufficient Evidence	1 experimental or quasi-experimental study, or 2 or fewer descriptive studies	Varies, generally lower quality studies.
Mixed Evidence	Two or more studies of any type	Body of evidence inconclusive, body of evidence leaning negative.
Evidence of Ineffectiveness	1 or more systematic review(s), or 3 experimental or quasi-experimental studies, or 6 descriptive studies	Studies have strong design, significant negative or ineffective finding(s), or strong evidence of harm.