CHOICES NATIONAL ACTION KIT:

Policy to Reduce TV Time in Early Care and Education Settings Strategy Report

CHOICES uses cost-effectiveness analysis to compare the costs and outcomes of different policies and programs promoting improved nutrition or increased physical activity in schools, early care and education and out-of-school settings, communities, and clinics. This strategy report describes the projected national population reach, impact on health and health equity, implementation costs, and cost-effectiveness for an effective strategy to improve child health. This information can help inform decision-making around promoting healthy weight. To explore and compare additional strategies, visit the CHOICES National Action Kit at www.choicesproject.org/actionkit.

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SUGGESTED CITATION:
Barrett JL, Bolton AA, Gortmaker SL, Cradock AL. CHOICES National Action Kit: Policy to Reduce TV Time in Early Care and Education Settings Strategy Report. CHOICES Project Team at the Harvard T.H. Chan School of Public Health, Boston, MA; December 2023.

ACKNOWLEDGMENTS:
We thank the following members of the CHOICES Project team for their contributions: Molly Garrone, Banapsha Rahman, Ya Xuan Sun, Shilpi Agarwal, Ana Paula Bonner Septien, Stephanie McCulloch, Jenny Reiner, Matt Lee, Zach Ward.

This work is supported by the National Institutes of Health (R01HL146625), The JPB Foundation, the Centers for Disease Control and Prevention (U48DP006376). The findings and conclusions are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention or other funders. The information provided here is intended to be used for educational purposes. Links to other resources and websites are intended to provide additional information aligned with this educational purpose.

Contact the CHOICES Project: choicesproject@hsph.harvard.edu

Policy to Reduce TV Time in Early Care and Education Settings

STRATEGY PROFILE

Describes the estimated benefits, activities, resources, and leadership needed to implement a strategy to improve child health. This information can be useful for planning and prioritization purposes.

Policy to limit noneducational television time in licensed early care and education (ECE) programs to 30 minutes per week for young children ages 2-5.

WHAT POPULATION BENEFITS?

Children ages 2-5 who attend licensed early care and education programs.

WHAT ARE THE ESTIMATED BENEFITS?

Relative to not implementing the strategy

Reduce child daily television time which can help promote healthy child weight.

✓ **Reduce child daily television time**

✓ **Prevent cases of obesity**

✓ **Projected to be cost-effective**

✓ **Likely to improve health equity by race and ethnicity**

More details available on the CHOICES National Action Kit at choicesproject.org/actionkit

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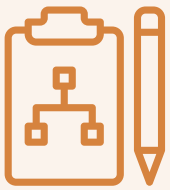
WHAT ACTIVITIES AND RESOURCES ARE NEEDED?

Activities	Resources	Who Leads?
Assess compliance with new policy to limit television time to no more than 30 minutes per week	• Time for state licensor to assess compliance with new policy during monitoring visit • Time for early care and education directors to participate in monitoring visit	State early care and education licensing agency
Provide materials and equipment for promoting physical activity (such as CDs with activity-promoting music and templates for parent newsletters)	• Time for state licensor to provide technical assistance related to policy to limit television time • Time for early care and education directors to receive technical assistance related to policy	State early care and education licensing agency
Produce educational materials about new policy for early care and education directors	• Cost of educational materials	State early care and education licensing agency



Strategy Modification

This strategy could be implemented at the state or local level through different mechanisms, including as a requirement for early care and education (ECE) programs participating in a state's Quality Rating and Improvement System (QRIS) or as best practice recommendations for ECE providers issued by a local health department or via a resolution from a local board of health, alone or in combination with other health-related objectives. Using these mechanisms, the impact on health and the activities and resources needed to carry out the television time policy are expected to be similar, however the cost and reach may vary.

- See our resource library for relevant peer-reviewed publications, research reports, & briefs at choicesproject.org/resource-library
- Learn more about strategy modifications and CHOICES projections of the strategy Policy to reduce TV time in early care and education settings for U.S. states and local areas:
  Mississippi
  Oklahoma
  Philadelphia, PA
  Detroit, MI
- Learn more about the evidence for the strategy Policy to reduce TV time in early care and education settings in the CHOICES peer-reviewed publication:
  Kenney et al. 2021. *Child Obes*

Adapted from CHOICES Strategy Profile: Policy to Reduce TV Time in Early Care and Education Settings. CHOICES Project Team at the Harvard T.H. Chan School of Public Health, Boston, MA; September 2023.

Policy to Reduce TV Time in Early Care and Education Settings

NATIONAL RESULTS

Projected national population reach, impact on health behaviors and prevention of excess weight gain, implementation costs, and cost-effectiveness of the strategy. These national results may help inform your organization's decision-making around promoting healthy weight.

DESCRIPTION	Policy to limit noneducational television time in licensed ECE programs to 30 minutes per week for ages 2-5

OUTCOME	**Mean** (95% UI)*
BEHAVIOR CHANGE PER PERSON *Change in health behavior per person in the first year*	**878 fewer minutes of television viewed** (670; 1,020) *Per year*
COST PER PERSON *Average annualized cost per person to implement the strategy over the model period*	**$0.07** ($0.06; $0.08) See Cost Results
POPULATION REACH *Reach over the model period*	**25,900,000** (25,300,000; 26,400,000)
OBESITY PREVENTED *Cases of obesity prevented in the final year*	**11,100** (4,580; 19,600)
CHILD OBESITY PREVENTED *Cases of child obesity prevented in the final year*	**11,100** (4,580; 19,600)
HEALTH EQUITY IMPACT *Impact on obesity-related health equity in the final year*	***Likely to improve health equity by race and ethnicity, but not likely to improve health equity by income due to differences in population reach by household income*** See Health Equity Indicators
QUALITY-ADJUSTED LIFE YEARS (QALYS) GAINED *Quality-adjusted life years (QALYs) gained (totals over the model period)*	**3,500** (1,460; 6,040)
OBESITY YEARS PREVENTED *Years with obesity prevented (totals over the model period)*	**75,000** (31,000; 132,000)
HEALTH CARE COSTS SAVED PER $1 INVESTED *Total health care costs saved per total intervention costs over the model period*	**$0.74** ($0.30; $1.33)
COST PER QALY GAINED *Net cost per quality-adjusted life year (QALY) gained (totals over the model period)*	**$1,140** (-$999; $8,970)

Projections for the model period 2022-2031 (10 years, inclusive of the start and end years).
Costs are in 2019 dollars and discounted at 3% annually.
*Results displayed are the mean and 95% uncertainty interval (UI). CHOICES calculates 95% uncertainty intervals by running the model 1,000 times and reporting the range (95% of estimates, centered on the mean) of projected outcomes that account for uncertainty from data sources and population projections.

✓ Explore our User Guide for more information about the CHOICES National Action Kit at choicesproject.org/action-kit-user-guide
✓ Learn more about CHOICES Methods at choicesproject.org/methods
✓ Find definitions of each modeled outcome in the Glossary (p.12) at choicesproject.org/action-kit-glossary

COST RESULTS

Describes the estimated costs by activity and payer needed to implement a strategy to improve child health nationally. This information can be useful for planning and prioritization purposes.

This report includes estimates of the implementation costs of a policy to reduce TV time in early care and education settings if implemented in each state in the United States. Costs are estimated from a societal perspective, meaning costs needed to implement the strategy are included regardless of who pays or whether the costs are budgetary or opportunity costs.

Average Annual Strategy Implementation Cost by Activity and Payer

Activity	Resources	Cost per Person†	Payer	Percent of Total Cost
Assess compliance with new policy to limit television time to no more than 30 minutes per week	• Time for state licensor to assess compliance with new policy during monitoring visit • Time for early care and education directors to participate in monitoring visit	$0.04	State government, School (Early care and education programs)	58%
Provide materials and equipment for promoting physical activity (such as CDs with activity-promoting music and templates for parent newsletters)	• Time for state licensor to provide technical assistance related to policy to limit television time • Time for early care and education directors to receive technical assistance related to policy	$0.03	State government, School (Early care and education programs)	39%
Produce educational materials about new policy for early care and education directors	• Cost of educational materials	$0.002	State government	3%
TOTAL	--	**$0.07**	--	**100%**

Costs are in 2019 dollars and discounted at 3% per year. Sums may not equal total due to rounding.
†Average annualized cost per person to implement the strategy over the model period 2022-2031 (10 years).

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Average Annual Strategy Implementation Cost by Payer and Cost Type			
	Cost per Person†		
Payer	**All Costs (% of Total)**	**Budgetary Costs (% of All Costs by Payer)**	**Opportunity Costs (% of All Costs by Payer)**
Federal government	--	--	--
State government	**$0.04 (54%)**	**$0.002 (5%)**	**$0.04 (95%)**
Local government	--	--	--
School district	--	--	--
School (Early care and education programs)	**$0.03 (46%)**	**$0.00 (0%)**	**$0.03 (100%)**
Family/Individual	--	--	--
Industry	--	--	--
Nonprofit	--	--	--
Health care	--	--	--
TOTAL	**$0.07 (100%)**	**$0.002 (3%)**	**$0.07 (97%)**

Costs are in 2019 dollars and discounted at 3% per year. Sums may not equal total due to rounding.
†Average annualized cost per person to implement the strategy over the model period 2022-2031 (10 years).

→ To compare the costs and impacts of strategies, use the CHOICES National Action Kit comparison builder. The strategy implementation cost tables included in this report may provide information useful for planning purposes.

DEFINITIONS

All costs include budgetary and opportunity costs.

Budgetary costs refer to the actual financial costs incurred.

Opportunity costs refer to the value of what you have to give up in order to choose something else. For example, if an annual professional development training for bullying prevention is replaced with a training for active physical education, there is no budgetary impact, but costs for teachers to attend the training are considered an opportunity cost. The opportunity cost of their time is included in a cost analysis from a societal perspective.

HEALTH EQUITY INDICATORS

Describes the projected impact of implementing a strategy nationally on health equity by race, ethnicity, and income.

Every person deserves access to healthy foods and drinks and opportunities to be physically active, which can help them grow up and live at a healthy weight. However, obesity levels vary by race, ethnicity, and income. Nationally, current and future projected obesity levels are highest among Black or African American and Hispanic or Latino race and ethnicity groups and populations with low household incomes.[1] These disparities are driven by many forces, including commercial determinants leading to increased intake of highly processed and marketed foods and drinks, as well as structural racism and social and economic determinants of health.[2-4] Effective policy and programmatic strategies promoting improved nutrition and increased physical activity can reduce health disparities and improve health equity.

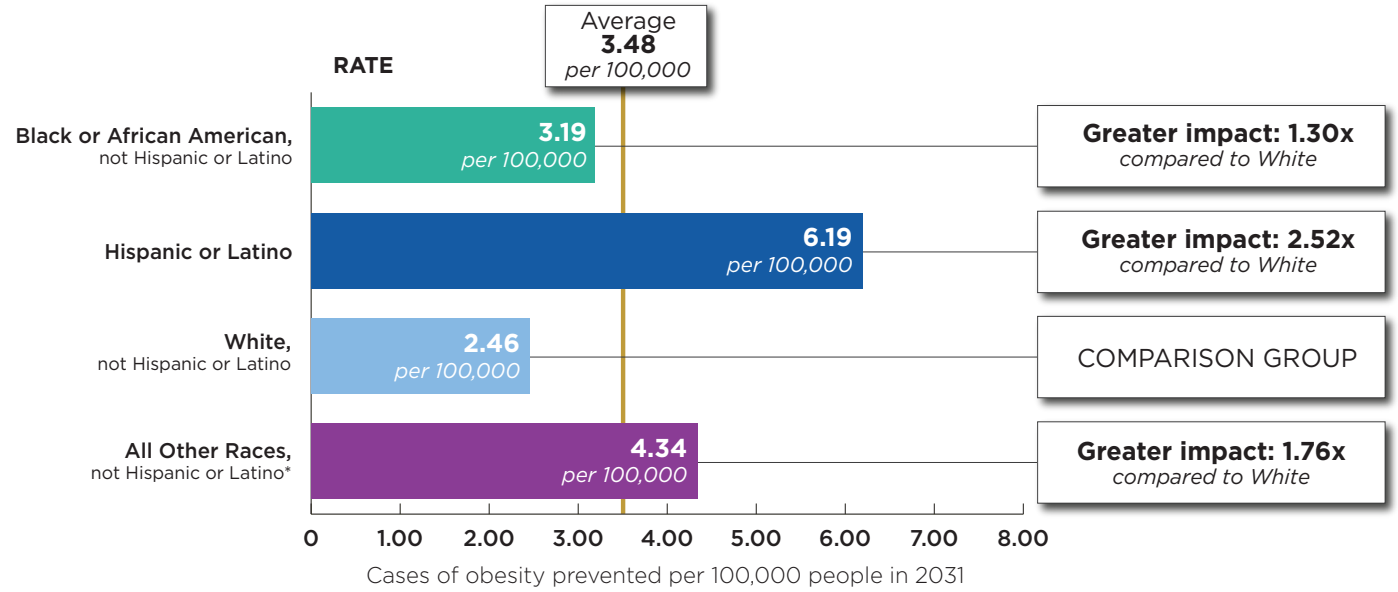
KEY TAKEAWAYS

If implemented over 10 years (2022-2031), this strategy is projected to:

- ✓ **Prevent 11,100 cases of obesity in 2031**
- ✓ **Prevent cases of obesity in all race, ethnicity, and income groups**
- ✓ **Improve health equity by race and ethnicity**
- ✓ **Not likely to improve health equity by income**

Learn more about CHOICES methods for projecting health equity impacts at choicesproject.org/methods/healthequity

Comparative projected impact of the strategy by race and ethnicity



*All Other Races includes people who identify as American Indian/Alaska Native, Asian, Native Hawaiian or Pacific Islander, Multi-racial, or another race or ethnicity not represented in the categories shown. While each of these groups represent distinct populations with differences in health opportunities, risk, and outcomes, they are summarized together due to limited data in national- and state-level surveillance systems.

The Black or African American and Hispanic or Latino populations are projected to experience preventive benefits that are 1.30 and 2.52 times greater compared to the White population. *The comparative impact in each population group compared to the population average is provided in a table on page 9.*

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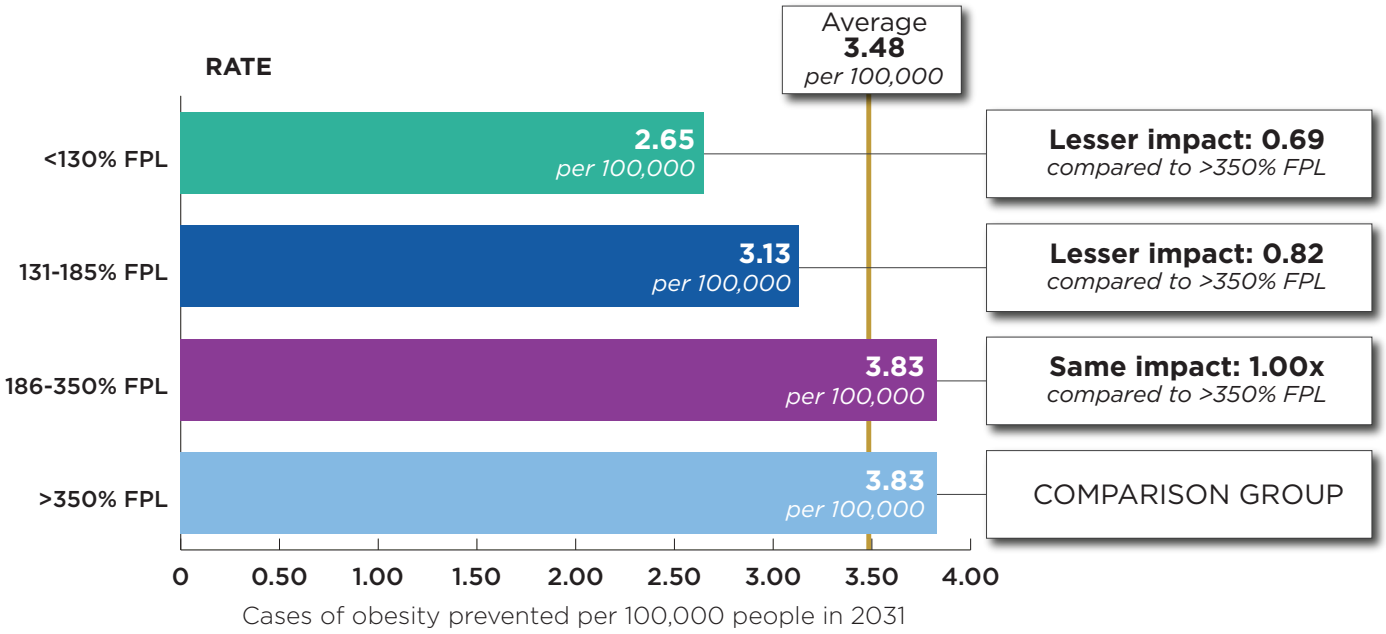
Comparative projected impact of the strategy by household income *as a percentage of the federal poverty level (FPL)*



Populations with lower household incomes (185% FPL or less) are projected to experience preventive benefits that are 0.69-0.82 times the benefits projected among populations with the highest income (>350% FPL). *The comparative impact in each population group compared to the population average is provided in a table on page 9.*

How is this strategy expected to impact health equity?

Every child deserves opportunities to grow up at a healthy weight. Television viewing can lead to increased risk for obesity because it exposes children to advertising for unhealthy foods and drinks that influences intake and choice preferences.[5,6] Further, food and beverage companies disproportionately market less healthy foods and beverages to Black and Hispanic/Latino consumers,[7] and Black and Hispanic/Latino people and people from households with lower incomes spend more time viewing television compared to other population groups. Young children attending family child care homes may spend over half an hour per day viewing television,[9,10] with Black and Hispanic/Latino children spending more time viewing television during early care and education (ECE) programs compared with non-Hispanic White children.[11] One strategy to limit the health risks associated with marketing and advertising is to minimize television viewing time. This can be accomplished through a policy to limit noneducational television time in licensed ECE programs to 30 minutes per week for ages 2-5. ECE policies and practices to reduce television time can support healthy growth when children are young and help young children build a foundation for healthy living. Implementing this strategy is expected to improve health the most among Black and Hispanic or Latino children, who spend more time viewing television during ECE programs compared with White children.[11] Thus, the strategy is likely to improve health equity by race and ethnicity. Multiple barriers to accessing ECE programs exist for families with lower incomes,[12] resulting in lower enrollment in ECE programs among children from households with lower incomes compared with higher incomes.[13] Therefore, implementing this strategy in licensed ECE programs statewide is not likely to improve health equity by income. However, prioritizing efforts to support adoption of the policy in ECE programs that serve more children from households with low incomes could lead to improved health equity by income.

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Projected impact of the strategy by race, ethnicity and income, mean (95% UI)[a]

	OBESITY PREVENTED[b]	OBESITY PREVENTED PER 100,000[b]	COMPARATIVE IMPACT[c]	
	Cases of obesity prevented in the final year	*Cases of obesity prevented per 100,000 people in the final year*	*Ratio of obesity prevented per 100,000*	
Race and Ethnicity			***Compared with White, not Hispanic or Latino***	***Compared with Population Average***
Overall	**11,100** (4,580; 19,600)	**3.48** (1.44; 6.15)	--	**1.00 (Reference)** N/A
Black or African American, not Hispanic or Latino	**1,290** (411; 2,680)	**3.19** (1.01; 6.58)	**1.30** (0.58; 2.33) *76% likelihood of greater impact*	**0.92** (0.45; 1.47) *66% likelihood of lesser impact*
Hispanic or Latino	**4,020** (1,440; 7,670)	**6.19** (2.24; 11.8)	**2.52** (1.36; 4.63) *>99% likelihood of greater impact*	**1.78** (1.19; 2.42) *>99% likelihood of greater impact*
White, not Hispanic or Latino	**4,550** (1,850; 8,260)	**2.46** (1.00; 4.46)	**1.00 (Reference)** N/A	**0.71** (0.50; 0.92) *>99% likelihood of lesser impact*
All Other Races, not Hispanic or Latino[d]	**1,220** (282; 2,930)	**4.34** (0.994; 10.4)	**1.76** (0.54; 3.74) *85% likelihood of greater impact*	**1.25** (0.44; 2.32) *65% likelihood of greater impact*
Household Income *as a percentage of the federal poverty level (FPL)*			***Compared with >350% FPL***	***Compared with Population Average***
Overall	**11,100** (4,580; 19,600)	**3.48** (1.44; 6.15)	--	**1.00 (Reference)** N/A
<130% FPL	**2,010** (746; 3,580)	**2.65** (0.981; 4.70)	**0.69** (0.44; 1.06) *95% likelihood of lesser impact*	**0.76** (0.54; 1.03) *96% likelihood of lesser impact*
131-185% FPL	**1,040** (334; 2,030)	**3.13** (1.02; 6.14)	**0.82** (0.48; 1.34) *80% likelihood of lesser impact*	**0.90** (0.55; 1.35) *71% likelihood of lesser impact*
186-350% FPL	**3,150** (1,230; 5,610)	**3.83** (1.51; 6.82)	**1.00** (0.67; 1.47) *48% likelihood of greater impact*	**1.10** (0.84; 1.38) *76% likelihood of greater impact*
>350% FPL	**4,890** (1,880; 8,950)	**3.83** (1.48; 7.03)	**1.00 (Reference)** N/A	**1.10** (0.91; 1.29) *84% likelihood of greater impact*

Projections for the model period 2022-2031 (10 years, inclusive of the start and end years).
[a]Results displayed are the mean and 95% uncertainty interval (UI). CHOICES calculates 95% uncertainty intervals by running the model 1,000 times and reporting the range (95% of estimates, centered on the mean) of projected outcomes that account for uncertainty from data sources and population projections.
[b]All cases of obesity prevented are among children, since all people reached by the strategy would still be children in the final model year.
[c]Ratio that compares cases of obesity prevented per 100,000 in each population group with the reference group. When the value is greater than 1.0 for a population group, we project a greater health benefit for that group compared with the reference group. When the value is less than 1.0, we project a lesser health benefit. Note: Ratios are sensitive to extremely high and low rates, so they should be interpreted in the context of the absolute rates, represented by Obesity Prevented per 100,000 here. Results may differ if estimating absolute rates and relative impacts among children only. Likelihood of greater or lesser impact compared with the reference group is estimated based on running the model 1,000 times.
[d]All Other Races includes people who identify as American Indian/Alaska Native, Native Hawaiian or Pacific Islander, Multi-racial, or another race or ethnicity not represented in the categories shown. While each of these groups represent distinct populations with differences in health opportunities, risks, and outcomes, they are summarized together due to limited data in national- and state-level surveillance systems.

STRATEGY DETAILS & MODELING METHODS

Describes the reach, effect, and cost assumptions used to make national projections for the strategy, and provides links to additional resources related to the strategy.

STRATEGY

The CHOICES model for nationwide implementation of a policy to limit noneducational television viewing in early child care and education (ECE) settings to 30 minutes per week would be through a state-by-state regulatory policy change.[14,15] Implementing the policy would include the incremental time to monitor policy compliance through site visits and distributing a printed handout to each ECE program about the policy.[14]

The American Academy of Pediatrics *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs* provides more information about the screen time recommendations for early care and education settings.[15]

REACH

This strategy would reach children ages 2-5 years old who attend a licensed early care and education program.[14] We estimate that 48% of children ages 2-5 nationally attend a licensed ECE program, with children from households with higher incomes more likely to attend licensed ECE programs compared to those from households with lower incomes.[13,16]

This strategy would have a 10-year reach of 25.9 million children if implemented nationwide.

EFFECT

CHOICES estimates that in 2031, 11,100 cases of childhood obesity would be prevented.

The population reached by this intervention would decrease television viewing time by 878 minutes per year. There is no experimental evidence for this strategy so, to estimate the impact on behavior and health, we assumed the effect would be the difference between the current and the mandated levels of noneducational television viewed in child care.[14] We assumed children ages 2-5 years who attend family child care homes view 0.58 hours per day of television during care, and those who attend child care centers view 0.03 hours per day of television during care.[9-11] In these early care and education settings, we assume Black and Hispanic/Latino children spend more time viewing television compared with non-Hispanic White children.[11] To convert change in television hours viewed per day to change in BMI, we used an estimate of the average change in child BMI per one hour reduction per day of television from two randomized trials (-0.33 BMI units/hour).[17,18]

COST

Implementation of this strategy involves the time for the licensing staff to visit ECE programs and monitor compliance and providing ECE programs with education materials that explain the policy.[14]

A policy to reduce TV time in licensed early care and education settings would incur an annual cost per child of $0.07.

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CHOICES METHODS

CHOICES uses cost-effectiveness analysis to compare the costs and outcomes of different policies and programs promoting improved nutrition or increased physical activity in schools, early care and education and out-of-school settings, communities, and clinics. Our methods include:

- **Key partner consultation:** Working with key partners & researchers to identify the most promising programs & policies for evaluation
- **U.S. population model:** Building a computer model of the U.S. population & projecting Body Mass Index (BMI) changes & health outcomes over time
- **Systematic reviews & meta-analyses:** Synthesizing scientific literature to estimate the likely effects of promising obesity prevention interventions on BMI & physical activity
- **Cost-effectiveness analysis:** Integrating information on the economic costs & health effects of interventions, utilizing a structured & transparent process
- **Health equity lens:** Projecting the impact of effective intervention strategies on population health and health equity

Learn more about CHOICES methods at choicesproject.org/methods.

WHY DOES CHOICES USE BMI AS A POPULATION HEALTH INDICATOR?

CHOICES focuses on programs and policies that can help reverse the societal and environmental conditions that drive increases in excess body weight and that emphasize healthy eating, improved physical activity, and reduced screen viewing. Excess body weight is associated with reduced quality of life and increased risk for chronic diseases like diabetes, heart disease, and cancers,[19] greater healthcare expenditures,[20] and increased mortality risk.[21] Obesity is a category of excess weight defined by body mass index (BMI), which is calculated as the ratio of a person's weight (kg) to their height squared (m^2).[22] Obesity is a chronic health condition recognized by the National Institutes of Health, the American Medical Association, Medicare, and Medicaid.

BMI is a useful population health indicator, although it does have limitations. BMI has been shown to be a good measure of individual-level adiposity, correlating highly (r=0.8) with gold standard measures of percent body fat, among adults, children and adolescents and for different gender and racial and ethnic groups.[23,24] BMI is relatively simple to collect and easy to calculate, and it is used widely in medical and scientific research to measure population health.

However, weight stigma occurs when people are blamed for their weight. Weight stigma can increase a person's risk of engaging in unhealthy eating behaviors and low levels of physical activity and can reduce both the quality of health care a person receives and their utilization of care, all undermining public health.[25] CHOICES evaluates the cost-effectiveness of policies and programs aimed at improving nutrition and physical activity environments, promoting related health behaviors, and promoting a healthy weight across all population groups and BMI levels.

For Additional Information

Contact the CHOICES team at choicesproject@hsph.harvard.edu for additional information about model assumptions.

For more information about this strategy, see:

Kenney EL, Mozaffarian RS, Long MW, Barrett JL, Cradock AL, Giles CM, Ward ZJ, Gortmaker SL. Limiting Television to Reduce Childhood Obesity: Cost-Effectiveness of Five Population Strategies. Child Obes. 2021. doi: 10.1089/chi.2021.0016. Available at: https://www.liebertpub.com/doi/full/10.1089/chi.2021.0016

CHOICES NATIONAL ACTION KIT: MODELED OUTCOMES GLOSSARY

Provides definitions for each modeled output displayed in the National Results table.

Modeled Output	Definition
BEHAVIOR CHANGE PER PERSON* *Change in health behavior per person in the first year*	The change in health behavior a person is projected to have after a strategy is put in place. Health behavior changes may include decreases in sugary drink intake, increases in physical activity, decreases in time spent watching TV, or increases in water intake. Behavior change per person is reported when the strategy aims to improve a specific health behavior and data are available to project how much a behavior would improve. *Averaged across people who actually receive the strategy.*
COST PER PERSON *Average annualized cost per person to implement the strategy over the model period*	The average annualized cost to implement the strategy over the model period (e.g., 10 years) per person reached over the model period. This includes cost by all payers (government, private sector, non-profit, individual/family). See the Cost Results for a breakdown of implementation costs by activity and payer. *Averaged across people in the intended population of focus where the strategy is adopted (that is, people who are eligible based on age, income, geographic area, and/or participation in the setting or program of focus, and who could potentially receive the strategy based on estimated adoption rates).*
POPULATION REACH* *Reach over the model period*	The number of people reached by the strategy over the model period. *Includes all people in the intended population of focus where the strategy is adopted (that is, people who are eligible based on age, income, geographic area, and/or participation in the setting or program of focus, and who could potentially receive the strategy based on estimated adoption rates).*
OBESITY PREVENTED* *Cases of obesity prevented in the final year*	In the final year of the model, the difference in the projected number of people with obesity if the strategy were not put in place and the projected number of people with obesity if the strategy were put in place.
CHILD OBESITY PREVENTED* *Cases of child obesity prevented in the final year*	In the final year of the model, the difference in the projected number of children with obesity if the strategy were not put in place and the projected number of children with obesity if the strategy were put in place.
HEALTH EQUITY IMPACT* *Impact on obesity-related health equity in the final year*	The projected impact on differences in obesity levels between population groups defined by race, ethnicity, and by household income. Learn more about our methods for projecting health equity impacts.
QUALITY-ADJUSTED LIFE YEARS (QALYS) GAINED *Quality-adjusted life years (QALYs) gained (totals over the model period)*	The difference in total number of quality-adjusted life years (QALYs) in the population over the model period if the strategy were not put in place compared with if the strategy were put in place. A QALY is a measure of both the quantity and quality of life. CHOICES estimates the QALYs gained as a measure of how much implementing a strategy to prevent future excess weight gain could improve the quantity and quality of life for a population. See our User Guide for more information about QALYs.
OBESITY YEARS PREVENTED *Years with obesity prevented (totals over the model period)*	The difference in total number of person-years lived without obesity if the strategy were not put in place compared with if the strategy were put in place. This measure sums up portions of years lived without obesity across all the persons in the model, comparing the result if the strategy were put in place or not.
HEALTH CARE COSTS SAVED PER $1 INVESTED *Total health care costs saved per total intervention costs over the model period*	The amount avoided in health care cost related to excess weight for every dollar spent to implement the strategy over the model period. See the Cost Results for a breakdown of implementation costs by activity and payer.
COST PER QALY GAINED *Net cost per quality-adjusted life year (QALY) gained (totals over the model period)*	The total cost impact to improve population health in terms of quality-adjusted life years gained. Cost per QALY gained is a measure of cost-effectiveness. It includes costs to implement a strategy, cost savings due to efficiencies when implementing a strategy, and health care cost savings related to reductions in excess weight after a strategy is implemented. See our User Guide for more information about QALYs and cost per QALY gained.

All metrics reported for the population over the model period and discounted at 3% per year, unless otherwise noted. Definitions for these modeled outputs are all written assuming that an intervention is implemented.
* Not discounted.

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