2010

LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY

MINUTES

Legislative Task Force on Childhood Obesity (2009)

SENATE APPOINTMENTS	Telephone / Office
• Sen. William Purcell, MD (Co-Chair)	733-5953 / 625 LOB
• Sen. Charlie Dannelly	733-5955 / 2010 LB
• Sen. Donald Davis	733-5621 / 525 LOB
• Sen. Jean Preston	733-5706 / 1121 LB
• Sen. Jerry W. Tillman	733-5870 / 628 LOB
• Sen. Michael Walters	733-5651 / 2108 LB

HOUSE APPOINTMENTS	
• Rep. Douglas Yongue, (Co-Chair)	733-5821 / 2207 LB
• Rep. Larry Brown	733-5607 / 609 LOB
• Rep. Bob England, MD	733-5749 / 303 LOB
• Rep. Robert Grady	715-9644 / 302 LOB
• Rep. Sandra Spaulding Hughes	733-5754 / 537 LOB
• Rep. Jennifer Weiss	715-3010 / 532 LOB
• Rep. Verla Insko (Advisory Member)	733-7208 / 307 B1 LOB

Legislative Task Force on Childhood Obesity

2010 Interim

SENATE APPOINTMENTS	Telephone / Office
• Sen. William Purcell, MD (Co-Chair)	733-5953 / 625 LOB
• Sen. Charlie Dannelly	733-5955 / 2010 LB
• Sen. Donald Davis	733-5621 / 525 LOB
• Sen. Jean Preston	733-5706 / 1121 LB
• Sen. Jerry W. Tillman	733-5870 / 628 LOB
• Sen. Michael Walters	733-5651 / 2108 LB
• Sen. Bob Atwater (Advisory Member)	715-3036 / 312 LOB
• Sen. Josh Stein (Advisory Member)	715-6400 / 410 LOB

HOUSE APPOINTMENTS	
• Rep. Douglas Yongue, (Co-Chair)	733-5821 / 2207 LB
• Rep. Larry Brown	733-5607 / 609 LOB
• Rep. Bob England, MD	733-5749 / 303 LOB
• Rep. Robert Grady	715-9644 / 302 LOB
• Rep. Sandra Spaulding Hughes	733-5754 / 537 LOB
• Rep. Jennifer Weiss	715-3010 / 532 LOB
• Rep. Verla Insko (Advisory Member)	733-7208 / 307 B1 LOB
• Rep. Ray Rapp (Advisory Member)	733-5732 / 2213 LB

House Bill 945

PART XLIX. LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY
(Yongue)

SECTION 49.1. There is created the Legislative Task Force on Childhood Obesity.
SECTION 49.2. The Task Force shall consist of 12 members as follows:
(1) Six members of the House of Representatives.
(2) Six members of the Senate.
SECTION 49.3. The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Vacancies on the Task Force shall be filled by the same appointing authority that made the initial appointment. A quorum of the Task Force shall be a majority of its members.
SECTION 49.4. The Task Force shall include, but should not be limited to, study of issues relating to childhood obesity. In the course of the study, the Task Force shall consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity and encouraging healthy eating and increased physical activity among children through:
(1) Early childhood intervention;
(2) Childcare facilities;
(3) Before and after-school programs;
(4) Physical education and physical activity in schools;
(5) Higher nutrition standards in schools;
(6) Comprehensive nutrition education in schools;
(7) Increased access to recreational activities for children;
(8) Community initiatives and public awareness; and
(9) Other means.
SECTION 49.5. The Task Force shall encourage input from public nonprofit organizations, promoting healthy lifestyles for children, addressing the problems related to childhood obesity, encouraging healthy eating, and increasing physical activity among children.

SECTION 49.6. Members of the Task Force shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Task Force, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Task Force may meet at anytime upon the joint call of the cochairs. The Task Force may meet in the Legislative Building or the Legislative Office Building. With approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Task Force in its work. The House of Representatives' and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Task Force, and the expenses relating to the clerical employees shall be borne by the Task Force. The Task Force may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02. If the Task Force hires a consultant, the consultant shall not be a State employee or a person currently under contract with the State to provide services. All State departments and agencies and local governments and their subdivisions shall furnish the Task Force with any information in their possession or available to them.
SECTION 49.7. The Task Force shall submit a final report of the results of its study and its recommendations to the 2010 Regular Session of the 2009 General Assembly. The Task Force shall terminate on May 1, 2010, or upon the filing of its final report, whichever occurs first.

STATE OF NORTH CAROLINA
NORTH CAROLINA
GENERAL ASSEMBLY
STATE LEGISLATIVE
BUILDING
RALEIGH, NORTH CAROLINA
27601

December 28, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R Purcell
Chairman, Representative Douglas Y Yongue

SUBJECT: **Meeting time has changed to 1:00 pm**

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY: **Tuesday** **TIME:** **1:00 pm**

DATE: **January 26, 2010**

LOCATION: **Room 643, Legislative Office Building**

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend tomorrow's meeting.

Posted:

cc: Committee X
Record
Interested Parties X

MINUTES

LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY
January 26, 2010, 1 P. M.

Room 643, Legislative Office Building

The Joint Legislative Task Force on Juvenile Obesity held its initial meeting on January 26, 2010 at 1 P. M in Room 643 of the Legislative Office Building. Representative Yongue, Co-Chair presided. ***(SEE ATTACHMENT: Members and Guest List.)*** In his opening remarks, Co-Chair Yongue said this panel represented about eight years work in trying to address the obesity problem. The issue came home to him especially after visits to several foreign countries, including Singapore. He said Singapore considered obesity a national issue for children and adults and that the people there believed that children had to have healthy bodies to have healthy minds.

Co-Chair Purcell also welcomed the members and thanked them for serving.

Co-Yongue recognized Senator Michael Walters who has been appointed to the Task Force in place for former Senator David Weinstein.

After assuring members and the audience that the upcoming agendas represented examples of issues, but not a fixed agenda, Co-Chair Yongue introduced Lee Dixon of the Fiscal Research Staff to provide an overview of the Task Force's Work.

Mr. Dixon outlined the schedule of the next four meetings:

February 2 Active Living and Nutritious Food in the Community
February 11 Children's Access to Nutritious Food
February 15 Children's Physical Activity
February 23 Food Industry

He said the meeting format agreed to would devote the morning sessions to overviews of successful efforts in other states to combat obesity. The afternoon sessions would provide presentations of successful efforts in North Carolina. From this the Task Force would draw information for possible policy changes.

Co-Chair Yongue said that members had expressed issues for consideration and that "nothing has been thrown in the trash can."

PRESENTATIONS

Childhood Obesity Epidemic: Impact on Schools

Superintendent of Public Instruction June Atkinson provided the members with the view from the school system. ***(SEE ATTACHMENT: Epidemic of Obesity)*** She noted that the General Assembly had appropriative $500,000 to address health, well being and the obesity issue in middle and high schools and that the Centers for Disease Control has continued its program to provide $750,000 for the Healthy Schools Program.

Ms. Atkinson introduced Paula Collins, Chief Health Officer and Lynn Harvey, Director of Child Nutrition from the Department of Public Instruction. She said the North Carolina Child Nutrition Program is the 8th largest meals program in the U. S. One-half of the students depend on school meals for their primary nutrition source. She recommended the book, "Brain Rules" to illustrate why child health is linked to learning.

Eighty-five per cent of the state's elementary schools have set up nutritional standards based on the Dietary Guidelines for Americans. Middle school nutrition standards are in the drafting stage.

The State Board of Education is one of the first to adopt a Healthy Active Children Policy. Through the Policy's required School Health Advisory Council in each area, physical activity, physical education and healthy living curriculum are combined.

The nutrition program in the schools in funded by federal money only. North Carolina is one of five states that do not appropriate money for the school lunch program.

In the discussion following the presentation, Representative Grady calculated that school systems served about 300 million meals per year. He said he had heard complaints that schools don't have enough money to serve the types of food they would like to provide. Ms. Atkinson said the school lunch program statewide operates at a deficit. She reiterated there were no state funds in the program. Representative Grady said that unless there was money appropriate by the General Assembly the problems that exist in nutrition would continue.

Representative Grady asked why some school systems resisted efforts to include physical education programs. Ms. Atkinson said it was less a matter of resistance than it was lack of resources and qualified teachers. She said with a five and half hour school day, systems opted to spend more time on basics: reading, arithmetic, etc. In further discussion, Ms. Atkinson told Representative Grady that Dr. Lynn Harvey would be the person to see concerning child nutrition and that Dr. Harvey would appear before the Task Force at the February 11th meeting.

Co-Chair Yongue said that with the budget constraints cafeteria managers could not serve the meals that they might like to serve, but were forced to serve "the cheapest meals you can find."

Representative Weiss noted that the school breakfast program often provided pancakes, bacon, sausage, eggs and taking her own breakfast of cereal, juice and skim milk as an example she asked if local systems could serve fruit, cereal bought in bulk, and make an adjustment that way. Dr. Lynn Harvey said such a choice could be made.

Representative Weiss said a pediatrician had told her of his observations that when children are given the choice between sweets and more nutritional items, those sweets were usually the choice. She said that limiting the choice to nutritional items might solve part of the problem. Ms. Atkinson said that one of the reasons for the nutritional teams at the local school level is to help the people operating the school programs make better choices for the meals they plan.

Co-Chair Yongue observed that often students would have a good meal at school, and then eat less nutritious foods at home. He said that there was a need to educate the students on why the meal was better for them and then educate the people at home of the nutritional values.

Co-Chair Purcell asked if the indirect costs cafeterias pay for space, utilities, etc. could be kept in the cafeteria budget rather than paid back to the schools, what impact that might have on the ability to buy such things as fruit and more nutritional foods. Ms. Atkinson said that there is a federal register that must be followed for indirect costs. The child nutrition directors she said know that the indirect costs must be paid and that the meals must be served and the nutrition directors don't wish to be seen as the scapegoat for a deficit in the system's budget. Co-Chair Yongue noted that the subject will be covered in more depth at a later meeting. He asked if there was federal money coming to the Department of Public Instruction for indirect costs. Ms. Atkinson said there were such funds going into a fund and the schools draw against those funds.

Obesity and North Carolina's Health Care System

In providing this presentation, Maria Spaulding, Deputy Secretary of the Department of Health and Human Services, began with a national picture. ***(SEE ATTACHMENT: Obesity and N. C. Health Care System.)*** She said that the direct medical costs for obesity in the U. S. are estimate at more than $92 billion each year. The cost to employers, in 1994, was $12.7 billion including nearly $8 billion in health care costs alone.

In 2003, Blue Cross/Blue Shield figured that overweight and obesity accounted for $83 million in medical costs for those insured by that company. BCBS Customers with healthy weight cost 32% less than the obese. Nationally North Carolina is the 10th highest state in the U. S. in terms of obesity-associated costs.

Ms. Spaulding outlined highlights of the various Department of Health and Human Services obesity efforts ranging from those in Medicaid to the links to Public Health, Child Care Standards and collaboration with other agencies.

Representative Hughes asked how one qualified for Medical Nutrition Therapy. Ms. Spaulding said the service would have to come through the local health department, a clinic, or a doctor's office by virtue of a prescription for the service.

Childhood Obesity Epidemic: Impact on Children's Health

Dr. Jeffrey Engel, State Health Director, began his presentation by noting that obesity, while not contagious, was a national problem.***(SEE ATTACHMENT: Obesity in North Carolina.)*** His figures tracked a growing nationwide trend in obesity beginning in 1985. No state has experienced a decrease in obesity in the past 16 years.

Dr. Engel's figures show that 67.7% of North Carolinians as obese and 78% do not meet the daily vegetable requirement. In North Carolina 32.8% of the youth between 10 and 17 are obese or overweight.

The presentation went on to provide the relation between obesity and other diseases such as diabetes, heart disease, etc. In North Carolina, diabetes was the 7th leading cause of death in 2006, and the prevalence in diabetes in the state has more than doubled since 1995

NOTE to the attachment: Dr. Engel's correct phone # is 707-5001.

Childhood Obesity Epidemic: Impact on State's Economy

Dr. David Chenoweth, Worksite Health Promotion Director in the Department of Health Education and Promotion at ECU, began with a presentation of material from the organization Be Active North Carolina, Inc plus further data concerning costs. ***(SEE ATTACHMENTS: Tipping the Scales and Childhood Obesity in North Carolina: Economic Costs and Implications.)***

The study notes that an overweight or obese worker costs an employer about $250,000 in lost productivity during a career span. This relates to about 115 hours of lost productivity per year.

There are 54.1% of North Carolina children who are physically inactive and thus are 600 times more likely to develop heart disease as adults. In a study from UNC-Chapel Hill, reported in Mr. Chenoweth's material, an estimated 15-45% of the new diabetes cases in children were the Type II category. That is often considered an adult disease.

In considering young people Be Active North Carolina report used five common diagnoses associated with the risk factors: lack of physical activity, excess weight and diabetes:

Musculo-skeletetal problems
Circulatory conditions
Metabolic/endocrine related disorders
"Ill-defined" signs and symptoms
Mental disorders

The report says that the three risk factors cost $105.13 million in 2006 and the cost is likely to rise.

In additional material, Mr. Chenoweth noted that North Carolina pays more per capita on illness care than Virginia and Georgia. Further, 10% of the gross state product goes to pay for 4 health risk factors.

N. C. Obesity Prevention Funders Alliance

Jennifer MacDougall, of the Blue Cross Blue Shield of NC Foundation joined with Meka Sales of the Duke Endowment, gave an overview of the Alliance and its objectives. ***(SEE ATTACHMENTS: Addressing the Obesity Crisis and Prevention for the Health of North Carolina.)***The Alliance began in 2008 and while it has funding from foundations and trusts, it is not limited to private funding or only health care funding.

The Alliance seeks to make investments in obesity prevention. In part, the idea was to seek out programs that are showing success in prevention and help implement similar initiatives. The Alliance seeks to provide an educational platform, plus the ability to work across various foundations and other organizations in the public and private sector.

The Alliance held an obesity summit in 2008, to take an assessment of the various programs, people and focuses on obesity in North Carolina. The Summit was aligned

along four bases: Individual Behavior, Community Involvement, Public Policy and Clinical Care.

Further, Ms. MacDougall said the Alliance supported the N. C. Institute of Medicine Action Plan because of the strength and validity used to formulate the plan.

Meka Sales, of the Duke Endowment, provided additional information as she cited the cross-sectional approach to reduce smoking. She said obesity strategies should use the same approach. She urged the development of technical assistance to deal with how obesity can be reduced.

Ms. Sales said that the Alliance supported replicating as examples successful programs across the state and by taking advantage of expertise in and outside North Carolina.

Representative Weiss asked what specific recommendations the Alliance would want to present to the Task Force. Ms. MacDougall said the NC IOM Action Plan represented that Alliance's positions.

Co-Chair Yongue welcomed suggestions from members about the Task Force work and providing information about the work.

With an announcement that the next meeting would be February 2, at 10 a.m., this meeting was adjourned at 3:07 p.m.

Representative Doug Yongue, Co-Chair

Katie Stanley, Clerk

Senator William Purcell, Co-Chair

Ted Harrison, Minutes.

Taskforce on Childhood Obesity

AGENDA

Tuesday, January 26, 2010
1:00 p.m.

Legislative Office Building
Room 643

I. Welcome, Introductions, and Remarks
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

II. Childhood Obesity Epidemic: Impact on Schools
June Atkinson, State Superintendent

III. Childhood Obesity Epidemic: Impact on the Health System
Maria Spaulding, Deputy Secretary, DHHS

IV. Childhood Obesity Epidemic: Impact on the Health of Children
Jeffrey Engel, NC State Health Director

V Childhood Obesity Epidemic: Impact on the State's Economy
David Chenoweth, Worksite Health Promotion Director, Department of Health Education and Promotion, ECU

VI. NC Obesity Prevention Funders Alliance
Jennifer MacDougall, Blue Cross Blue Shield of NC Foundation
Meka Sales, Duke Endowment

VII. Discussion

VIII. Adjournment and Future Meeting Dates:

***February 2*-Active Living and Nutritious Food in the Community,**
***February 11*-Children's Access to Nutritious Food: Preschool to High School,**
***February 15*- Children's Physical Activity, BMI, and Fitness,**
***February 23*- Food Industry**

Taskforce on Childhood Obesity

AGENDA

Tuesday, January 26, 2010
1:00 pm

Legislative Office Building
Room 643

I. Welcome, Introductions, and Remarks
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

II. Childhood Obesity Epidemic: North Carolina's Response

- **Impact on Schools**
  June Atkinson, State Superintendent
- **Impact on the Health System**
  Maria Spaulding, Deputy Secretary, DHHS
- **Impact on the Health of Children**
  Jeffrey Engel, NC State Health Director

III. Childhood Obesity Epidemic: Impact on the State's Economy
David Chenoweth, Worksite Health Promotion Director, Department of Health Education and Promotion, ECU

IV. NC Obesity Prevention Funders Alliance
Jennifer MacDougall, Blue Cross Blue Shield of NC Foundation
Meka Sales, Duke Endowment

V Discussion

VI. Adjournment and Future Meeting Dates:

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VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — Tuesday, Jan. 26, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Shore	NC Pediatric Society
Greg Griggs	NC Academy of Family Physicians
Ron Monroe	NCAAHPERD
JUDY MARTINO	NCAAHPERD
RUTH PETERSEN	NC DPH
Jamie Cousins	NC DPH
Cathy Thomas	NC DPH
JEFF ENGEL	NC DPH
Marjorie Wilson	WakeMed Health + Hospitals
Laura Aiken	WakeMed Health & Hospitals
Alice Levihan	NC DPH

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — Tuesday, Jan. 26, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer MacDougall	BCBSNC Foundation
Mark Fleming	BCBSNC
[signature]	NCAEC
Jeri Krentz	The Duke Endowment
[signature]	Carolinas HealthCare System
Shivani Mehta	Carolinas Healthcare System
[signature]	Carolinas HealthCare System
[signature]	DPI
[signature]	YA10
Lean Hambright	The Duke Endowment
Lin Hollowell	The Duke Endowment

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — Tuesday, Jan. 26, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
KAYE WEBB	The LINKS, Inc 1920 Belfast Dr Raleigh NC 27609 kwebb@bellsouth.net
Christine Cruz	WakeMed
Mitch Kokai	John Locke Foundation

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — Tuesday, Jan. 26, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Bowdish Consulting
S Wilson	DHHS
Maria Spaulding	DHHS
June Atkinson	DPI
Matt Farrell	TPG
Ken Melton	MA
Timothy Williams	TPG
[illegible]	WCPSS
Katherine Joyce	NCASA
Chris Minard	State Bd of Ed
Meka Sales	The Duke Endowment

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — Tuesday, Jan. 26, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peg O'Connell	CFS,
Betsy Vetter	AHA
Jennifer Park	NCAH
Paula Hudson Collins	DPI/SBE
Ben Matthews	DPI
Lynn Harvey	DPI
Amy McCorkey	NC Beverage Assoc.
Butch Gunnells	NC Beverage Ass'n
Billy WARDEN	Comms & IMAGINATION
Lee Wenner	NCSBA

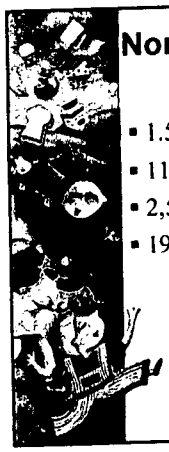


Epidemic of Obesity

Legislative Obesity Task Force
January 26, 2010

NC Department of Public Instruction

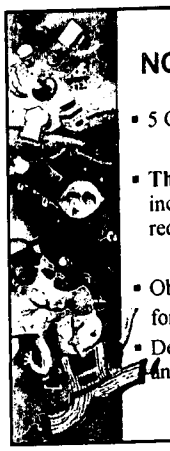
June St. Clair Atkinson
State Superintendent of Public Instruction



North Carolina Public Schools

- 1.5 Million Students
- 115 Local Education Agencies
- 2,500 Schools
- 190,000 Teachers/Staff

The Message: Graduate!



NC State Board of Education

- 5 Goals Support the SBE's Mission
- **The Healthy Responsible Students Goal** includes efforts for obesity prevention and reduction of obesity related diseases.
- Obesity Pilot Programs funded by GA for School Year 2008-2009 are on-going
- Developed/implemented at middle school and high school levels



NC Department of Public Instruction

- NC Healthy Schools Section
  - One State funded positions
  - Five Federally funded positions
  - One position housed in DPH
- Competitive Funding by CDC in 5 year cycles, ~ $750,000 annually
- Promotes Coordinated School Health Programs (CSHP)



Coordinated School Health

- Health Education
- Physical Education
- Child Nutrition Services
- Health Services
- Healthy School Environment
- Mental Health
- Staff Wellness
- Family/Community Involvement



- DPI continues to enjoy a strong and productive working relationship with the Division of Public Health (DHHS) strengthened over the years through the collaborative agreement with the Centers for Disease Control and Prevention (CDC) to promote the link between health and education.
- Examples include joint community grants, the Eat Smart Move More Plan and the PAN Branch collaborations



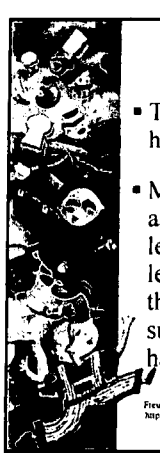
NC Department of Public Instruction

- Child Nutrition Services Section
  - 28 Federally funded positions
    - 18 housed regionally to directly serve LEAs
  - One Federally funded position housed at DPH



Child Nutrition Services

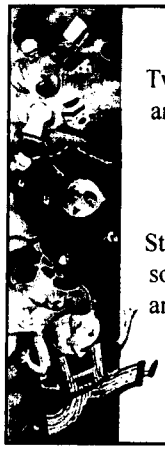
- 8th Largest School Meals Program in the nation
- Serving 1.8 million meals per day
- 50 % of students depend on school meals for their primary source of nutrition
- 15,000 Employees



Student Success

- There is direct link between a student's health and their academic performance.
- More formal education is consistently associated with lower death rates, while less education predicts earlier death. The less schooling people have, the higher their levels of risky health behaviors such as smoking, being overweight, or having a low level of physical activity.

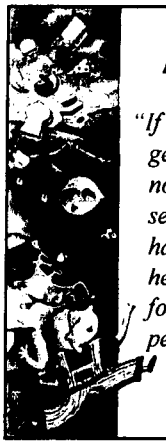
Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. Prev Chronic Dis 2007;4(4) http://www.cdc.gov/pcd/issues/2007/oct/07_0063.htm. Accessed 9/11/2008.



Two character traits which impact obesity are:

Good judgment and **self-discipline**

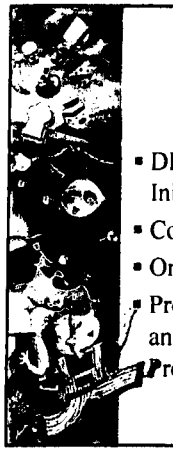
Student Services, including counselors, social workers and school psychologists, are also key in addressing obesity.



Academic Connections

"If we are serious about saving a generation of children, ensuring that not one of them is left behind, we must see that health and achievement go hand-in-hand. Only when children are healthy and safe will we be able to focus on improving their academic performance."

Pat Cooper, Superintendent McCombs County Schools, MS



Child Nutrition Efforts

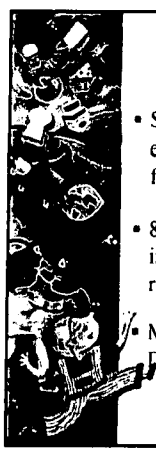
- DPI has formed the School Meals Initiative Team (SMI)
- Composed of 8 RDs/LDNs
- One per each of 8 educational regions
- Provides training, technical assistance, and monitoring of LEA Child Nutrition Programs



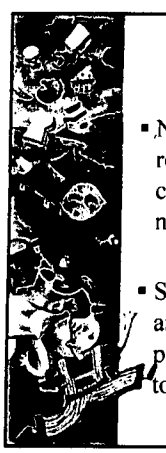
Local Wellness Policy

- Physical Activity
- Nutrition Education
- Nutrition Standards
- Other School Based Activities

The law requires goals, guidelines, assurances, a plan for measuring, and a plan for involving various stakeholders in each of these areas.



- SBE developed nutrition standards for elementary schools per Dietary Guidelines for Americans.
- 85% of elementary schools have voluntarily implemented these standards which are required for implementation in 2010.
- Middle School Nutrition standards (based on Dietary Guidelines) have been drafted.



- NC is the only state in the nation to require LEAs to document routine compliance with Federal and State nutrition standards.
- SBE requires a semi-annual nutrient analysis and software has been purchased and is utilized in the schools to assist in nutrient analysis of menus.



- There are 4,300+ students with diabetes and the number of students with Celiac Disease, food allergies and sensitivities is on the rise.
- The SMI Team works with the Section 504 Plans and accommodations to address these student needs and to provide appropriate meals.



- The sale of competitive foods and beverages undermines the nutritional, operational and financial integrity of the Child Nutrition Program.
- SBE policy prohibits the sale of foods/beverages to students (except through Child Nutrition Services) during the school day.



Healthy Active Children Policy

In recognition of the need for students to become more active during the school day, the SBE was among one of the first in the nation to adopt a comprehensive Healthy Active Children Policy.



Healthy Active Children Policy

- Requires School Health Advisory Councils in each LEA (SHACs)
- Mandates 30 minutes of physical activity daily (K-8)
- Recommends 150 minutes of physical education in elementary schools per week
- Recommends 225 minutes of healthful living education in middle schools per week
- Protects recess and other PA time
- Promotes Coordinated School Health
- Reports to State Board of Education, annually



- Development and use of *Energizers*
- Fit Kids Website (HWTF)
- UNC Study of the HAC policy
- 40% of NC elementary schools provide 150 minutes of physical education per week
- 44% of NC middle schools provide 225 minutes of the *Healthful Living Standard Course of Study* per week.



Health Data Collection

- **Youth Risk Behavior Survey (YRBS)**
  CDC Randomly Selected Middle and High Schools
- **School Health Profiles**
  Principals and Lead Health Teacher(s) in randomly selected Middle Schools and High Schools by CDC
- **School Level Impact Measures** (SLIMS) directed by CDC



Healthful Living Standard Course of Study

- K – High School
- Blending of health education and physical education standards
- Promotes use of evidenced-based programs and curricula selection at the local level



NCAAHPERD Partnership

- In School Prevention of Obesity and Disease (*ISPOD*)
- All physical educators conduct bi-annual *FITNESSGRAM* testing
- All North Carolina physical educators trained in *SPARK* as a baseline program

For information www.ispod.info



In School Prevention of Obesity and Disease, IsPOD

- Targets K-8 students
- Some High Schools have paid to participate
- 4 year cycle of funding, 2008-2012
- Funding at $3.5 Million from Kate B. Reynolds Charitable Trust
- To date, 65 LEAs and 6 charter schools participated in the IsPOD training



IsPOD

- Conducts 5 *FITNESSGRAM* Measures: muscular strength, muscular endurance, flexibility, cardio-vascular endurance and BMI.

480,000+ *FITNESSGRAM* data sets to date

Goal of 1,000,000,000 + students by 2012



- In partnership with Be Active NC and funded by the Health and Wellness Trust Fund, 32,500 classroom teachers were prepared to implement the Healthy Active Children Policy and utilize the *Energizers.*

- UNC Greensboro served as evaluators



- Encourage Walk/Bike to School Events
- Work with school architects to encourage open activity spaces



- Encourage joint-use policies for schools and communities
- Provide before and after school programs (e.g., 21st Century Learning Centers, Intramurals)



Schools promote activities or programs that limit children's screen time

- Encourage time for activity in and out of the school day
- *LimiTV* brochure produced by Healthy Schools Section
- Substitute interactive video games such as *HOPSports, DDR* and *Wii* sports for sedentary games



SCORE

Southern Collaborative on Obesity Reduction Efforts (SCORE)

- $10,000 grant from the Council of State Governments (CSG)
- Educating Policy Makers
  - NC General Assembly
  - NC State Board of Education
  - NC School Boards Association
  - Others



Numerous Health Partners

- NC Department of Agriculture
- NC Institute of Medicine
- NC Prevention Partners
- Healthy Carolinians
- Be Active NC
- Health and Wellness Trust Fund
- School Nutrition Association
- NC School Boards Association



Children must be healthy in order to be educated, and they must be educated to be healthy.

Former United States Senator William Cohen, Maine



- For more information, please go to

www.dpi.state.nc.us/stateboard/hrstudents/

Obesity and North Carolina's Health Care System

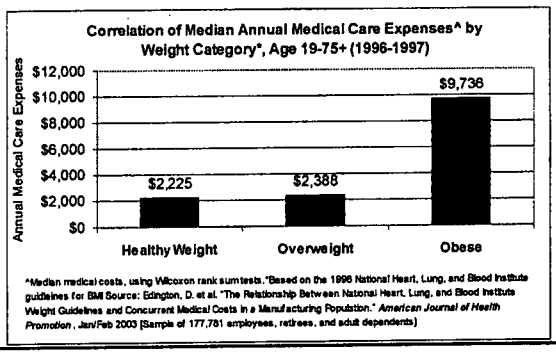
presentation to the
North Carolina General Assembly
Task Force on Obesity
January 26, 2009

Maria Spaulding
Deputy Secretary
North Carolina Department of Health and Human Services

U.S. Costs

- The direct medical costs of obesity in the U.S. have been estimated to be greater than $92 billion a year.
- Obese people have annual medical costs that are 37% higher than their healthy weight counterparts, representing an additional $732 per obese person per year.
- Nearly one half of overweight and obesity attributable medical spending is the responsibility of the public sector (Medicaid and Medicare).

Workplaces

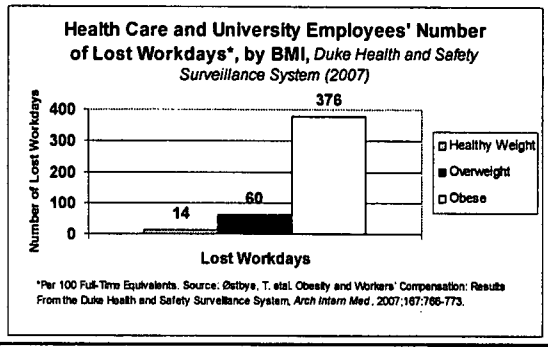


^Median medical costs, using Wilcoxon rank sum tests. *Based on the 1998 National Heart, Lung, and Blood Institute guidelines for BMI Source: Edington, D. et al. "The Relationship Between National Heart, Lung, and Blood Institute Weight Guidelines and Concurrent Medical Costs in a Manufacturing Population." *American Journal of Health Promotion*, Jan/Feb 2003 (Sample of 177,781 employees, retirees, and adult dependents)

U.S. Costs to Employers

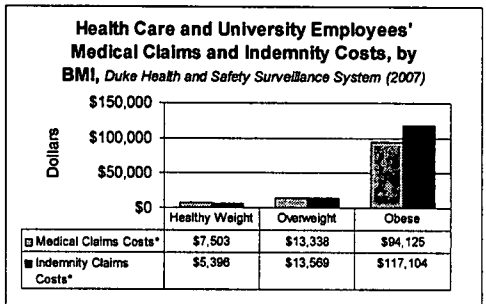
- **Obese workers have 21% higher health care costs compared with those of a healthy weight.**
- **In 1994, the estimated cost of obesity to U.S. businesses was $12.7 billion, including $7.7 billion in health care costs alone.**

U.S. Lost Workdays



*Per 100 Full-Time Equivalents. Source: Østbye, T. etal. Obesity and Workers' Compensation: Results From the Duke Health and Safety Surveillance System, *Arch Intern Med*. 2007;167:766-773.

U.S. Medical Claims & Indemnity Costs



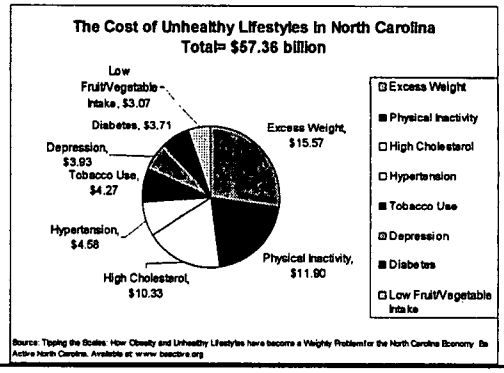
	Healthy Weight	Overweight	Obese
Medical Claims Costs*	$7,503	$13,338	$94,125
Indemnity Claims Costs*	$5,396	$13,569	$117,104

*Per 100 Full-Time Equivalents. Source: Østbye, T. etal. Obesity and Workers' Compensation: Results From the Duke Health and Safety Surveillance System, *Arch Intern Med*. 2007;167:766-773.

North Carolina Costs

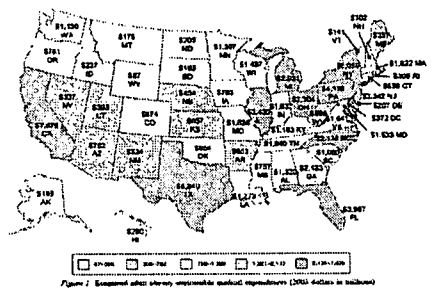
- In N.C., overweight and obesity accounted for $83 million in medical costs in 2003 for those with Blue Cross Blue Shield (BCBS) cover age.
- The N.C. BCBS customers who were obese had costs 32% higher than those with healthy weights.

North Carolina Costs



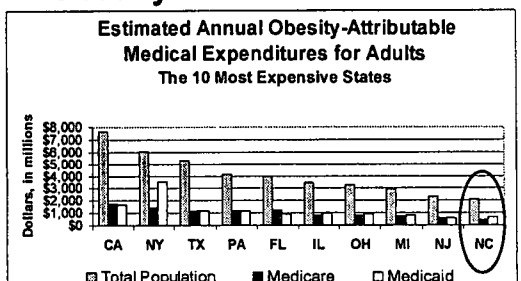
Source: Tipping the Scales: How Obesity and Unhealthy Lifestyles have become a Weighty Problem for the North Carolina Economy. Be Active North Carolina. Available at: www.beactive.org

Estimated Adult Obesity-Attributable Medical Expenditures (2003 dollars in millions)



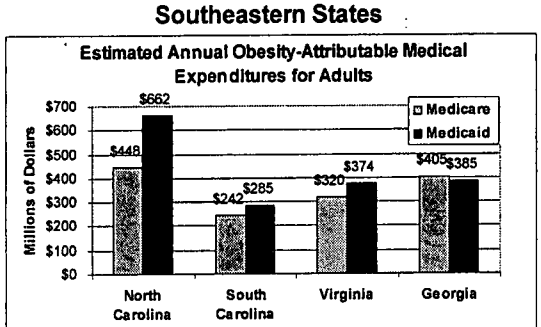
Finkelstein EA., Fiebelkorn IC, Wang G. State-level estimates of annual medical expenditures attributable to obesity. Obes Res. 2004; 12: 18-24.

N.C. is 10th Highest for Obesity-Attributable Costs



Finkelstein EA., Fiebelkorn IC, Wang G. State-level estimates of annual medical expenditures attributable to obesity. Obes Res. 2004; 12: 18-24.

Obesity-Attributable Medical Costs
Southeastern States



Finkelstein EA., Fiebelkorn IC, Wang G. State-level estimates of annual medical expenditures attributable to obesity. Obes Res. 2004; 12: 18-24.

Costs: Children and Youth

Nationally

- Among children 6-17 years old, obesity-associated annual hospital costs increased from $35 million during 1979-1981 to $127 million during 1997-1999.

In North Carolina

- Direct and indirect costs of obesity in N.C. youth were nearly 16 million dollars per year.

NC DHHS Efforts to Reduce and Prevent Obesity

Selected Highlights

Medicaid Reimbursement for Obesity-Related Care

- **Medical Nutritional Therapy (MNT) allowable since Jan 2008**
  - For children and qualified pregnant/post-partum women
  - Must be delivered by a dietician/nutritionist currently licensed by the NC Board of Dietetics/Nutrition or a dietician currently registered with the Commission of Dietetic Registration
  - Available through Medicaid-enrolled providers who employ or contract with licensed dieticians/ nutritionists or registered dieticians

WIC Food Package

- Implementation began October 1, 2009
- Impacts over 270,000 WIC participants in North Carolina
- New WIC Food Package is designed to:
  - Address public health nutrition-related concerns obesity and low breastfeeding rates
  - Meet 2005 Dietary Guidelines for Americans
  - Meet the American Academy of Pediatrics recommendations on infant feeding
  - Provide breastfeeding incentives and support
  - Offer greater balance, variety and choice and cultural appropriateness

Physical Activity and Nutrition Branch

- Promotes increased opportunities for physical activity and healthy eating through policy and environmental change
- The Branch uses evidence-based strategies to create policies and physical environments conducive to physical activity and healthy eating, including in:
  - Worksites
  - Schools
  - Child Care Centers
  - Healthcare Settings
  - Faith Centers
  - Communities at large

Eat Smart, Move More NC

Partners in the Statewide Movement

- Over 60 organizations (including NC DPH)
- Developed State Plan to Address Obesity
- Created Policy Agenda aligned with State Plan, NC IOM Task Force Recommendations, and CDC guidance

Links to Local Public Health

- **Healthy Carolinians**
  - Assists with Community Health Assessment process used to identify and address local health priorities
- **Statewide Health Promotion**
  - Provides technical assistance to local health departments to address local health priorities including physical activity, nutrition, and tobacco

Child Care Standards

Proposed changes to be considered by ChildCare Commission in February:

- Include a minimum of one hour of outdoor time daily for full day programs and 30 minutes of outdoor time daily for half day programs
- Specify a daily gross motor activity in the daily schedule
- Have a full range of equipment and materials to support children's learning activities in the outdoor learning environment
- Support breastfeeding mothers by providing seating and an electrical outlet, if needed
- Limit screen time to no more than 2 ½ hours a week. No screen time for children under 2 years old

Interagency Collaboration

- **Healthy Environments Collaborative** with NC Departments of Transportation, Commerce, and Environment & Natural Resources
- **Healthy Schools** – Collaboration between DHHS and Department of Public Instruction

Contact Information

Maria Spaulding
Deputy Secretary for Long-Term Care and Family Services

North Carolina Department of Health and Human Services

maria.spaulding@dhhs.nc.gov

Obesity in North Carolina

Jeffrey Engel, MD
State Health Director
North Carolina Division of Public Health

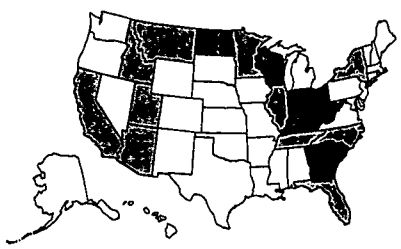
NC Legislative Task Force on Obesity
North Carolina General Assembly
January 26, 2010

North Carolina Public Health

The Challenge:
Obesity in North Carolina

Obesity Trends* Among U.S. Adults

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

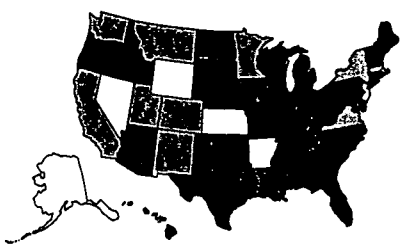


1985 BRFSS

No Data | <10% | 10%-14%

Obesity Trends* Among U.S. Adults

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



1990 BRFSS

No Data | <10% | 10%-14%

Obesity Trends* Among U.S. Adults

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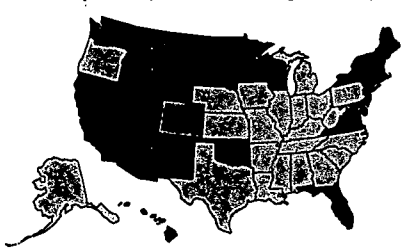


1995 BRFSS

No Data | <10% | 10%-14% | 15%-19%

Obesity Trends* Among U.S. Adults

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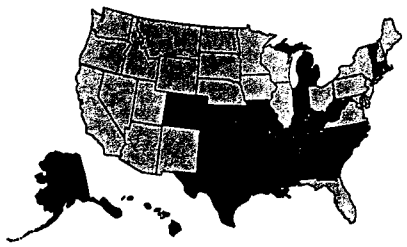


2000 BRFSS

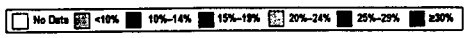
No Data | <10% | 10%-14% | 15%-19% | ≥20%

Obesity Trends* Among U.S. Adults

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

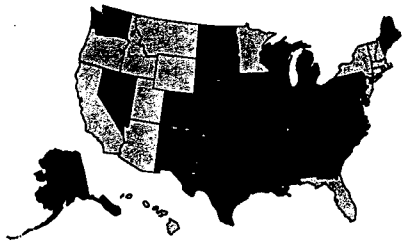


2005 BRFSS

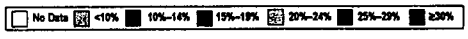


Obesity Trends* Among U.S. Adults

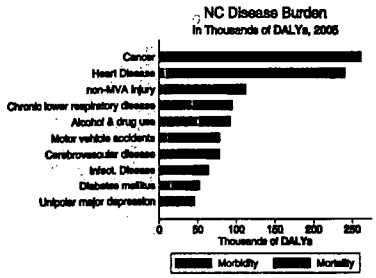
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

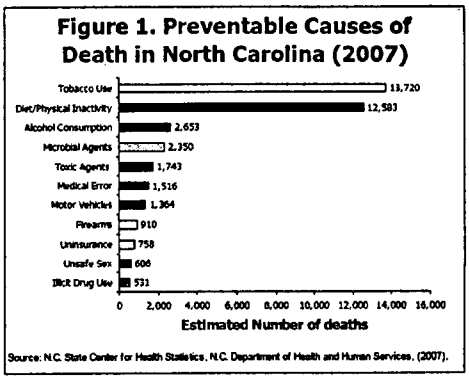


2008 BRFSS



Leading Causes of NC Morbidity and Mortality (in Disability Adjusted Life Years)



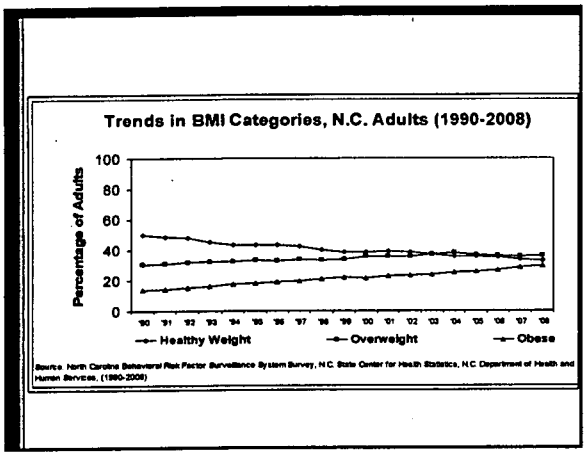


National Burden of Obesity

- 2 out of 3 adults are overweight or obese
- None of the states have experienced a decrease in obesity for 16 years
- In the past year, 31 states experienced an increase in obesity

Adult Obesity in NC

- 65.7% of NC adults are overweight or obese, **above** the national average
  - –56% are <u>not</u> meeting the physical activity recommendation
  - –78% are <u>not</u> meeting the fruits or vegetables recommendation

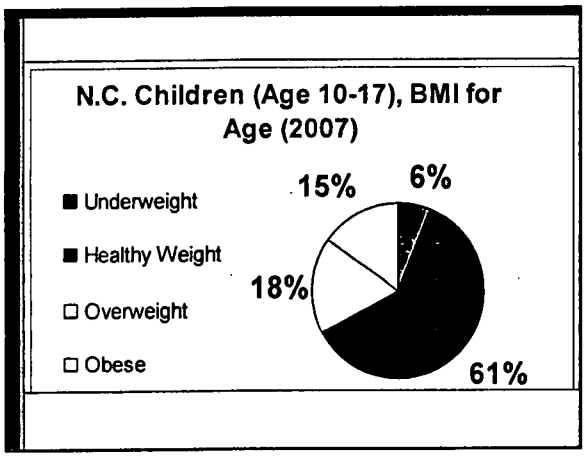


NC Children and Youth

- 32.8% of NC children ages 10-17 were overweight or obese in 2008
  - 17.6% overweight; 15.2% obese

According to the 2007 Youth Risk Behavior Survey (YRBS):

- One-third of NC children typically consumed one serving or less of vegetables per day.
- 20% of NC children did not meet the physical activity recommendation (60 minutes per day).
- 50% of NC children watched more than two hours of television on a typical day.



Obesity-Related Chronic Disease

- 53% of all premature deaths among North Carolinians are preventable.
- Overweight and obesity are significantly associated with diabetes, high blood pressure, high cholesterol, asthma, arthritis, and poor health status.
- Inadequate fruits and vegetables, lack of leisure time physical activity, obesity, and overweight make up 80% of NC's risk factor or behaviors.

Adverse Health Consequences Due to Obesity

Chronic Diseases:
- Diabetes
- Heart Disease
- Kidney Disease and Failure
- Cancer
- Asthma
- Arthritis

Other Consequences:
- Mental Health
- Oral Health
- Disability
- Reproductive Health

Diabetes in NC

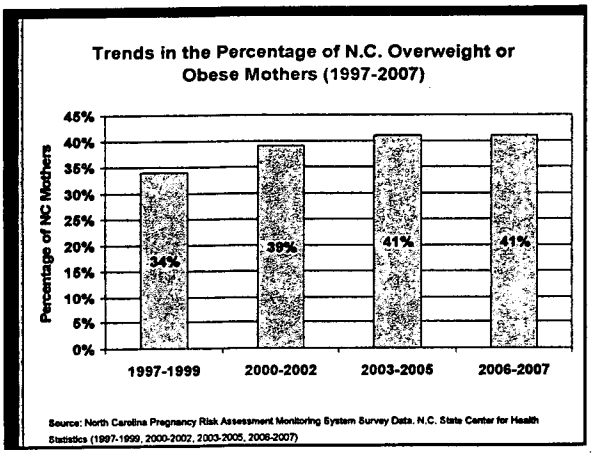
- 7th leading cause of death in NC in 2006
  - 4th among African Americans
  - 3rd among American Indians
- Diabetes prevalence has more than doubled in NC since 1995.
- Nearly one-in-ten (9.1%) NC adults reported having been diagnosed with diabetes in 2007, higher than 8.1% among US adults.
- More than 1.2 million NC adults have pre-diabetes or diabetes, and many are unaware of their condition.

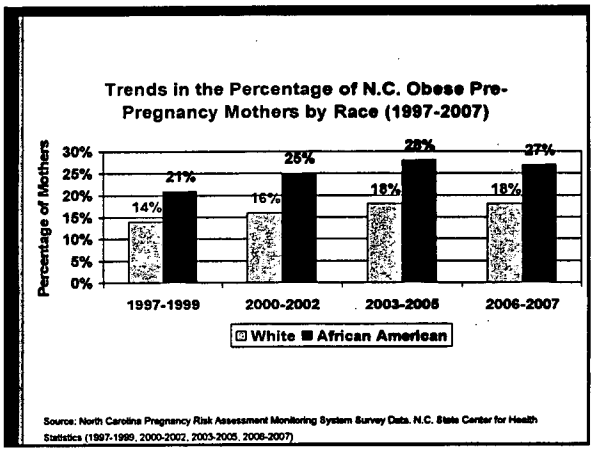
Childhood Diabetes in North Carolina

- Several national studies have reported increases in prevalence and incidence of Type 2 diabetes in children and youth with one of the key links being obesity.
- Data gathered for the 2008-2009 North Carolina School Health Services Report included:
  - 4,584 public school students had diabetes
  - 3,548 monitored blood glucose at school
  - 2,101 received insulin injections at school
  - 1,544 had insulin pumps

Heart Disease and Obesity

- High blood pressure is twice as common in adults who are obese than in those who are at a healthy weight.
- Overweight individuals are nearly 40 percent more likely to develop heart disease than healthy weight individuals; the rate increases to 50 percent for obese individuals.
  - Morbidly obese persons have an elevated risk of nearly 70 percent.

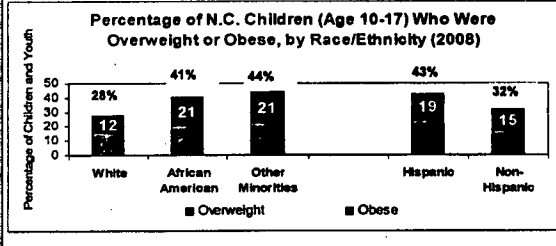


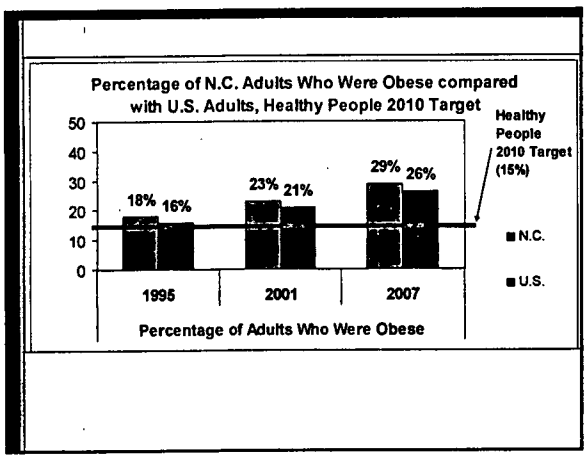


NC Adults Who are Obese by Race/Ethnicity

BRFSS (percentages) 2007:

White, Non-Hispanic	African American, Non-Hispanic	American Indian, Non-Hispanic	Other Races, Non-Hispanic	Latino/ Hispanic	TOTAL
26.4	39.2	26.7	22.9	25.4	28.7





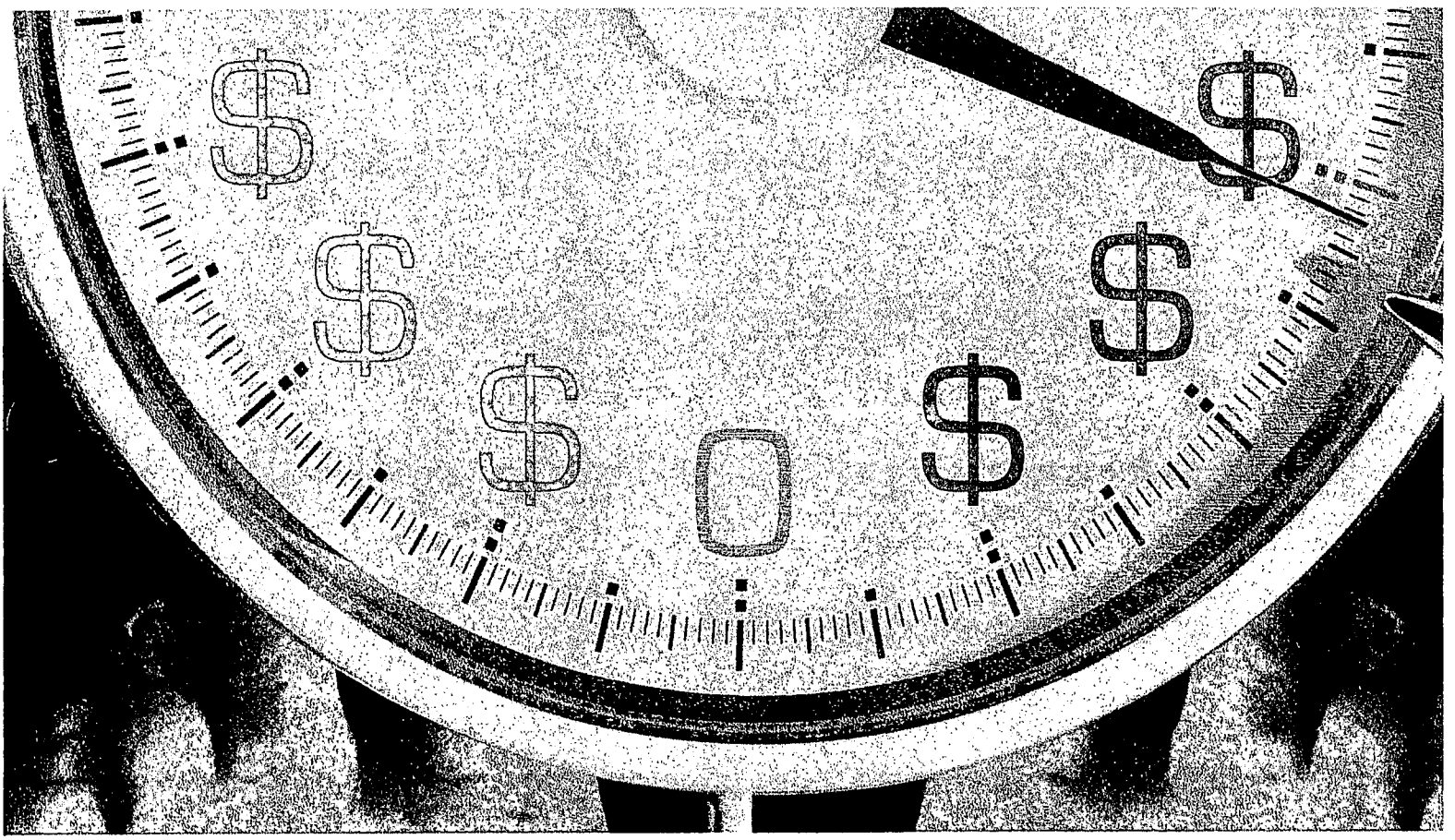
Contact Information

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http://www.ncpublichealth.com/

Tipping the Scales



How obesity and unhealthy lifestyles have become a weighty problem for the North Carolina economy.

beactive N★C

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3 Executive Summary

3 Background and Scope of the Report

4 Key Findings

5 The Economic Costs of Risk Factors and Unhealthy Lifestyles Among North Carolina Adults

5 Prevalence of the Targeted Risk Factors and Their Relationship to Diseases/Conditions

6 Assessing the Eight Risk Factors

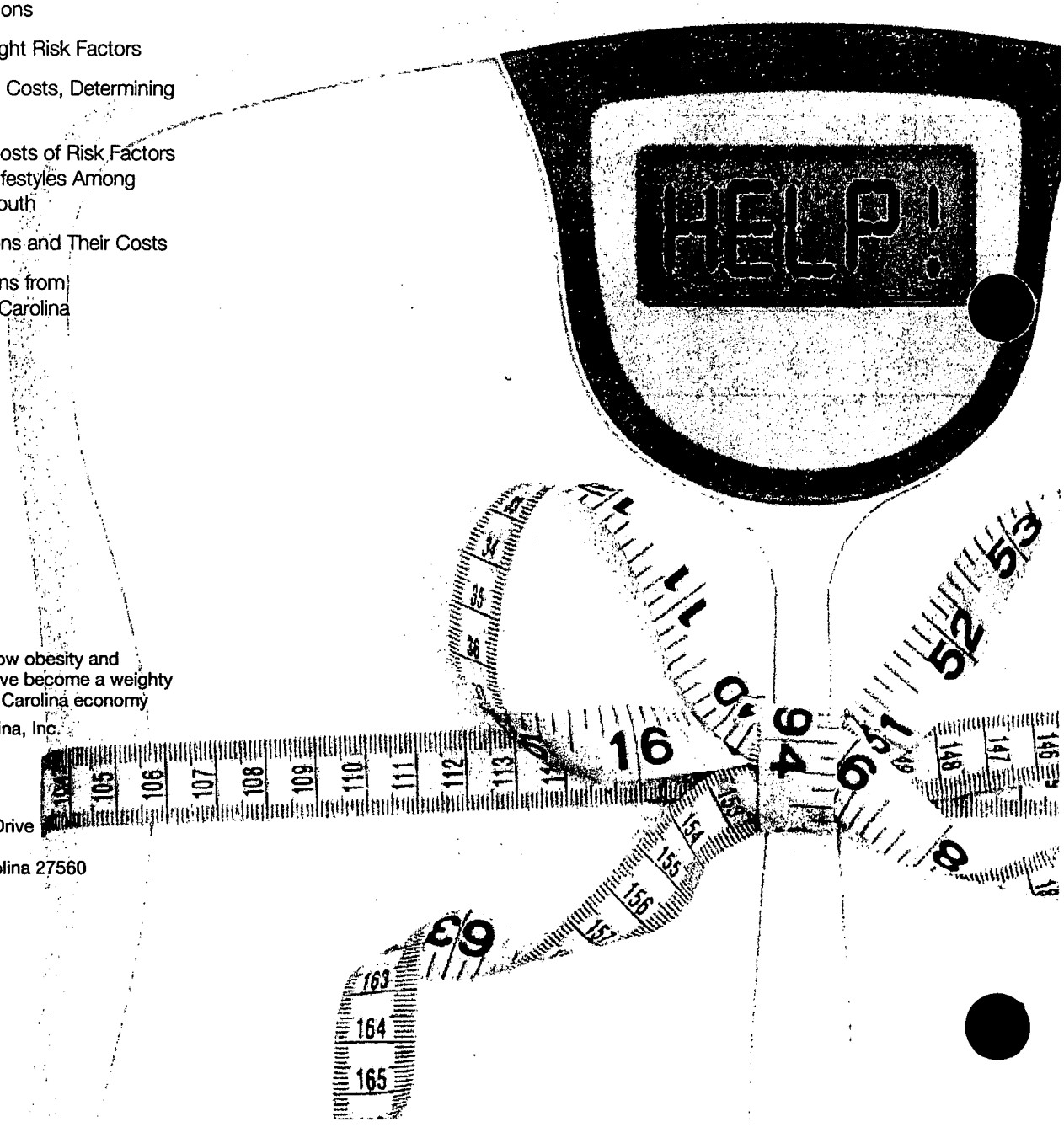
8 Tracking Medical Costs, Determining Causes

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13 Medical Conditions and Their Costs

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Tipping the Scales: How obesity and unhealthy lifestyles have become a weighty problem for the North Carolina economy

Be Active North Carolina, Inc.
June 2008

1600 Perimeter Park Drive
Suite 125
Morrisville, North Carolina 27560
www.beactivenc.org

Executive Summary

North Carolinians are fat. Statewide, we are tipping the scales at an ever-increasing rate and adding pounds that are costing us money – big money. Who pays? Largely, it's the employer. Although all North Carolinians who pay taxes are affected by these costs, employers are disproportionately burdened. That's because they insure over 63 percent of all North Carolinians.

This economic study cites eight important risk factors among both adults and children that contributed to an annual loss of $57.36 billion in 2006. By a large margin, excess weight – including being overweight or obese – is the most "expensive" risk factor with weighty impacts on medical care, prescription drugs and lost productivity. To put that $57.36 billion figure into perspective, the entire 2008 annual budget for the state of North Carolina is over $20 billion.

Alarming as the findings are, the study suggests things are likely to get worse. Without aggressive efforts to reverse the trend, the annual drain on North Carolina's economy could jump to more than $75.64 billion by 2011, a cumulative five-year increase of 31.8 percent.

North Carolinians are suffering from ill-health or have health and lifestyle habits that predispose them to a host of diseases. Tragically, even children are experiencing diseases and conditions that historically were associated with older adults. Lives are limited and, in some cases, cut short by health that is certainly not ideal. What's more, poor health also has an economic cost. Nationwide, the annual bill for treating seven of the most common chronic diseases is nearly $300 billion; the lost productivity costs associated with these conditions are a staggering estimated $1 trillion a year.[1]

Many public health experts believe that lifestyle choices account for more than half of the health problems that adults experience—and in the case of children, that is even more likely to be the case. That means how and what we eat, the amount of physical activity we get, how vigilant we are about health screenings and how disciplined we are in our habits can largely influence whether we stay healthy or stay sick.

Unfortunately for North Carolina, too few people are taking steps to improve their health habits and lifestyle. And the costs for treating diseases and conditions that often result from their choices are escalating. Unless a significant percentage of North Carolinians improve their health, employers, taxpayers and ultimately patients themselves will shoulder the burden of the increased cost of health care. This will leave less money for investment in statewide infrastructure, education, capital projects and job creation.

Background and Scope of the Report

Be Active North Carolina is the nation's best statewide organization for the promotion of health and physical activity[2] As an organization dedicated to promoting health and fitness among all North Carolinians, Be Active is concerned about the escalating cost of medical problems caused by or related to lifestyle factors. The organization commissioned its first report on these costs in 1997, and issued follow-up reports in 2001 and 2005.

The 2005 report focused on four risk factors known to be precursors of chronic illness and other conditions:

- Excess weight
- Physical inactivity
- Type II diabetes
- Low dietary consumption of fruits and vegetables.

In that report, the price tag for 11 common medical conditions tied to these four risk factors was $24.1 billion.[3] This figure included $8 billion in direct and indirect medical care, $16.1 billion in lost productivity among workers, and that is just the cost of caring for adults. For the state's children (ages 5 to 17), the bill was estimated to be $38.16 million in direct costs based on the prevalence of the three known risk factors associated with the most common chronic medical conditions. These risk factors, or precursory conditions, are physical inactivity, Type II diabetes and excess weight.

For this current study, which uses 2006 data, four new risk factors were added to the cost-appraisal analysis when looking at North Carolina's adults:

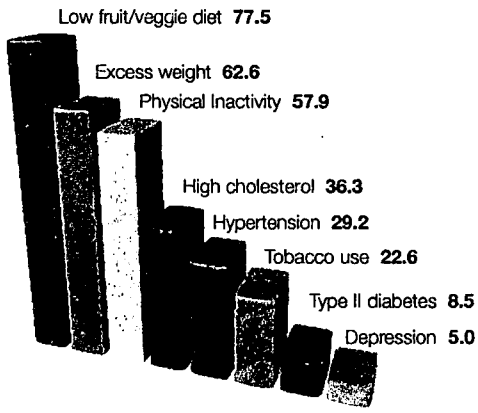
- Hypertension (high blood pressure)
- Abnormal blood lipid level (high cholesterol)
- Depression
- Tobacco use

While only one of these risk factors is considered an actual habit—tobacco use—all four are modifiable and/or treatable. Since they are all closely linked with lifestyle choices, high incidences of chronic illness and high utilization of health care, adding them to the equation will produce a more comprehensive analysis of the challenges North Carolinians face.

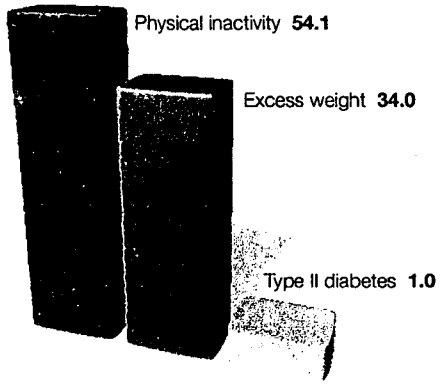
1 "An Unhealthy America: The Economic Burden of Chronic Disease—Charting a New Course to Save Lives and Increase Productivity." Report by Ross DeVol, Armen Bedroussian et. al. for the Milken Institute, October 2007.
2 National Association for Health and Fitness (NAHF).
3 Using 2003 data obtained/analyzed by Chenoweth & Associates, Inc.

Key Findings

The Eight Health Risk Factors in North Carolina Adults
Percentage Affected



The Three Health Risk Factors in North Carolina for Youth
Percentage Affected



Youth Risk Factor Responsibility for Medical Costs

Risk factor	Cost	% of all medical conditions
Phys. inactivity	$41.38 million	12.18%
Excess weight	$33.33 million	9.81%
Type II diabetes	$30.43 million	8.96%

What's the Big Deal...

Unhealthy eating and physical inactivity cost the State an estimated **$57 billion annually** in avoidable medical expenses, workers compensation claims and lost productivity. That amount is predicted to sky rocket to **$75 billion by 2011** unless preventative measures are taken. Of the risk factors contributing to this problem, excess weight is the "most expensive" for adults, while physical inactivity ranks at the top for children.

There is no question about the direct value of physical activity in preventing disease and the associated costs. Simply decreasing the prevalance of excess weight by a modest 3% could save North Carolinians $152.5 million annually in healthcare costs.

- For adults, the total cost of medical conditions/diagnoses related to eight health risk factors was **$57.36 billion** in medical care, prescription drug care and lost productivity in 2006.
- At the current rate of increase, the costs associated with the risk factors for adults will rise to **$75.64 billion in 2011**, a cumulative **five-year increase of 31.8 percent**
- **Sixty-one cents of every dollar** spent on primary medical care for the 11 common medical conditions in adults can be attributed to the eight risk factors.
- If the prevalence of the eight risk factors is reduced by a modest **three percent** among adults, North Carolina would **save $2.25 billion per year. Losing weight would have the most impact**—a **$610 million cost savings** between 2007-2011—due to its pervasiveness and its strong correlation with lost productivity costs.
- **Maintaining the three youth risk factors** at their current prevalence level would reduce potential costs by **$15 million a year.**
- Although physical inactivity is the most expensive risk factor for kids, **excess weight** is the fastest growing. Moreover, excess weight results largely from physical inactivity and is a **physiological precursor to Type II diabetes.**

and what does it mean for:

Employers: An overweight or obese adult will incur approximately **$250,000 in lost productivity costs** during the span of their career. Did you know that by promoting healthier lifestyles and getting your employees moving, you could save up to **115 hours of lost productivity per employee each year**? Do the math – that's big money.

Parents: It's hard to admit, but there's a one in four chance that your child is overweight. It's estimated that **15-45% of all new diabetes cases in North Carolina children are Type II**, a disease previously found only in adults. In addition, 54.1% of North Carolina children are physically inactive, which means that they are 600 times more likely to develop heart disease as adults!

Educators: Incorporating at least **30 minutes of physical activity into the school day** to get up, stretch and get their hearts pumping will actually improve children's levels of focus and ability to retain information.

Insurers: Insurers are all too familiar with the economic impact of unhealthy lifestyles. In North Carolina, **three out of every four prescriptions written are for the treatment of illnesses and disorders linked to inactivity and unhealthy habits.**

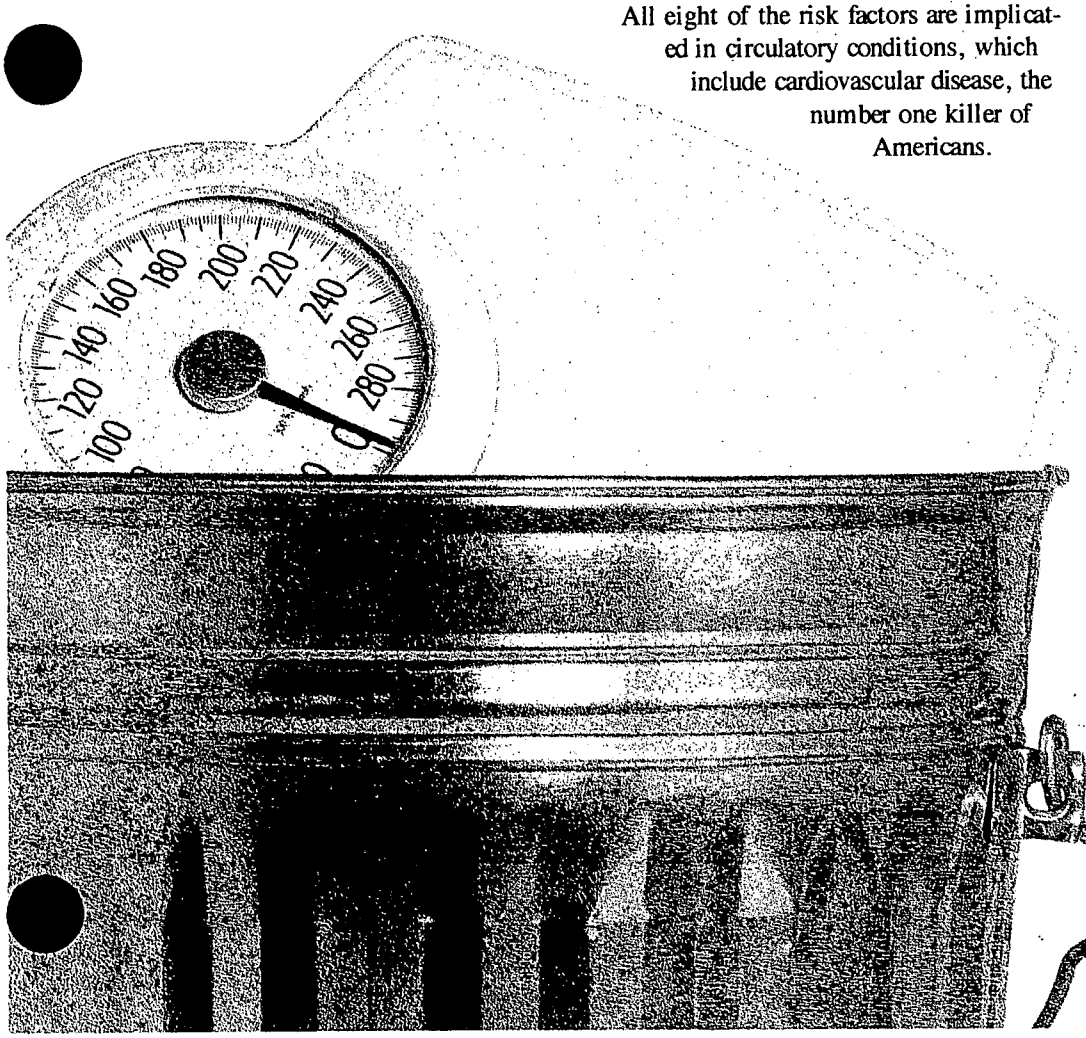
Government: If just **three percent** of overweight or obese North Carolinians achieved a normal weight through healthy eating and regular movement, the result would be a savings of over **three billion dollars**. That's more than

The Economic Cost of Risk Factors and Unhealthy Lifestyles Associated with North Carolina Adults

Prevalence of the Targeted Risk Factors and Their Relationship to Diseases/Conditions

Hard numbers bear what economists and health professionals have long observed: the cost of poor health is rising. Although some illnesses and most traumas have no known cause or are unpredictable, the majority of health problems adults suffer can be traced to the way they live their lives.

This report studied 11 common diagnoses known to be associated with eight known risk factors. These are:[4]



Musculo-skeletal conditions

Many musculo-skeletal problems in adults are associated with several of the targeted risk factors, including physical inactivity, tobacco use and excess weight.

Cancer

Research shows that several risk factors included in this analysis are linked with bladder, breast, colorectal, esophageal, endometrial, laryngeal, lung, ovarian, oral, prostate, stomach and renal cancer. These include tobacco use, excess weight, physical inactivity, low fruit and vegetable intake and depression.

Circulatory conditions

All eight of the risk factors are implicated in circulatory conditions, which include cardiovascular disease, the number one killer of Americans.

Neuro-sensory disorders

Cataracts and carpal tunnel syndrome are two of the neurological conditions associated with several of the risk factors in this analysis. In particular, these conditions are closely associated with tobacco use, low fruit and vegetable intake, excess weight and Type II diabetes.

Metabolic/endocrine/nutrition-related disorders

Although Type II diabetes is one of the risk factors analyzed in this report because it is a contributing factor in many other diseases and conditions, it is also a diagnosis in itself.[5] Other metabolic/endocrine disorders include gout and impaired immune response. Research shows that these conditions are more prominent in people who use tobacco, do not eat the recommended amount of fruits and vegetables and are physically inactive.

Digestive disorders

Four such disorders are directly associated with the risk factors analyzed: gallbladder disease, biliary and alcoholic pancreatitis, liver disease and end-stage renal disease. These conditions are most common in people with risk factors such as excess weight and tobacco use.

Complications of pregnancy

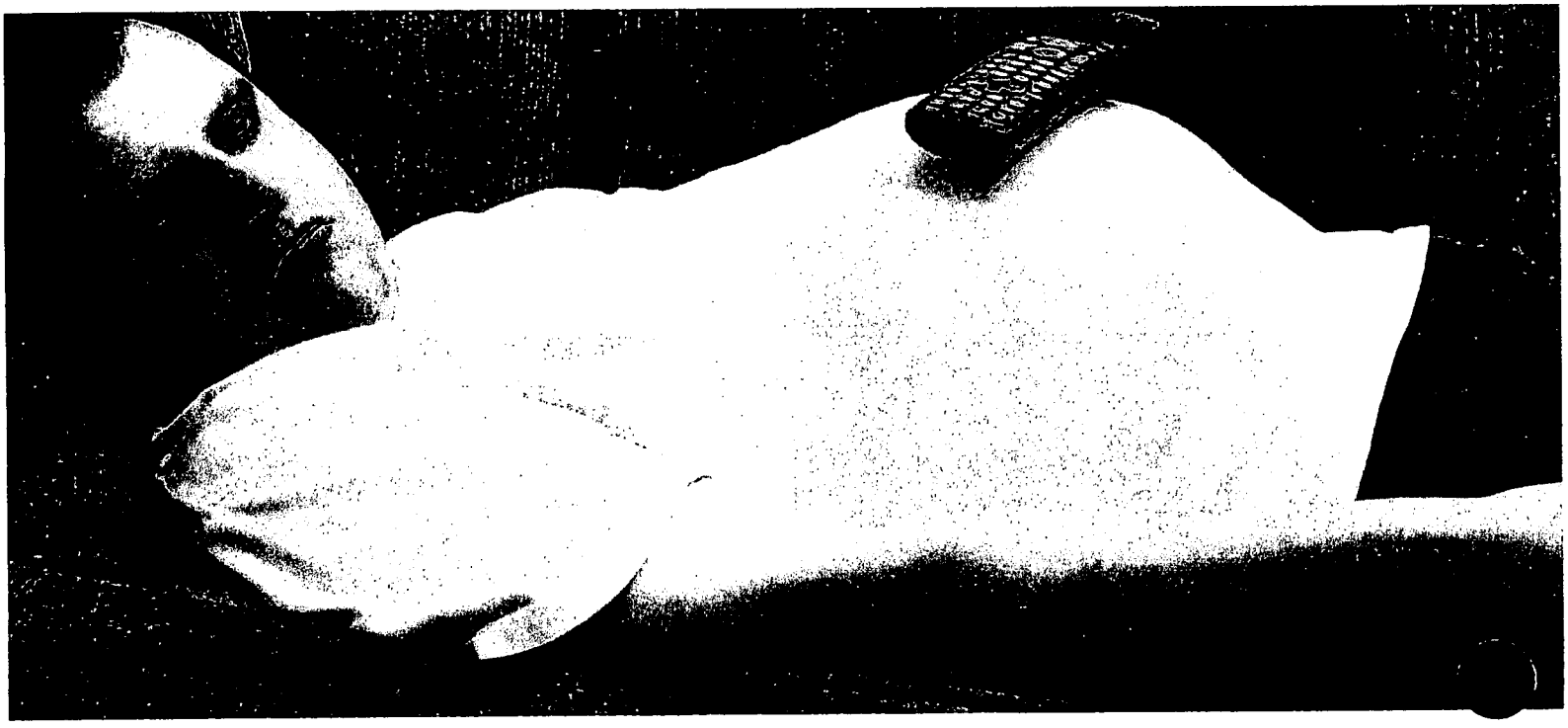
Obstetric complications are most likely to occur in women who have several of the risk factors analyzed. These include excess weight, Type II diabetes, hypertension, tobacco use and low fruit and vegetable intake.

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4 The analysts recognize that physical inactivity, low fruit and vegetable consumption and cigarette smoking are primarily behavioral decisions while excess weight, Type II diabetes, depression, abnormal blood lipid level, hypertension and depression are often classified as signs, symptoms or conditions. However, they consider all these entities precursory risk factors that, independently or in conjunction, raise an individual's probability of incurring the 11 diagnoses discussed in this report.

5 Ibid

One third of all persons with diabetes are unaware that they have the condition.



Certain injuries/complications

Medical conditions such as post-infection wounds, heart disorders and hip fractures are related to four risk factors: tobacco use, excess weight, physical inactivity and low fruit and vegetable intake.

Mental disorders

Depression and anxiety are closely associated with several risk factors examined in this report. Research reveals that one or both of these conditions are more common in people with excess weight, physical inactivity and tobacco use.

Ill-defined signs/symptoms

These conditions tend to be associated with physical inactivity, tobacco use and excess weight. However, they also include sleep apnea, urinary stress incontinence and impaired respiratory function.

Respiratory disorders

Breathing problems such as asthma, bronchitis, chronic obstructive pulmonary disease (COPD) and impaired respiratory syndrome are associated with excess weight, tobacco use, physical inactivity and low fruit and vegetable intake.

Assessing the Eight Risk Factors

These eleven common diagnoses are most commonly associated with the following eight risk factors:

Excess weight

For this report, overweight is defined as a Body Mass Index (BMI)[6] of between 25 and 29.9. Obesity is defined as a BMI of between 30 and 39.9, with morbid obesity being a BMI of 40 or higher.

Physical inactivity

One benchmark for measuring a person's physical activity level is to look at their participation in moderate physical activity over most of the week or shorter bursts of vigorous activity a few days a week. Fitness advocates now recommend that adults participate in 30 minutes or more a day of moderate physical activity for at least five days a week, or 20 minutes a day of vigorous activity for at least three days a week.

Type II diabetes

This type of diabetes, also known as non-insulin dependent diabetes mellitus or adult-onset diabetes, affects 90 percent of the roughly 14.6 million people in the United States diagnosed with diabetes. It is the sixth leading cause of death in the nation and is responsible for more than 50 percent of all non-traumatic limb amputations. Diabetes is also the leading cause of blindness and end stage renal disease in adults.

6 BMI refers to a person's relative weight for height. The calculation is [weight in lbs/height in inches squared] x 704.5.

Low dietary fruit/vegetable intake

Recent evidence has found that diets low in fruits and vegetables are strongly correlated with higher-than-normal rates of cardiovascular disease, obesity, diabetes, and certain cancers. Although it was once recommended that adults consume five servings of fruit and/or vegetables a day, the federal government in 2005 upgraded its standards to a recommended seven servings a day for women (expressed as 3.5 cups) and nine servings for men (expressed as 4.5 cups). Indeed, a growing body of research shows that additional health and potential disease-prevention benefits can accrue with a higher intake of such foods.

Depression

Major depression is characterized by a persistent sad mood and/or an inability to experience pleasure. According to the National Institute of Mental Health, one in 10 American adults, or about 21 million people, suffer from a depressive illness each year. Most people view depression as a mood disorder. However, it is becoming clearer that it is strongly related (physiologically or behaviorally) to risk factors like tobacco use, obesity, physical inactivity, hypertension, abnormal blood lipids and diabetes.

Abnormal blood lipid level (high cholesterol)

Abnormal cholesterol and triglyceride levels are strongly linked to cardiovascular disease. In most people, high-density lipoprotein or HDL, also known as "good" cholesterol, should be proportionately high, while low-density lipoprotein, i.e., "bad" cholesterol, should be low. Triglyceride, another blood lipid, is measured along with cholesterol and should, ideally, be no higher than 150 mg/unit. Although some poor blood lipid readings may be due to hereditary factors, cholesterol levels are often affected by diet. In recent years, North Carolinians' rate of high cholesterol rose more than seven percent.

Hypertension (high blood pressure)

High blood pressure is arguably one of the most widely known—and predictive—risk factors for cardiovascular disease. In fact, hypertension alone may contribute as much as 11 percent of the total risk for many types of cardiovascular disease. Blood pressure that stays between 120-139 systolic (the upper measurement) and 80-89 diastolic (the bottom measurement) is considered pre-hypertension, and readings above 140/90 are considered to be high blood pressure.

Tobacco use

Although the percentage of adult smokers has dropped dramatically in the past three decades, cigarette smoking still accounts for 20 percent of all deaths in the United States each year. The U.S. Surgeon General has called smoking the single most preventable cause of death in the United States, and nationwide, smoking is responsible for an estimated $157 billion in annual health-related losses. Smoking is responsible for approximately 30 percent of all coronary heart disease deaths in the United States. The ill-effects of smoking—as well as smokeless tobacco—are well documented. Yet Americans—primarily men, people from low socio-economic backgrounds and those with less than a high school education—continue to use tobacco products.



Eight Risk Factors for Adults[7]

Excess weight

In North Carolina, 62.6 percent of adults have excess weight (36.7 percent being overweight and 25.9 percent considered obese).

Physical inactivity

In North Carolina, 57.9 percent of adults are physically inactive. Specifically, 40.4 percent reported getting some physical activity, but less than recommended, wh 22 percent reported not being physically active at all.

Type II diabetes

In North Carolina, an estimated 547,000 adults, or approximately 8.5 percent of tl adult population, were diagnosed with Type II diabetes.

Low dietary fruit/vegetable intake

Statistics show that 77 percent of North Carolina adults eat fewer than five daily servings of fruit and vegetables.

Depression

In North Carolina, five percent of adults report being dissatisfied or very dissatisfied with life, an indicator of depression absent of a clinical diagnosis.

Abnormal blood lipid level (high cholesterol)

In North Carolina, 36.3 percent of North Carolinians reported having abnormal blood lipid levels.

Hypertension (high blood pressure)

In North Carolina, 29.2 percent of adults have been diagnosed with hypertension.

Tobacco use

In North Carolina, 22.6 percent of all adults smoke cigarettes.

7 Source: The 2005 Behavioral Risk Factor Surveillance Survey by the N.C. State Center for Health Statistics.

Hard numbers bear what economists and health professionals have long observed: the cost of poor health is rising.

Table 1: Medical Care Costs Associated With the Risk Factors

	2004 Data[8]		2006 Data[9]	
Risk Factor	Medical Costs	% of All 11 Conditions	Medical Costs	% of All 11 Conditions
Excess weight	$ 649.26 million	9.86%	$ 2.81 billion	16.41%
Physical inactivity	$ 422.20 million	6.41%	$ 2.32 billion	13.49%
Low fruit/veggie intake	$ 506.02 million	7.69%	$ 2.29 billion	13.31%
Tobacco use	not analzyed		$ 1.24 billion	7.18%
Poor blood lipids	not analzyed		$ .86 billion	5.00%
Hypertension	not analzyed		$ .73 billion	4.27%
Type II diabetes	$ 15.92 million	<.01%	$ .22 billion	1.29%
Depression	not analzyed		$ .06 billion	<.50%
TOTAL	$ 1.59 billion	23.97%	$10.53 billion	61.45%

8 Based on a 2003 statewide hourly wage of $13.17; fringe benefits of 18.24% of salary/wages; and number of full-time employed workers.
9 Based on a 2006 statewide hourly wage of $14.41; fringe benefits of 18.24% of salary/wages; and number of full-time employed workers.

Tracking Medical Costs, Determining Causes

Outpatient and inpatient medical claims

The price tag for medical treatment of the 11 adult medical conditions examined in this report was $17.12 billion in 2006. Of this number, the eight risk factors were responsible for $10.53 billion. That is 61.45 percent of the total. To put it in perspective, 61 cents of every dollar spent on outpatient or hospital treatment of these conditions resulted from one or more of the risk factors.

That cost was borne by employers, workers, the government and taxpayers. Circulatory problems—including heart disease—top the list as the most expensive health problem, costing payers $6.3 billion in 2006. This is not surprising, given the prevalence of heart disease in North Carolina and across the country. Cancer is the second-most-expensive condition in terms of outpatient and inpatient claims, costing taxpayers $2.2 billion in 2006. Together, these two conditions account for almost half of the total bill.

The most expensive risk factor is excess weight, which is responsible for $2.81 billion in medical costs, or 16.41 percent of the $17.12 billion total. This risk factor was followed by physical inactivity and low fruit and vegetable intake. **Table 1** illustrates the proportionate distributions of medical care costs per risk factor.

Factoring in Prescription Drug Costs

Because clinicians write a prescription in three out of every four health care encounters[10], the cost of prescription drugs is responsible for a significant portion of health care expenses. If the current upward trend in prescription drug use continues, prescription drug spending will soon outpace spending for inpatient hospital services.

In 2006, prescription drug costs associated with the eight risk factors totalled $4.22 billion, which is 55 percent of risk-factors specific to medical care costs and about 34 percent of the total medical care costs. Combined outpatient, inpatient and prescription drug charges for the 11 conditions amounted to nearly $17 billion in 2006. Drugs to treat digestive disorders were the most expensive category, followed by respiratory conditions, endocrine/metabolic conditions and circulatory conditions.

To determine the cost of drugs prescribed to treat the 11 conditions, analysts used a mathematical model that excluded drugs prescribed for conditions such as infections and non-risk-factor related causes. They found that the majority of drugs prescribed in North Carolina are commonly prescribed for conditions associated with the eight risk factors.[11]

Analysts used a second model to determine the approximate cost of prescription medicine tied to each risk factor individually rather than in the aggregate.[12] They found that, just as with outpatient and inpatient care, excess weight was the single most expensive risk factor in terms of prescription drug costs, followed by physical inactivity and low fruit and vegetable intake.

10 McCaig, L. and Burt, C. National Ambulatory Medical Care Survey/2002 Emergency Department Summary. U.S. Dept. of Health and Human Services, March 2004.
11 See Appendix B for a description of the analysts' prescription drug cost determination model.
12 Ibid.

Table 2: The Cost of Drugs to Treat Conditions Associated With Each Risk Factor In North Carolina

	2004 Data	2006 Data
Risk Factor	Rx drug cost	Rx drug cost
Excess weight	$175.4 million	$960.9 million
Physical inactivity	$114.0 million	$792.9 million
Low fruit/vegetable intake	$136.8 million	$782.1 million
Tobacco use	not analzyed	$423.1 million
Type II diabetes	$ 1.3 million	$425.1 million
Poor blood lipids	not analzyed	$292.5 million
Depression	not analzyed	$290.6 million
Hypertension	not analzyed	$249.7 million
TOTAL	$427.5 million	$4.22 billion

Table 2 above illustrates the proportionate distribution of prescription drug costs by risk factor.

Prescription drug costs continue to rise. They represent about 40 cents of every dollar spent on risk-factor based medical care costs (outpatient and inpatient services). The combined cost for medical care and prescription drugs linked to the eight risk factors was $14.75 billion in 2006.

The Cost of Lost Productivity in the Workplace

In most companies, personnel costs represent a significant percentage of operating costs. As a result, the impact of illness and other causes of absenteeism can be devastating to a business' economic performance. Even an employee who is present but performing below expectations due to a medical condition or injury (presenteeism) can greatly reduce a company's economic output.

In 2006, the cost of this loss of productivity associated with the eight risk factors was $42.7 billion. This figure considers the measures of lost productivity (absences, short-term disability and presenteeism).

Tying risk factors to lost productivity

Table 3 (page 10) illustrates the impact of lost productivity as a result of the risk factors. This $42.7 billion cost is almost three times higher than the cost of medical and prescription drug costs combined despite the exclusion of low fruit and vegetable intake risk factors in the productivity calculation. **Table 4** (page 11) illustrates the distribution of risk-factor costs across all three cost-appraisal categories.

Comparing 'apples to apples'

The $57.36 billion total for all costs cannot be compared equitably with data from Be Active's last report because four additional risk factors are included in this analysis.

However, if just the original four risk factors studied in the 2005 report—physical inactivity, excess weight, low fruit and vegetable intake and Type II diabetes—are compared, it is clear that costs have risen dramatically. In the 2005 report, the total cost for medical care, prescription drugs and lost productivity was $24.10 billion. In 2006, these four risk factors were responsible for $33.87 billion in costs. Adjusted for population growth and the variance in risk factor prevalence, that amounts to an increase of about 40 percent.

One risk factor emerges as the most expensive of all

It comes as no surprise to North Carolina's public health community that excess weight is the most expensive risk factor. It has the highest contribution in all three cost-appraisal categories—medical costs, prescription drug costs and lost productivity—and has an economic impact of $15.57 billion a year. Physical inactivity and poor cholesterol levels follow fairly closely in the rankings.

Excess weight was also the most expensive risk factor in the 2005 report. That percentage increased in total cost over the 2003-2006 period to 48.89 percent, followed by physical inactivity, which increased by 41 percent.

That excess weight is such a significant contributor to the negative impact of health risk factors is actually good news. Except in rare cases, people can control their weight. Unlike high blood pressure and high cholesterol, for instance, which have hereditary influences and often must be controlled with medication, weight is largely influenced by caloric balance. By eating a lower calorie diet and becoming more active, weight loss can be achieved. Even a weight loss of 10 to 15 percent of a person's body weight can improve many health indicators, including blood glucose, blood lipids and blood pressure.

Who really pays?

In today's marketplace, the bulk of medical care, prescription drugs and lost productivity costs is paid by North Carolina's employers, workers and taxpayers (in the form of Medicaid and Medicare programs). But who pays

Unfortunately for North Carolina, too few people are taking steps to improve their health habits and lifestyles. The costs of treating the diseases and conditions that often result from their choices are escalating.

Table 3: Lost Productivity Outcome Measures and Costs Tied to Selected Risk Factors

	2004 Data[13]		2006 Data[14]	
Risk Factor	Hours Lost (yearly per worker)	Lost Productivity Cost	Hours Lost (yearly per worker)	Lost Productivity Cost
Excess weight	173.3	$ 6.4 billion	267.4	$11.8 billion
Poor lipids	not analzyed		359.0	$ 9.2 billion
Low fruit/vegetable intake	not analzyed		not analzyed	
Physical inactivity	173.3	$ 6.8 billion	215.3	$ 8.8 billion
Hypertension	not analzyed		174.8	$ 3.6 billion
Depression	not analzyed		1,015.4	$ 3.6 billion
Type II diabetes	568.0	$ 2.9 billion	511.8	$ 3.1 billion
Tobacco use	not analzyed		163.6	$ 2.6 billion
TOTAL	914.7	$16.1 billion	2,707.3	$42.7 billion

13 Based on a 2003 statewide hourly wage of $13.17; fringe benefits of 18.24% of salary/wages; and number of full-time employed workers.
14 Based on a 2006 statewide hourly wage of $14.41; fringe benefits of 18.24% of salary/wages; and number of full-time employed workers.

more? Although this study could not determine the actual distribution of costs among these payers, analysts isolated the most expensive risk factor—excess weight—and assigned costs based on the payers' prevalence in the population. Hypothetically, if the costs associated with the eight risk factors were borne exclusively by any one of these payer groups, then:

- Each North Carolina taxpayer's share of the cost of excess weight would be approximately $1,740 per year.
- Each full-time worker's share of the cost of excess weight would be approximately $2,468 per year.
- Each non-farm worksite's share would be approximately $73,094 per year.

Small changes yield big results

Given North Carolina's population growth, upward trends in several of the risk factors and the rising costs of health care and prescription drugs, the $57.36 billion cost associated with the risk factors will surely continue to increase.

Analysts predict that unless people get healthier soon, the bill for the targeted risk factors in 2011 will total $75.64 billion in medical costs, prescription drug expenses and lost productivity—a cumulative five-year increase of 31.8 percent.

Additionally, the five risk factors that became the most prevalent over the past few years will likely show associated cost increases in the future. On the other hand, the remaining risk factors (depression, tobacco use and physical inactivity) may display some cost-containment potential if their annual prevalence rates continue to improve to a level low enough to offset the cost inflation and statewide population growth.

Decreasing prevalence rates for tobacco and to a lesser extent, physical inactivity and depression, suggest that many North Carolinians have successfully reduced one or more of these risk factors over the past few years. In particular, the number of people who use tobacco decreased by 5.49 percent over the three-year period examined. Combined, the three risk factors showed a baseline improvement index of 3.05 percent per year.

Analysts calculated what would happen to the aggregate risk factor cost dimensions—medical care, prescription drugs and lost productivity—if North Carolinians experienced an across the board improvement of 3.05 percent each year in the targeted risk factors. (An improvement means a reduction in the prevalence of each risk factor.) If such an improvement were to occur, North Carolina's taxpayers would save $10.65 billion between 2007-2011.



Table 4: Aggregate Costs Associated with Eight Targeted Risk Factors

Risk Factor	Medical Cost	Prescription Drug Cost	Lost Productivity Cost	TOTAL
Physical Inactivity	$ 2.32 billion	$ .79 billion	$ 8.79 billion	$11.9 billion
Excess weight	$ 2.81 billion	$ .96 billion	$11.80 billion	$15.5 billion
Low fruit/vegetable diet	$ 2.29 billion	$ .78 billion	not analyzed	$ 3.1 billion
Poor blood lipids	$ 0.86 billion	$ .29 billion	$ 9.19 billion	$10.3 billion
Tobacco use	$ 1.24 billion	$ .42 billion	$ 2.61 billion	$ 4.3 billion
Depression	$ 0.06 billion	$ .29 billion	$ 3.58 billion	$ 3.9 billion
Hypertension	$ 0.73 billion	$ .25 billion	$ 3.60 billion	$ 4.6 billion
Diabetes	$ 0.22 billion	$ .43 billion	$ 3.07 billion	$ 3.7 billion
TOTAL	$10.53 billion	$4.21 billion	$42.64 billion	$57.37 billion

Excess weight is the risk factor with the most cost-savings potential. This is because excess weight has a high prevalence among North Carolinians (62.6 percent) and comprises a substantial portion (27.6 percent) of lost productivity costs. A 3.05 percent drop in those classified as overweight or obese would save **$3.03 billion** over the 2007-2011 period.

It is apparent that even small changes—such as 3 out of every 100 overweight or obese people achieving a normal weight—can mean big savings for the state. The impact of an annual cost savings from a **3.05% improvement** in risk-factor prevalence could fund (in today's dollars) nearly **68,000 full-time jobs** in North Carolina. ■

Glossary of terms

Absenteeism: Absenteeism is the act of consistent absence from work or school due to poor health.

Body Mass Index (BMI): This equation is a person's weight in kilograms divided by height in meters squared (BMI = kg/m2). Generally, "healthy weight" is defined as a BMI equal to or greater than 19 and less than 25 among all people aged 20 and over. Obesity is generally considered to be a BMI equal to or great than 30 (roughly 30 pounds of excess weight).

Cardiovascular Disease: Also known as heart disease, cardiovascular disease includes a number of conditions affecting the heart such as congestive heart failure, congenital heart disease and heart attack.

High Cholesterol: Cholesterol is a waxy, fat-like substance made in the liver and found in certain foods, such as food from animals like dairy products (whole milk), eggs and meat. Bad cholesterol, also known as low-density lipoprotein (LDL), contributes to heart disease by laying down artery-clogging plaque; good cholesterol, or high-density lipoprotein (HDL), helps clear it away.

Hypertension (High Blood Pressure): Hypertension is diagnosed by a consistently elevated blood pressure reading that exceeds 140 systolic pressure over 90 diastolic pressure. Normal blood pressure is generally considered to be 120 systolic pressure over 80 diastolic pressure.

Non-Insulin Dependent (Type II) Diabetes: A form of diabetes mellitus characterized by diminished tissue sensitivity to insulin and sometimes impaired beta cell function, exacerbated by obesity and often treatable by diet and exercise.

Obese: Women with over 30% body fat and men with over 25% body fat are considered obese.

Overweight: The National Institutes of Health defines overweight in terms of a BMI of 27.3% or more for adult women and a 27.8% or more for men.

Presenteeism: Presenteeism is the act of regularly attending work or school, without the ability to perform at full capacity due to poor health.

The Economic Cost of Risk Factors and Unhealthy Lifestyles Associated with North Carolina Youth

More than a third of North Carolina youth are classified as overweight. For the first time in history, this generation may be sicker and die younger than their parents. Across the country and here in North Carolina, 34% of children ages 2 to 17 are battling excess weight or are at risk for becoming overweight.[15]

Children who are overweight and physically inactive are now exhibiting cases of Type II diabetes, a diagnosis once unheard of in children. In addition, they are not getting enough exercise or eating enough fruits and vegetables, leading to a host of chronic conditions.

Five of those conditions were selected for this study. Only inpatient and outpatient treatment were examined.[16] Researchers sought first to identify the risk factors/lifestyle habits associated with ill-health in youth, and to measure prevalence of these risk factors among the population. The risk factors and their prevalence are as follows:

Physical inactivity

In 2005, the last year for which figures were available, 54.1 percent of school-aged children were physically inactive.[17] While that number represents an improvement of about 3.4 percent over the level of physical inactivity in 2003, it is still disturbing that more than half of North Carolina's children are participating in little to no exercise.

Excess weight

The term "excess weight" is used to describe children and adolescents whose body mass index (BMI) is at or above the 95th percentile for kids of the same age and sex. Based on the 2005 Behavioral Risk Factor Surveillance Study (BRFSS) targeting the State's youth, 34 percent fall into the "excess weight," category, with 16 percent classified as overweight and 18 percent at risk of overweight.

Diabetes

An estimated 15-45% of all new diabetes diagnoses in children fell into the Type II category. In North Carolina, approximately one percent of all children and adolescents were diagnosed with Type II diabetes or pre-diabetic syndrome, based on a study by UNC-Chapel Hill researchers.



15 "At risk" of overweight means that a child's BMI is between the 85th and 95th percentile.
16 Unlike in the adult analysis, prescription drug costs and lost productivity costs were not included. That is because children do not work and are prescribed prescription drugs in insufficient quantities to produce valid analysis.
17 2005 NC Youth Risk Surveillance Survey (YRSS)

Medical Conditions and Their Costs

This report studied five common diagnoses known to be associated with three known risk factors or precursory conditions.

Musculo-skeletal

As with adults, overweight children and adolescents who do not exercise their muscles, joints and tendons regularly are prone to musculo-skeletal injuries and conditions. Other risk factors for such problems are high-risk activities, being male, having a medical history and experiencing high levels of stress.

Circulatory

Medical evidence indicates that the same risk factors linked to circulatory conditions in adults are also responsible for such problems in youth. In addition to the three risk factors—excess weight, physical inactivity and Type II diabetes—other risk factors for circulatory diseases in youth include depression, hypertension, abnormal blood lipids, family history and tobacco use.

Metabolic/endocrine-related disorders

While diabetes is the most prevalent of these conditions and is a category for treatment in itself, researchers also included it as a risk factor condition (same as the adult study). Other metabolic/endocrine conditions include gout and impaired immune response. In addition to excess weight and physical inactivity, risk factors for these problems include smoking, genetics, high cholesterol, being of Hispanic or African-American descent, poverty, substance abuse and hypertension.

"Ill-defined" signs and symptoms

Several medical conditions that fall into this category are associated with physical inactivity and excess weight, including impaired respiratory function, sleep apnea and urinary stress incontinence. Research shows that these conditions are associated with smoking, existing illness, air pollution and genetics/family history.

Mental disorders

Recent studies suggest that depression stemming from physical inactivity and/or obesity is not limited to adults. One study shows that youth who are substantially overweight throughout their childhood and adolescence have a higher incidence of depression than their healthy-weight peers.

Tallying the Toll

The cost to treat the five medical conditions associated with the child/youth risk factors was $339.64 million in 2006. Of that total, $105.13 million can be directly attributed to the three risk factors. Physical inactivity was the most expensive risk factor, accounting for $41.38 million in health care costs, or 12.18 percent of the total tab. Approximately $1 of every $3.23 spent to treat the targeted medical conditions can be traced to one or more of the risk factors. **Table 5** below illustrates the total cost and distribution of risk factors for the targeted medical conditions.

Table 5: Risk Factor Responsibility for Youth Medical Costs

Risk factor	Cost	% of all medical conditions
Phys. inactivity	$41.38 million	12.18%
Excess weight	$33.33 million	9.81%
Type II diabetes[18]	$30.43 million	8.96%

The $105.13 million cost associated with the three risk factors is likely to increase. As North Carolina's population grows, so will the prevalence of high risk factors and general medical costs. Without any containment, these costs could reach $164.59 million in 2011, an increase of more than 56 percent.

Containing these factors at their current prevalence levels would generate cumulative cost savings of approximately $77 million by 2011—or $15 million per year.

Although physical inactivity has the highest impact among the risk factors, excess weight is growing in prevalence at the fastest rate. By examining the cost of risk factors among North Carolinian adults, it is clear that excess weight will continue to be the most expensive of all chronic diseases in children.

This is clearly shown in the per-capita costs of excess weight. Currently, that figure stands at $62 per child per year with excess weight each year (2006 dollars). With medical care inflation at about 7.7 percent each year, the excess weight cost would more than double—from $62 to $130 per child per year—in a decade. When today's youth join the workforce at approximately age 23, the price tag of their excess weight will substantially increase because lost productivity costs will also enter the equation. Per capita medical care and lost productivity costs among North Carolina's overweight adults are about $4,000 per capita each year. Furthermore, an overweight or obese adult in North Carolina will incur costs of more than $28,619 by the halfway point in their career—and more than $250,000 by the time they reach retirement age. So, the benefit of reducing the number of youth who enter adulthood with excess weight is obvious. ■

18 As a risk factor for the targeted conditions, diabetes is estimated to cost approximately $430,092 in direct medical care. The $30.43 million figure represents insurance/medical claims coded specifically as Type II diabetes.

Working together to make it happen

Recommendations from Be Active North Carolina, Inc.

Community Wide Efforts

Once considered just a personal problem, it is now clear that excess weight and other risk factors studied in this report have a profound impact on North Carolina's families, communities and businesses. Employers in particular bear most of the cost because they provide health insurance to the majority of North Carolinians. Employers also suffer the consequences of lost productivity. Shouldering such expenses limits companies ability to boost the economy through capital investment and job creation.

In fact, some State leaders worry that the unhealthy habits and poor health profiles of so many North Carolinians are making the state less competitive, both nationally and globally.

North Carolina needs well-crafted efforts across communities to reduce the unacceptably high prevalence of the eight risk factors. It is essential that these efforts be:

- Initiated in all public and private schools as well as churches, community centers and workplaces.
- Directed to all people regardless of sex, age, lifestyle, socioeconomic status or other segmentation factors.
- Customized to meet the unique needs and interests of each group.
- Aligned to each community's physical environment.
- Subjected to formal process, impact and outcome evaluations to determine short-term, intermediate and long-term results.

Moving Toward Healthier Children

North Carolina's schools and other organizations with a stake in the welfare of our children need to be more involved in promoting healthy lifestyles. One of the most effective ways to boost physical fitness levels in students—and thereby reduce their risk for excess weight and Type II diabetes—is through daily physical activity. School-based obesity prevention programs were found to be a cost-effective way to prevent at-risk youth from developing adult obesity. School districts that require daily physical education typically report higher academic achievement among their students than systems without such mandates. The gap in academic performance between fit and unfit youth can significantly increase in as little as two years.[19]

All communities must join in the effort to reduce the number of children who suffer from Type II diabetes, have excess weight or are physically inactive. That includes the State's most rural counties, where the prevalence rates for the three risk factors are disproportionately higher than they are in urban or suburban areas.

For programs to be effective, it is essential that they be:

- Initiated in schools, day care centers, churches, community centers and other venues frequented by children and adolescents.
- Customized to meet the unique needs and interests of all groups.
- Receptive to process, impact and outcome evaluations to measure short-term, intermediate and long-term results.

Be Active North Carolina has long expressed concern about the physical health and wellness of North Carolinians. Obesity and other problems create health threats that damage the quality of life for many North Carolinians. This study and others like it continue to provide tangible, solid evidence about the negative impact of unhealthy lifestyles on our economy. The challenge lies in convincing North Carolinians to take genuine steps toward improvement.

19 See Appendix B for more information.



Appendix

A: Summary of the Methodology

A variety of sources and methods were used to obtain the patient data collected to analyze medical and lost productivity costs in North Carolina. Inpatient medical claims and costs tied to the targeted medical conditions were provided by the North Carolina Hospital Association. Outpatient medical claims and costs tied to the target conditions were provided by the state's largest private insurer, Blue Cross and Blue Shield of North Carolina, as well as the Division of Medical Assistance of the North Carolina Department of Health and Human Services. Because there is no public statewide database on prescription drug usage and cost patterns in North Carolina, the analysts based their calculations on national norms provided by several industry-leading vendors. They estimated prescription drug costs for each of the medical conditions based on median costs of selected drugs, estimated annual prescription drug use, and the number of North Carolina adults with selected medical conditions.

Similar sources and methods were used to analyze the cost impact of the risk factors in children and youth. Prescription drug costs and lost productivity costs were not analyzed for children.

For their analysis of lost productivity costs, Chenoweth & Associates based their estimates of the costs of absenteeism, short-term disability and "presenteeism"—defined as working at less than full capacity—on U.S. worksite case studies. They obtained wage and salary data for 2006 from the North Carolina Department of Commerce.

20 Wang, L. et al (2003) Economic analysis of a school-based obesity prevention program. Obesity Research, 11, 1313-1324

21 *PE4Life*, Kansas City, MO

B: Methodology Used in Analyzing Costs

This report was prepared using data collected and analyzed by Chenoweth & Associates, Inc. To analyze medical costs for both children and adults, and prescription drug and lost productivity costs for adults, C&A obtained statistics from insurers, associations and government agencies. The firm's analysts customized a Proportionate Risk Factor Cost Appraisal™ (PRFCA) to use with the medical care and prescription drug data they received. PRFCA is an epidemiologically based appraisal framework based on each risk factor's prevalence in North Carolina, the total value of inpatient and outpatient claims and charges for each diagnosis, and the premise that an individual with one or more of the targeted risk factors will experience a specific illness or medical condition. Risk factor weights are subject to change as new scientific evidence evolves or health care utilization patterns change.

Below is an overview of the methods C&A used to produce its analysis.

Medical Care Costs

Inpatient medical claims and costs tied to targeted medical conditions were provided by the North Carolina Hospital Association (NCHA). Outpatient medical claims and costs tied to targeted medical conditions were provided by BlueCross BlueShield of North Carolina (BCBSNC) and the Division of Medical Assistance (DMA) of the North Carolina Department of Health & Human Services. Collectively, BCBSNC and DMA subjects comprise approximately 24.54 percent of the state's adult population. Upon comparing (a) this composite percentage to the size of the remaining sectors and (b) the composite annual premium against those of the remaining four sectors, a multiple of 5.45 was calculated and used to estimate state wide outpatient claims and costs for each of the selected target areas.

Prescription Drug Costs

A public access state-wide database or clearinghouse on prescription drug usage and cost patterns in North Carolina does not currently exist.

Prescription drug utilization and costs associated with each of the targeted medical conditions was based on national norms provided by several industry-leading vendors.

Estimated prescription drug costs for each of the targeted medical conditions were based on (1) median costs of selected drugs, (2) estimated annual prescription drug usage, and (3) the number of North Carolina adults with the selected medical conditions.

Estimated prescription drug costs for each of the targeted risk factors were based on multiplying the risk factor-specific cost per medical condition by the percentage of total prescription drug costs to total medical care costs.

Lost Productivity

Absenteeism, short-term disability and "presenteeism" rates associated with seven of the eight targeted risk factors were estimated and based on actual U.S. worksite case studies.

Wage and salary data was obtained for the calendar year of 2006 from the North Carolina Department of Commerce.

C: The Link Between Fitness and Scholastic Aptitude

School-based obesity[20] prevention programs have been found to be a cost-effective way to prevent at-risk youth from adulthood obesity. Studies such as those conducted by PE4Life[21], Kansas City, MO show a strong correlation between Scholastic Aptitude Tests (SAT) and Fitness Standard Achievement scores.

Authors of this report

About Be Active North Carolina, Inc.

Be Active North Carolina, Inc. is a 501(c)3 nonprofit organization dedicated to increasing physical activity levels and promoting healthy lifestyles among all North Carolinians. Since 1971, the organization has worked to increase public awareness of the effects of physical inactivity, build grassroots advocacy and volunteerism, create model statewide programs, and advocate for policies that reduce barriers and create opportunities for physical activity.

Long before it was popular, Be Active was in the forefront building awareness about the human and financial costs of sedentary lifestyles and developing programs to combat obesity.

For the past seventeen years, the organization has raised over $16 million and has grown to a staff of fourteen. Be Active continues to expand with a regional office on the campus of university partner Appalachian State University and programs in all 100 counties.

Today, Be Active is nationally recognized for its work and offers a wide variety of signature programs to get North Carolinians started and to keep them moving toward a healthy active lifestyle. In 2007, Be Active North Carolina was named the nation's best statewide organization for health and physical activity by The National Association for Health and Fitness (NAHF).

About Chenoweth & Associates

Chenoweth & Associates, Inc. (C&A) is a leading econometrics consulting firm based in New Bern, North Carolina. Since 1979, C&A has provided strategic econometric services to business, industrial, health care, and governmental organizations. Since the late 1990's, C&A has conducted chronic disease risk factor analyses for various states – California (2005-6), Washington (2004), Michigan (2003), Massachusetts (2003), New York (1999 and 2001), Maine (2006) and three separate appraisals for North Carolina (1997, 2001, and 2005).

To analyze medical costs for both children and adults, and prescription drug and lost productivity costs for adults, C&A obtained statistics from insurers, associations, and government agencies. The firm's analysts customized a Proportionate Risk Factor Cost Appraisal™ (PRFCA) to use with the medical care and prescription drug data they received. PRFCA is an epidemiologically based appraisal framework based on the risk factor's prevalence in North Carolina, the total value of inpatient and outpatient claims and charges for each diagnosis, and the premise that an individual with one or more of the targeted risk factors will experience a specific illness or medical condition. Risk factor weights are subject to change as new scientific evidence evolves or health care utilization patterns change

Tipping the Scales: How obesity and unhealthy lifestyles have become a weighty problem for the North Carolina economy

Be Active North Carolina, Inc.
June 2008

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INPATIENT

PRIVATE COMMERCIAL

DRGs

A zero (0) indicates no volume was found. A blank indicates the number of records found was 5 or fewer.
DRG numbers and names for 2005 are in a separate tab of this spreadsheet.

Table 1

ALL STATE HOSPITAL

Condition	DRG	FY2005 DISCHARGES BY DRG, OVER AGE 18, NORTH CAROLINA [OVER 18]	FY2005 CHARGES BY DRG, OVER AGE 18, NORTH CAROLINA	FY2005 DISCHARGES BY DRG, UNDER AGE 18, NORTH CAROLINA [UNDER 18]	FY2005 CHARGES BY DRG, UNDER AGE 18, NORTH CAROLINA
A. MUSCULO-SKELETAL		**Claims**	**Charges**	**Claims**	**Charges**
OsteoarthritisKneeHip	237	85	$764,978	8	$75,383
Rheumatoid arthritis	241/242/244/245/246	1,822	$18,372,049	198	$1,823,262
Pain in Joint					
Stiffness in Joint					
Low Back Pain	243	5,101	$52,702,520	113	$1,142,548
Polymyalgia					
Tendon/Myo/Bursitis	248	1,044	$11,858,839	79	$675,912
Osteoporosis					
Low back strain/sprain					
		8052	$83,698,386		
B. NEOPLASM (Cancer)					
Pharyngeal					
Esophageal/gastric	154-156	2,626	$109,412,776		
Colo-rectal	172-173/148-49/179	14,437	$442,079,933	426	$11,513,029
Laryngeal					
Lung	82	4,210	$72,586,494		
Breast in women &	274-275	259	$3,403,690	0	$0
Endometrial	354-55/357-59	18,575	$234,639,050	144	$1,860,223
Bladder					
Renal (kidney)	318/319	378	$4,747,220		
Brain					
Lymphoma	400-404	2,390	$59,607,218	40	$2,522,510
		42975	$926,496,281		

		OVER 18			
Carcinoma in situ		42,875	$926,476,382	610	$15,895,762
C. CIRCULATORY					
Atherosclerosis					
Hypertension					
Cardiovascular dis	103-112/120-145	139,303	$2,522,181,739	1,320	$70,957,908
Myocardial infarction					
Angina pectoris					
Coronary					
Congestive hrt failure					
Stroke	14, 15, 16 & 17	17,505	$287,413,699	82	$1,798,414
Deep Vein Thrombosis					
Chron Venous Insuff					
		156,808	$2,809,595,437	1,402	$72,756,321
D. NERVOUS SYSTEM					
Autism					
Mental retardation	429	1,745	$19,123,728	45	$789,518
Cerebral palsy					
Carpal Tunnel Synd	6	12	$152,436	0	$0
Cataract					
		1,757	$19,276,164	45	$789,518
E. METAB/ENDO/NUTRITION					
Diabetes	294 & 295	8,711	$80,191,832	1,189	$6,589,156
Gout					
ImpairedImmuneResp	488-490	2,647	$60,437,333	14	$144,541
		11,358	$140,629,165		
F. DIGESTIVE					
Gallbladder disease	195-198	1,747	$45,505,195	17	$645,883
Liver disease	199-202	2,822	$53,755,963	15	$391,463
Acute & Chr	203 & 204	9,309	$133,201,917	121	$1,511,423
End Stage Renal Dis	316-317	11,444	$184,311,796	58	$846,153
		36,680	$557,404,036	1,414	$10,128,620
G. Sign/Symptom/Ill-def.					
Sleep apnea					
Urinary Stress Incontinence					

UNDER AGE 18

E. METAB/ENDO/NUTRITION							
Diabetes	250.0-250.9	395	$	493,092.53	15,865	$	9,369.01
Gout	274.0-274.9	0	$	-	1,443	$	96,534.33
ImpairedImmuneResp	279.0-279.9	182	$	200,727.27	427	$	529,287.24
F. DIGESTIVE							
Gallbladder disease	575.0-575.9	135	$	345,568.40	5,352	$	13,427,892.36
Liver disease	570.0-573.9	120	$	86,331.12	4,701	$	3,902,834.33
Acute & Chr Pancreatitis	577.0-577.1	90	$	98,922.41	1,417	$	1,741,082.91
End Stage Renal Dis	585	308	$	384,499.68	14,412	$	36,999,496.31
G. Sign/Symptom/Ill-def.							
Sleep apnea	780.5-780.57	423	$	450,029.64	7,470	$	9,018,726.20
Urinary Stress Incontinence	788.3-788.39	463	$	154,298.37	620	$	971,900.85
H. RESPIRATORY							
Acute bronchitis	466.0-466.1	1,302	$	459,207.94	4,546	$	1,714,483.20
Chron Obstruct Pulm Dis.	490.0-491.9	684	$	240,561.45	4,253	$	1,838,736.22
Asthma	493.0-493.9	3,337	$	1,385,940.96	4,660	$	2,164,344.37
Impaired Respir. Function	518.5-518.89	166	$	71,159.77	3,664	$	3,251,478.76
I. PREGNANCY (Complications)							
Obst & gyneco compl.	640.0-648.9	656	$	370,597.17	17,187	$	8,578,507.31
J. INJURY&POISONING							
Hip Fracture	3.0-808.1, 835.0-835.1,843.0-84	175	$	62,738.91	730	$	523,153.63
Infections fol'g wounds	910.1-919.9	1,725	$	589,826.55	3,783	$	1,579,838.41
Burns	940.0-949.5	586	$	277,068.82	1,215	$	623,662.56
Toxic Effects of Solvents	982.0-983.9	20	$	10,727.85	10	$	18,791.29
Lead/metallic poisoning	984.0-987.8	32	$	9,807.94	92	$	47,082.69
Heat disorders	992.0-992.9	96	$	71,067.42	322	$	231,358.97
Effects Hunger & Thirst	994.2-994.3	0	$	-	0	$	-
Surgical Complications	96.71-996.75, 996.83, 997.0-997	64	$	82,346.39	1,069	$	2,924,939.49
K. CONGENITAL							
Anencephaly	740.0-740.2	0	$	-	3	$	321.50
Spina bifida	741.0-741.9	218	$	118,847.58	75	$	55,189.32
Cleft palate	749.00-749.04	131	$	188,599.68	0	$	-
Cleft lip	749.1-749.14	39	$	63,558.36	0	$	-
Cleft palate w/cleft lip	749.2-749.24	98	$	274,925.37	2	$	297.50
Hypospadias	752.60-752.62	246	$	656,740.82	2	$	578.65
Omphalocele	756.7	9	$	2,191.25	0	$	-
Limb reduction defects	755.20-755.4	61	$	179,497.43	15	$	9,195.75
L. MENTAL							
Neurotic depression*	300.4	24	$	9,543.97	279	$	130,363.48
Depressive disorder	311	264	$	132,201.26	1,524	$	855,048.68
Anxiety states	300	470	$	195,732.91	3,065	$	1,491,939.33
M. E CODES							
Accidental falls	E880-E888	0	$	-	7	$	1,660.30

18 UNDER

OUTPATIENT

MEMBERSHIP For MHS Managed Care Lines of Business (HMO,POS,PPO

MHS Managed Care Outpatient Data (based on selected primary diagnosis codes)
Service Dates: January 2006 - September 2006 (processed thru December 2006; CDW)

Conditions	ICD - 9	Member Age <= 18		Member Age 19+	
		# Claims	Total Charged	#Claims	Total Charged
A. MUSCULO-SKELETAL					
OsteoarthritisKneeHip	715.0-715.9	32	$ 44,303.34	6,786	$ 8,800,945.19
Rheumatoid arthritis	714.0-714.9	468	$ 254,724.34	2,492	$ 1,757,336.73
Pain in Joint	719.4	5,967	$ 2,278,838.74	36,275	$ 17,027,732.81
Stiffness in Joint	719.5	25	$ 23,276.31	259	$ 333,458.61
Low Back Pain	724.2-724.5	1,601	$ 781,832.55	34,983	$ 26,425,488.74
Polymyalgia Rheumatica	725.0-725.9	0	$ -	54	$ 15,123.88
Tendon/Myo/Bursitis	726.0-729.9	4,604	$ 2,470,557.09	45,991	$ 53,147,352.39
Osteoporosis	733.0-733.9	741	$ 944,143.35	7,221	$ 6,767,997.89
Low back strain/sprain	847.9	82	$ 32,265.15	764	$ 337,732.90
B. NEOPLASM (Cancer)					
Pharyngeal	140.0-149.9	23	$ 22,579.75	2,165	$ 4,341,255.84
Brain	191.0-191.9	515	$ 1,021,946.29	1,847	$ 2,960,075.15
Lymphoma	200.0-208.9	1,901	$ 1,914,595.53	12,063	$ 16,810,238.26
Carcinoma in situ	230.0-231.9	3	$ 3,384.00	180	$ 304,331.23
Esophageal/gastric	150.0-152.9	0	$ -	1,828	$ 2,761,300.96
Colo-rectal	153.0-154.1	6	$ 915.75	6,047	$ 11,451,482.60
Laryngeal	160.0-161.9	9	$ 10,804.22	694	$ 1,385,072.58
Lung	162.0-164.9	17	$ 16,614.61	7,184	$ 11,841,603.42
Breast in women & men	174.0-175.9	2	$ 400.00	21,520	$ 35,222,213.50
Endometrial	182.0-183.9	20	$ 10,430.08	3,803	$ 6,366,604.27
Bladder	188.0-188.9	0	$ -	1,352	$ 2,033,935.15
Renal (kidney)	189.0-189.1	128	$ 79,583.44	1,575	$ 1,837,989.13
C. CIRCULATORY					
Atherosclerosis	440	2	$ 1,560.65	1,441	$ 6,596,068.69
Chron Venous Insuff	459.81	5	$ 8,987.06	801	$ 674,683.66
Hypertension	401.0-401.9	325	$ 140,657.82	15,837	$ 5,886,253.19
Cardiovascular dis	402.0-404.9	41	$ 18,717.75	1,329	$ 1,709,996.83
Myocardial infarction	410.0-412.9	2	$ 378.00	2,207	$ 3,567,906.16
Angina pectoris	413.0-413.9	13	$ 48,470.49	1,225	$ 1,697,870.90
Coronary atherosclerosis	414.0-414.9	18	$ 16,098.71	11,889	$ 48,768,620.80
Congestive hrt failure	428.0-428.9	10	$ 3,075.71	1,840	$ 3,715,966.32
Stroke	430.0-438.9	135	$ 142,050.43	6,786	$ 8,562,073.33
Deep Vein Thrombosis	437.6	0	$ -	0	$ -
D. NERVOUS SYSTEM					
Autism	299.0	202	$ 107,921.78	3	$ 610.00
Mental retardation	317.0-319	12	$ 10,795.73	4	$ 326.50
Cerebral palsy	343.0-343.9	1,082	$ 912,847.25	44	$ 41,657.01
Carpal Tu[redacted] Synd	354.0-354.3	30	$ 41,380.55	6,022	$ [redacted]559,405.11
Cataract [redacted]	366.0-366.9	73	$ 198,399.72	12,038	$ [redacted]28,115.89

Jennifer MacDougall, NCBCBS

ADDRESSING THE OBESITY CRISIS

NORTH CAROLINA OBESITY PREVENTION FUNDERS ALLIANCE members work together to improve the health of children and their families by addressing the obesity epidemic. The Alliance believes that collaboration can have a greater impact on decreasing the prevalence of obesity, and that strategically addressing the health needs of communities will better serve the people of North Carolina.

NORTH CAROLINA OBESITY PREVENTION FUNDERS ALLIANCE

Purpose

- Increase understanding of geographic funding disparities, encouraging foundations to invest strategically and recognize opportunities for innovation, particularly in rural areas
- Provide consistent messages to health promotion and health care practitioners statewide, ensuring the use of the most promising strategies across entities
- Create more opportunities for jointly funded initiatives
- Create knowledge of evidence-based programs, policies and practices to reduce the prevalence of obesity in North Carolina

Collaborative Projects

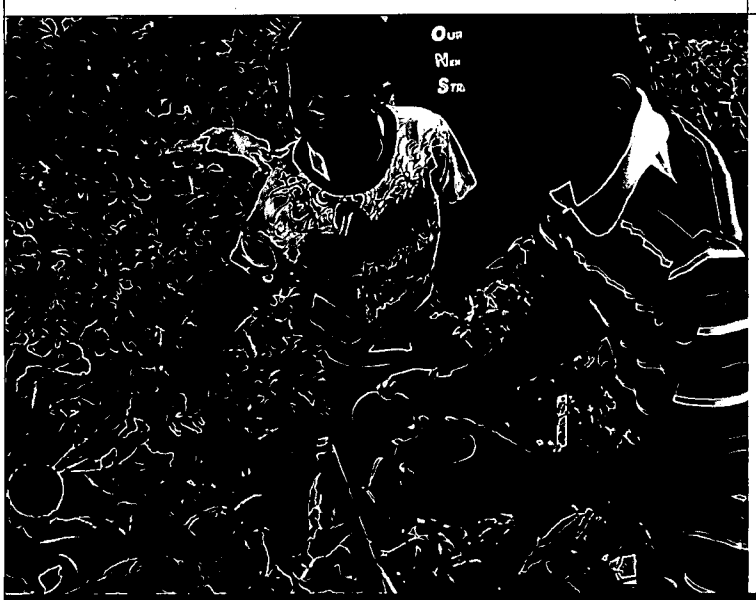
Obesity Summit

The Obesity Summit in October 2008 included more than 350 city and county planners, government officials, health care providers, school administrators, fitness experts and neighborhood leaders. Participants learned about physical activity and nutrition programs, workplace wellness, policy changes, media messages and faith-based interventions. Speakers focused on the crisis in North Carolina and how working together can bring change.

North Carolina Institute of Medicine Prevention Task Force

The North Carolina Institute of Medicine, in collaboration with the North Carolina Division of Public Health, convened a task force in 2008 to develop an action plan for the state. The task force examined preventable causes of death and disability and examined health disparities and prioritized recommendations based on evidence-based strategies.

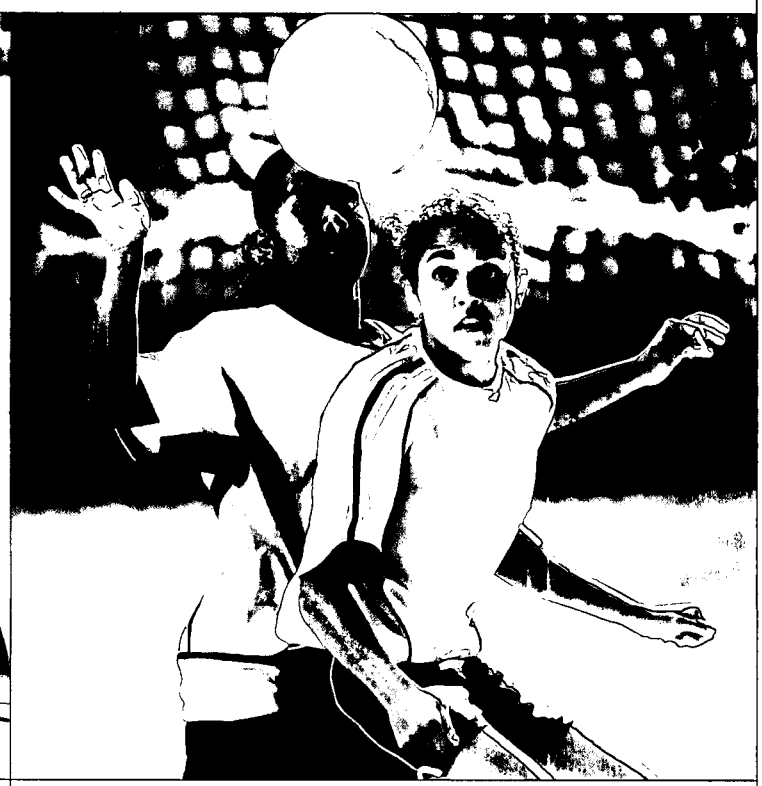
The action plan, released in October 2009, provides 45 recommendations, with 11 priorities that focus on influencing systematic change. The complete report is online at www.nciom.org.



NORTH CAROLINA IS THE **10TH** MOST OVERWEIGHT / OBESE STATE IN THE NATION.

Source: Prevention for the Health of North Carolina: Prevention Action Plan, October 2009





PROJECT HIGHLIGHTS

Blue Cross and Blue Shield of North Carolina Foundation
Nutrition and Physical Activity Self-Assessment for Child Care

Outcomes: Program partners, with state-trained child care health consultants, worked with early childhood programs to improve nutrition and physical activity practices and policies. The one-year investment reached 128 child care centers in 10 counties and led to an additional investment to North Carolina Partnership for Children and the N.C. State University Natural Learning Initiative to improve the outdoor environment at child care centers.

Grantee: North Carolina Partnership for Children

Funding Partners: n/a

Funding Period: June 2008 - June 2009

Amount: $240,217

John Rex Endowment
Advocates for Health in Action

Outcomes: Established coalition of agency and individual stakeholders to shape policies and environments in Wake County that support healthy eating and physical activity.

Grantee: WakeMed Health & Hospitals

Funding Partner: Blue Cross and Blue Shield of North Carolina Foundation

Funding Period: Fall 2007 - present

Amount: $163,226

Kate B. Reynolds Charitable Trust
Healthy Lives, Healthy Futures

Outcomes: By the end of its first year, five churches and six county Department of Aging sites were involved in the program. To date, 50 percent of participants have reduced their weight and body mass index and more people are eating the recommended allowance of fruits and vegetables. Within the next seven years, the grantee is committed to ensuring that at least 600 of 2,000 participants reduce their risk of chronic disease by making at least two positive lifestyle changes.

Grantee: Public Health Authority of Cabarrus County

Funding Partner: Cabarrus Health Alliance

Funding Period: January 2008 - January 2015

Amount: $1.2 million

NC Health & Wellness Trust Fund
Fit Community/A+ Fit School

Outcomes: Thirty-two communities have received $60,000 in grants and technical assistance to make healthy changes to the environment including enhanced parks, sidewalks and greenways. Nine schools received $7,500 to improve walking tracks, refurbish school gyms and create school/community gardens.

Grantees: Thirty-two N.C. communities (technical assistance provider: Active Living by Design); nine schools (technical assistance provider: East Carolina University's Health Education and Promotion Department)

Funding Partners: n/a

Funding Period: 2006 - present

Amount: $2 million

Physical Activity and Nutrition Branch, NC Division of Public Health
Childhood Obesity Demonstration Project

Outcomes: Sidewalks and greenways were constructed, 14 farmer's markets opened, 42 child care centers implemented policy and environmental changes to support healthy eating and physical activity, six hospital systems implemented worksite wellness initiatives and nine faith communities implemented policy and environmental changes.

Grantees: The following N.C. counties: Dare, Cabarrus, Henderson, Moore, Watauga

Funding Partner: North Carolina General Assembly

Funding Period: July 2008 - June 2009

Amount: $1.9 million

Reidsville Area Foundation
Reidsville Greenway Master Plan

Outcomes: After completing one mile of the six-mile Reidsville Greenway Master Plan, construction was discontinued because of funding constraints. With the Reidsville Area Foundation sharing the cost, two sections of the Master Plan have been completed and the trails are now a resource for the entire community.

Grantee: City of Reidsville

Funding Partners: Reidsville Area Foundation and the City of Reidsville

Funding Period: April 2005 - September 2015

Amount: $909,650

The Duke Endowment
Healthy Food Environments in Hospitals

Outcomes: Establishing healthy food environments in N.C. hospitals for employees, patients and visitors. Twenty-nine hospitals have implemented the full criteria to create a healthy food environment; 46 have action plans for implementation and 39 have expressed interest in joining the movement.

Grantee: North Carolina Hospital Association

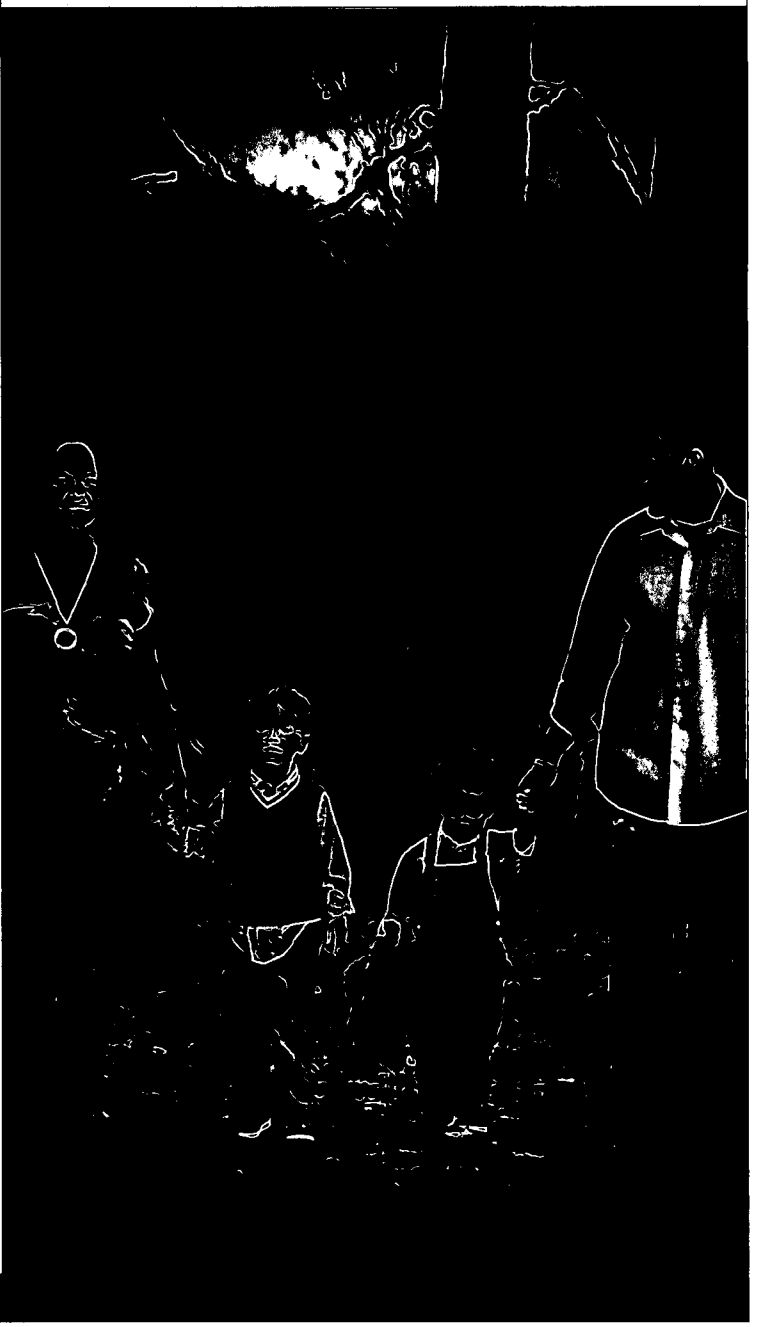
Funding Partners: n/a

Funding Period: 2008 - 2010

Amount: $1 million

AMONG NORTH CAROLINA CHILDREN AGES 10-17, 34% WERE OVERWEIGHT OR OBESE.

Source: North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics. Health Profile of North Carolinians: 2007



MEMBERS

Blue Cross and Blue Shield of North Carolina Foundation

The Blue Cross and Blue Shield of North Carolina Foundation is a separate, independent, charitable foundation based in Durham, N.C. Its focus is improving the health of vulnerable populations, supporting physical activity and nutrition programs and helping North Carolina nonprofits improve their organizational capacity. Since its inception, the Foundation has invested into the community more than $58 million through 390 grants to N.C. organizations. The Foundation also manages several Signature Programs, including Be Active Kids® and Healthy Community Institute for Nonprofit Excellence.

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John Rex Endowment

The John Rex Endowment invests in the development and support of activities, programs and organizations that improve the health of underserved people in Wake County, N.C. Currently, the Endowment supports visible and measurable improvements in the health of children and youth by improving access to health services, promoting healthy behaviors and providing opportunities for growth and development.

Kate Shirah
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Kate B. Reynolds Charitable Trust

The Kate B. Reynolds Charitable Trust in Winston-Salem, N.C., was established in 1947 to improve the quality of life and health for the financially needy of North Carolina. Since it began, the Trust has invested more than $450 million toward improving the life and health of needy residents of our state.

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NC Health & Wellness Trust Fund

The NC Health & Wellness Trust Fund was created by the General Assembly as one of three entities to invest North Carolina's portion of the Tobacco Master Settlement Agreement. The Fund invests in programs and partnerships to address access, prevention, education and research that help all North Carolinians achieve better health.

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Physical Activity and Nutrition Branch, NC Division of Public Health

The Physical Activity and Nutrition Branch in Raleigh, N.C., works to promote increased opportunities for physical activity and healthy eating through policy and environmental change. Staff members provide tools, resources and technical assistance to local health departments and community partners.

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Reidsville Area Foundation

The Reidsville Area Foundation, an independent foundation, established in July 2001, conducts grantmaking exclusively in Rockingham County, N.C., to support programs and initiatives that improve health, wellness, education and quality of life. The Foundation was formed with proceeds from the merger of Annie Penn Hospital with the Moses Cone Health System.

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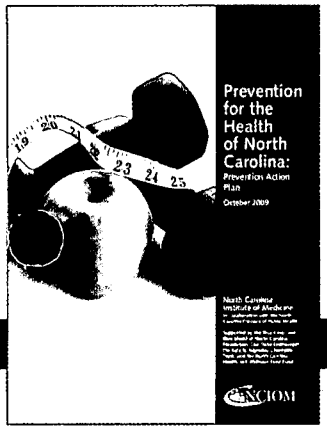
The Duke Endowment

The Duke Endowment, in Charlotte, N.C., seeks to fulfill the legacy of James B. Duke by enriching lives and communities in the Carolinas through higher education, health care, rural churches and children's services. Since its inception in 1924, the Endowment has awarded more than $2.6 billion in grants.

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Prevention for the Health of North Carolina

A Prevention Action Plan

October 2009

The burden of chronic diseases and other preventable conditions in our state is high and increasing steadily. North Carolina is 36th in overall health and 38th in premature death.[a,1] Further, North Carolina ranks poorly on many other health indicators, including health outcomes, health behaviors, access to care, and socioeconomic measures.

Why Prevention?

The most practical approach to address such conditions—from both a health and an economic perspective—is to prevent them from occurring in the first place. However, health care spending is drastically skewed toward paying for therapeutic procedures to manage or treat acute and chronic health problems, and not toward prevention. Reorienting our health system, as well as our overall society, towards a prevention focus represents a fundamental paradigm shift involving all members of our society. In addition to individual personal responsibility for health, health care providers, employers, schools, communities, businesses, and other institutions also play a critical role in ensuring the long-term health of our state. We must all invest in prevention before the burden on individuals, their families, employers, and the broader community becomes too great.

North Carolina Ranks Poorly on Most of the Major Health Indicators[a]

Indicator	North Carolina	United States	National Rank
Adults who are current smokers (2008)	20.9%	18.4%	37th
Overweight and obese adults (2008)	29.5%	26.7%	41st
Physically active adults (2007)	44.0%	49.5%	46th
Incidence of new STD cases (syphilis, gonorrhea, chlamydia) per 100,000 population (2007)	537.4	492.9	37th
Adults with alcohol and illicit drug abuse or dependence (2006-2007)	8.2%	9.2%	6th
Adults with serious psychological distress (2006-2007)	10.9%	11.1%	15th
Average air pollution (micrograms of fine particulate per cubic meter) (2005-2007)	13.6	13.1	35th
Motor vehicle fatalities per 100,000 (2008)	15.5	12.3	35th
Children ages 19 to 35 months with recommended childhood immunizations (4:3:1:3:3) (2007)	80.0%	80.1%	27th
Low-income families (<200% FPG) (2007-2008)	39.4%	35.8%	39th
Graduation rate (2004-2005)	72.6%	74.7%	39th
Race and ethnicity equity (2007)	33.7	24.1	42nd
Uninsured (2006-2007)	17.2%	15.3%	38th

Data sources for all figures are located in the reference section.

Relying on prevention as a basic strategy can save lives, reduce disability, improve quality of life, and, in some cases, decrease health care costs. Research has shown that several modifiable behaviors such as tobacco use, exercise, nutrition, and substance use can either positively or negatively affect health outcomes. Individuals and families can improve their health and well-being by making healthy lifestyle choices. Although such decisions are made by individuals, they are influenced by many factors, including family and friends, medical care (including health insurance and health care providers), and workplace policies. In addition, community and environmental factors, as well as state and federal laws and policies, can have a profound impact on an

[a] When rankings appear throughout this Issue Brief, number "1" reflects the state with the best health status.

individual's health behaviors. Working to address all of these factors will improve the health and well-being of North Carolinians in both the short- and long-term.

Task Force Charge

The North Carolina Institute of Medicine (NCIOM), in collaboration with the North Carolina Division of Public Health, convened a Task Force to develop *Prevention for the Health of North Carolina: Prevention Action Plan* for the state. The Task Force was convened at the request of North Carolina's leading health foundations, including the Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, the Kate B. Reynolds Charitable Trust, and the North Carolina Health and Wellness Trust Fund. The Task Force was chaired by Leah Devlin, DDS, MPH, former State Health Director;[b] Jeffrey Engel, MD, State Health Director, Division of Public Health, North Carolina Department of Health and Human Services; William Roper, MD, MPH, CEO, University of North Carolina (UNC) Health Care System, and Dean, UNC School of Medicine; Robert Seligson, MA, MBA, Executive Vice President and CEO, North Carolina Medical Society, and included 46 additional members.

The Task Force identified 10 preventable risk factors that contribute to the leading causes of death and disability in the state:

1. Tobacco use
2. Diet and physical inactivity, leading to overweight or obesity
3. Risky sexual behaviors
4. Alcohol and drug use or abuse
5. Emotional and psychological factors
6. Exposure to chemicals and environmental pollutants
7. Intentional and unintentional injuries
8. Bacterial and infectious agents
9. Racial and ethnic disparities
10. Socioeconomic factors

The *Prevention Action Plan* includes evidence-based strategies that, if followed, will improve population health in the state. The Task Force followed four steps in developing this plan. First, the Task Force identified the diseases and health conditions that have the greatest adverse impact on population health in terms of premature death or disability including cancer, heart disease, injuries, chronic lower respiratory disease, alcohol and drug use, stroke, infectious diseases, diabetes, and depression. Second, the Task Force identified the underlying risk factors which contribute to these leading causes of death and disability. (See text box.) Third, the Task Force examined the literature to identify evidence-based strategies that could prevent or reduce these risk factors. Too often in the past we have not always used strategies with evidence of effectiveness. The Task Force was particularly mindful of the need to use existing dollars more efficiently, and to limit new funding to evidence-based strategies, or, when unavailable, best or promising practices where there is evidence to suggest that this intervention could be effective.

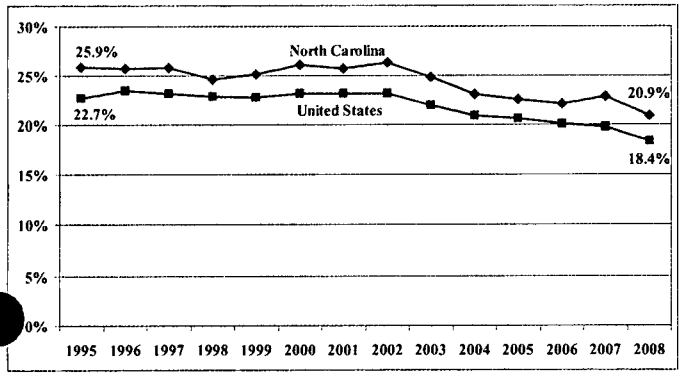
Finally, the work of the Task Force was guided by the understanding that changes in population health require multi-level interventions, or a "socioecological" model of prevention. Because people's decisions about whether to engage in risky health behaviors are influenced by other factors—including the opinions of family and friends, clinical advice, community and environment, and public policies—multi-level interventions are more likely to be successful.[2] For example, a coordinated effort to implement multifaceted, evidence-based interventions led to dramatic decreases in youth smoking rates. From 2003 to 2007, the high school use rate declined from 27.3% to 19.0%, after years of stagnation.[3] The lesson from our improvement in tobacco use is that broad-based, systematic investments in multifaceted interventions can be effective in addressing seemingly intractable public health problems. The path demonstrated by our success with tobacco should be replicated across the other risk factors outlined in this report.

[b] Dr. Leah Devlin served as one of the co-chairs for the Task Force from the inception of the work until she retired as State Health Director. At that time, Dr. Jeffrey Engel became one of the co-chairs. Dr. Devlin remained as a member of the Task Force.

Priority Recommendation:
Increase North Carolina's Tobacco Taxes

Tobacco use is the leading cause of preventable death in North Carolina. From 2005-2009, an estimated 13,000 North Carolinians aged 35 years or older died each year from a smoking-related death.[4] At least 30% of all cancer deaths and nearly 90% of lung cancer deaths—the leading cause of cancer deaths among men and women—are caused by smoking.[5] Despite decreases in smoking rates, North Carolina's tobacco use among adults continues to exceed the national rate.

North Carolinians are More Likely to Smoke than Rest of Nation



Increasing tobacco taxes will deter initiation of tobacco use by young people, encourage tobacco users of all ages to quit, and save lives. Research shows that a 10% price increase in a pack of cigarettes results in a 4.1% decrease in tobacco use within the general population, and a 4%-7% decrease among youth who smoke.[6] North Carolina has the 7th lowest cigarette tax in the country. Increasing the cigarette tax from our current tax rate ($0.45 as of September 1, 2009) to the national average ($1.32 as of August 12, 2009) would provide tremendous gain for the state in terms of reducing death and disability due to tobacco use.[7] In addition, raising the tax on other tobacco products (OTP) will discourage the use of these products as well.[8] The new revenues generated from the increase in tobacco taxes should be targeted to prevention efforts.

Other recommendations include funding and implementing the Comprehensive Tobacco Control Program; expanding tobacco-free policies; and expanding access to cessation services, counseling, and medications for smokers who want to quit.

Action Steps to Reduce Tobacco Use	
Individuals	Be tobacco free
Family/ Home	Don't use tobacco products at home
Clinical	Offer comprehensive cessation services (counseling and medication) to help smokers quit; stay up-to-date on evidence-based clinical preventive screenings, counseling, and treatment
Schools and Child Care	Enforce tobacco-free school laws; support the Coordinated School Health Program and participate in school health surveys; implement evidence-based health education programs
Worksites	Institute a worksite wellness program; create tobacco-free worksites; offer coverage for tobacco cessation services (counseling and medications)
Insurers	Pay for smoking cessation services and medications
Community	Expand tobacco-free policies to public places; fund and implement the comprehensive evidence-based tobacco prevention program
Public Policies	Expand tobacco-free policies to all workplaces; increase the tobacco tax; provide tax incentives to encourage comprehensive worksite wellness programs; fund and implement the Comprehensive Tobacco Control Program

Promote Healthy Eating and Physical Activity

Priority Recommendations:

1. Implement the Eat Smart, Move More North Carolina Obesity Plan and Raise Public Awareness
2. Implement Quality Physical Education and Healthful Living in Schools

Overweight and obesity pose significant health concerns for both children and adults. Excess weight is a risk factor for several serious health conditions and exacerbates existing conditions.[9] North Carolina is the 10th most overweight/obese state in the nation. Moreover, the trends in our state are alarming. The adult overweight/obese rate has increased dramatically from 52.3% in 1995 to 64.6% in 2008.[10] Trends in childhood obesity are equally disturbing.

Many North Carolina communities are trying to address this growing problem by implementing initiatives to improve nutrition and increase physical activity. Eat Smart, Move More North Carolina is a consortium of organizations that have developed a community-based plan to reduce obesity in our state and is ideally suited to lead this effort.

Currently the State Board of Education *recommends* schools provide 150 minutes of physical education in elementary schools and 225 minutes of Healthful Living education in middle schools; high school students are required to take one Healthful Living credit. *Requiring* schools to meet these guidelines and increasing the number of Healthful Living credits required of high school students would help ensure more students in North Carolina get the amount of daily physical activity that is recommended by the Centers for Disease Control and Prevention.

Other recommendations include implementing child nutrition standards in all elementary schools and testing strategies to deliver healthy meals in middle and high schools; ensuring all foods and beverages available in schools are healthy; expanding physical activity and nutrition in child care centers and after-school programs; expanding the availability of farmers markets and farm stands; promoting menu nutrition labeling; building active living communities; establishing joint-use agreements for school and community recreational facilities; expanding community grants program to promote physical activity; increasing the availability of obesity screenings and counseling; and expanding the Community Care of North Carolina (CCNC) childhood obesity prevention initiative.

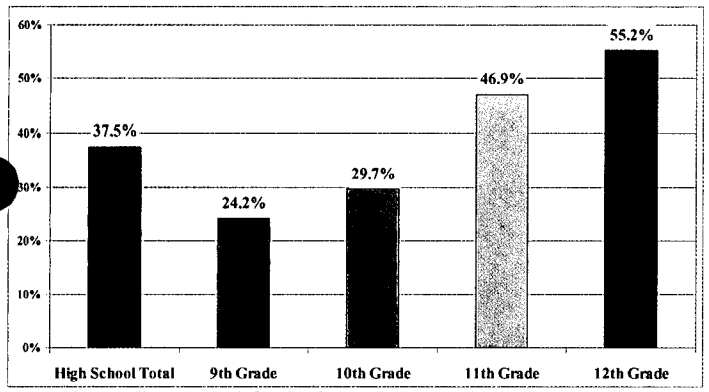
Action Steps to Promote Healthy Eating and Physical Activity	
Individuals	Eat healthy and exercise more
Family/ Home	Provide nutritious meals and snack choices
Clinical	Offer obesity screening and counseling for adults; expand CCNC childhood obesity prevention initiative for children; stay up-to-date on evidence-based clinical preventive screenings, counseling, and treatment
Schools and Child Care	Implement child nutrition standards; ensure all foods and beverages are healthy; implement high quality physical education and evidence-based healthful living classes; expand physical activity in after-school and child care programs; expand joint-use agreements; support the Coordinated School Health Program and participate in school health surveys
Worksites	Institute worksite wellness program; promote healthy foods and physical activity; offer farmers markets/stands at the workplace; provide coverage for obesity screening and counseling
Insurers	Offer coverage for obesity screening, counseling, and treatment
Community	Fund and implement Eat Smart, Move More community-wide obesity reduction strategies; promote menu labeling in restaurants; build active living communities; expand joint-use agreements
Public Policies	Fund schools to provide nutritious meals; require schools to offer high quality physical education and healthful living classes; fund Eat Smart, Move More community-wide obesity reduction plan; support community efforts to promote physical activity and build active living communitites; provide tax incentives to encourage comprehensive worksite wellness programs

Priority Recommendation:

Ensure Students Receive Comprehensive Sexuality Education in North Carolina Public Schools

Risky sexual behaviors can lead to sexually transmitted diseases (STDs), human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and unintended pregnancy. In 2007, nearly 54,000 cases of reportable STDs (non-HIV) were reported in North Carolina.[11] North Carolina has the 14th highest rate of new STD cases in the country (syphilis, gonorrhea, and chlamydia).[11] In addition, North Carolina has the 4th highest rate of new HIV cases out of 22 states.[12] Forty-five percent of all live births in 2006, including most births to teenagers, resulted from unintended pregnancies.[13] In 2006, North Carolina's teen (ages 15-19) birth rate was higher than the national rate (49.7 per 1,000 versus 41.9 per 1,000).[14]

More than One in Three North Carolina High School Students is Currently Sexually Active



Currently sexually active is defined as having had sex with one or more people during the past three months.

Until recently, North Carolina had a law requiring public schools to only teach abstinence until marriage. Evaluations of many abstinence programs, including abstinence-until-marriage programs, have shown no overall impact on delaying age of initiation of sex, number of sexual partners, or condom or contraceptive use.[15] In contrast, comprehensive sexuality education programs have been shown to be effective.[15] Despite a recent state law requiring local schools to offer comprehensive reproductive health and safety education, local Boards of Education are still required to adopt a policy to allow parents or legal guardians to consent or withhold consent for their student's participation.

An opt-out consent process would ensure that more young people in North Carolina receive evidence-based, scientifically accurate sexuality education.

Other recommendations include increasing awareness, screening, and treatment of STDs; increasing HIV testing in prisons, jails, and juvenile centers; reducing unintended pregnancies; and expanding the availability of low-cost family planning services to reduce unintended pregnancies.

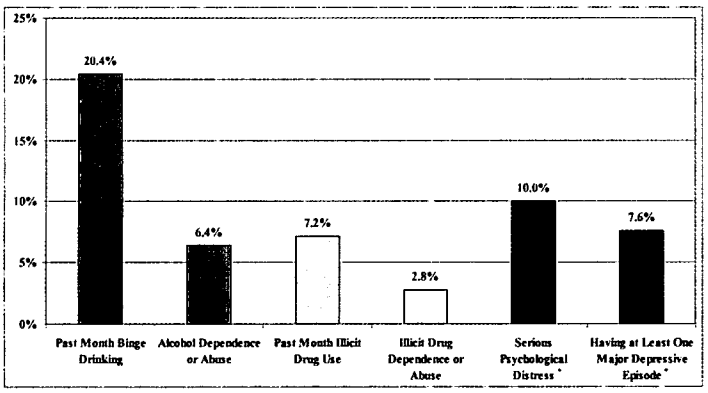
Action Steps to Reduce Risky Sexual Behavior	
Individuals	Use protection to prevent STDs and unintended pregnancy; know your STD/HIV status
Family/Home	Talk to your children about the consequences of risky sexual behavior
Clinical	Increase screening, counseling, and treatment of STDs/HIV and offer family planning services; stay up-to-date on evidence-based clinical preventive screenings, counseling, and treatment
Schools and Child Care	Ensure that more students receive comprehensive sexuality education; support the Coordinated School Health Program and participate in school health surveys; implement evidence-based health education programs
Insurers	Offer coverage for STD/HIV screening, counseling, treatment, and family planning services
Community	Expand availability of family planning services for low-income families; promote adolescent pregnancy prevention programs; increase testing for STDs/HIV in correctional facilities
Public Policies	Fund social marketing campaign to increase awareness, screening, and treatment of STDs and reduce unintended pregnancy; increase HIV testing in correctional facilities; expand the availability of family planning for low-income families

Priority Recommendation:

Develop and Implement a Comprehensive Substance Abuse Prevention Plan

Substance use and abuse is both a health problem in itself and a health risk contributing to other health problems. People with substance abuse problems or dependence are at risk for premature death, other health conditions, and disability.[16] Mental health disorders can have a profound effect on an individual, their interpersonal relations, their functioning in school or the workplace, and their overall sense of well-being.[17] Depression is also a leading cause of suicide.[18]

Many North Carolinians Report Substance Abuse and Mental Health Problems



* Data for serious psychological distress and having at least one major depressive episode are for adults ages 26 or older. Data for ages ages 18-25 are 16.6% and 8.6%, respectively. Due to differences in the questions asked of youth younger than 18, comprable data are not available.

Evidence-based prevention strategies have been shown to be effective in delaying initiation and reducing use of alcohol and other drugs. Many of these evidence-based programs have also demonstrated other positive effects, such as an improved sense of well-being and lower levels of depression.[19] Effective strategies targeting youth are needed because their developing brains are particularly susceptible to the effects of alcohol and drugs.[16,20]

Prevention should be the cornerstone of North Carolina's efforts to reduce inappropriate use, misuse, and dependence on alcohol and other drugs, and to prevent the incidence and severity of stress, depression, or other anxiety disorders. However, no prevention intervention will totally eliminate all harmful use of alcohol or other drugs, or feelings of isolation, depression, or stress. Thus, it is important to combine prevention with early intervention activities.

Other recommendations include screening, brief intervention, and treatment for people with behavioral health problems in the primary care setting; and expanding early intervention services in the faith community.

Action Steps to Prevent Substance Abuse and Improve Mental Health	
Individuals	Be substance abuse free and seek help for substance abuse or mental health problems
Family/ Home	Talk to your children about the dangers of substance use and help family members with behavioral health problems get into treatment
Clinical	Offer screening, brief intervention, and referral into treatment for substance abuse; offer behavioral health services in primary care offices; stay up-to-date on evidence-based clinical preventive screenings, counseling, and treatment
Schools and Child Care	Support the Coordinated School Health Program and participate in school health surveys; implement evidence-based substance abuse prevention and mental health programs
Worksites	Offer worksite wellness programs that include screening and referrals for substance use and depression
Insurers and Community	Offer coverage for substance abuse and mental health in parity with other services; pay for behavioral health services offered in primary care settings
Public Policies	Fund comprehensive community-based substance abuse prevention programs; increase tax on beer and wine; mandate coverage for substance abuse in parity with other services; fund expansion of co-location of behavioral health services in primary care settings; provide tax incentives to encourage comprehensive worksite wellness programs

The environment in which we live, work, learn, and play greatly affects our health. During the 20th century, the majority of the advances in population health were the result of public health interventions focused on improving the physical environment.[21] Despite these advances, air and water pollution persist. Air pollution has been shown to cause or worsen respiratory conditions (e.g. asthma and emphysema) and cardiovascular conditions (e.g. heart attack and stroke).[22] Water pollution has been linked to both acute poisonings and chronic effects. In addition, certain air and water pollutants have been linked to cancer.[21-24]

Action Steps to Decrease Environmental Risks	
Individuals	Keep your home healthy and safe
Family/ Home	Keep your home healthy and safe
Clinical	Offer counseling about safe homes, such as the use of smoke alarms and carbon monoxide detectors
Schools and Child Care	Train staff to conduct inspections and identify potential environmental hazards using the EPA's Tools for Schools Program; support the Coordinated School Health Program and participate in school health surveys
Worksites	Reduce environmental risks in the workplace
Community	Expand and enhance efforts to create healthy homes; clean up environmental hazards
Public Policies	Fund environmental assessments and create an interagency leadership commission to promote healthy communities, minimize environmental risks, and promote green initiatives; fund efforts to reduce environmental hazards in homes, schools, and child care

To build healthy, active communities, North Carolina needs to address the major pollutants and causes of pollution in the state, as well as the built environment. Many different agencies at the state and local level have responsibilities to monitor or enforce environmental standards and promote healthy communities. Thus interagency leadership is needed to develop an interagency plan to reduce environmental risks and promote healthy communities.

Environmental hazards in homes and schools can be particularly hazardous, especially to children and the elderly, as these are people who tend to spend a lot of their time in these environments. Multiple federal agencies are working together to improve housing conditions and create healthier homes by broadening the capacity of the different professionals who inspect homes to address multiple housing problems that can affect health or safety.[25] There are many different types of inspectors who work in North Carolina homes and who could be cross-trained to identify and help mitigate risks while in a home.

Many schools also have environmental hazards. Nationally, about one-third of schools in the United States are believed to have significant environmental risk issues and are in need of extensive repair or renovation.[26,27] The Environmental Protection Agency (EPA) has created the Indoor Air Quality Tools for Schools (TfS) Program as a means of reducing exposures to indoor environmental contaminants. Schools that have implemented the TfS Program have seen increases in comfort levels and reductions in absenteeism and poor health outcomes.[28]

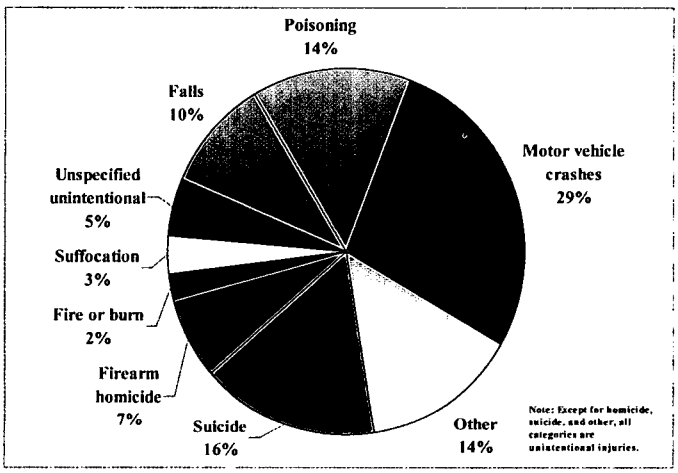
Recommendations include creating an interagency leadership commission to promote healthy communities, minimize environmental risks and promote green initiatives; developing an environmental assessment that links environmental exposures to health outcomes; ensuring healthy homes; and reducing environmental risks in schools and child care settings.

Priority Recommendation:

Create a Statewide Task Force or Committee on Injury and Violence

Injury and violence are significant problems in North Carolina, leading to death and disability for thousands each year. Injuries can be either unintentional or intentional. Unintentional injuries include motor vehicle collisions, falls, and unintentional poisonings. Violence, on the other hand, is defined as intentional injury resulting from the active, deliberate use of force against another person or oneself. Injuries and violence are often preventable.[29]

Leading Causes of Injury Deaths in North Carolina, All Ages, 2006



Injury is a serious cause of disability, resulting in more than 148,000 hospitalizations, 819,000 emergency department (ED) visits, and an unknown number of outpatient visits and medically unattended injuries in North Carolina each year.[30] Motor vehicle-related crashes and other unintentional injuries, including unintentional poisonings and falls, are the 4th leading cause of death in North Carolina, resulting in more than 4,300 fatalities in 2007.[31]

Historically, the North Carolina General Assembly has not given the same priority to injury prevention as it has to other public health activities. Prevention of injury and violence is not listed as an essential public health service, although injury and violence are both major causes of death and disability in the state. North Carolina should make injury and violence prevention explicit in the list of essential public health services at the state level. Further, a statewide task force or committee on injury and violence could facilitate greater interagency leadership and coordination across agencies involved with preventing injury and violence in the state. Good data also are important to establish targeted and effective injury prevention initiatives.

Other recommendations include reviewing and enforcing all traffic safety laws; enhancing injury surveillance, intervention, and evaluation; and enhancing training of state and local health professionals in injury control.

Action Steps to Reduce Injuries	
Individuals	Practice common sense safety; follow traffic laws
Family/ Home	Reduce potential hazards in the home
Clinical	Offer counseling to prevent injuries; learn about evidence-based strategies to prevent and reduce injuries; collect and report injury data
Schools and Child Care	Support the Coordinated School Health Program and participate in school health surveys; implement evidence-based injury and violence prevention programs
Worksites	Provide a safe working environment
Community	Enforce traffic safety laws; enhance injury surveillance, intervention, and evaluation
Public Policies	Review and enhance traffic safety laws; fund injury surveillance and intervention; create a statewide task force to prevent injury and violence; fund injury prevention training for health professionals

Reduce the Incidence of Vaccine Preventable Diseases and Foodborne Illness

Priority Recommendation:

Increase Immunization Rates

Over the last 100 years, the number of deaths from infectious diseases in the United States generally decreased until the 1980s when it started increasing due to HIV/AIDS and the emergence of antibiotic resistant illnesses.[31] There are many different types of infectious diseases; the Task Force focused on vaccine preventable diseases and foodborne illnesses.

Infectious diseases, including pneumonia and influenza, were the 10th leading cause of death among North Carolinians, causing 1,644 deaths in 2007.[32] Infectious diseases can also cause disabilities. However, vaccines are available to help prevent many diseases, including pneumonia and many forms of influenza.

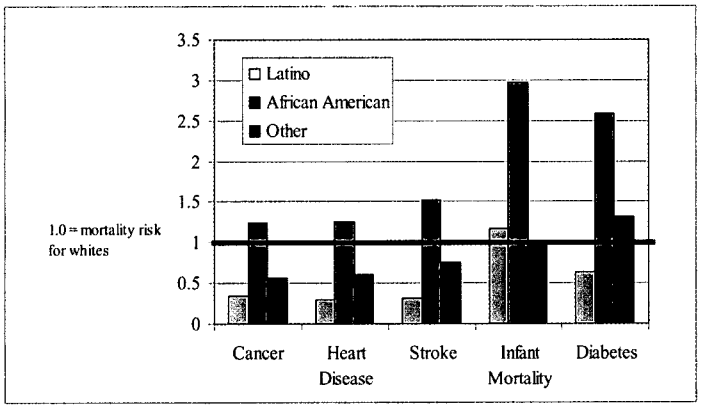
Childhood and adolescent vaccinations are a hallmark of preventive care. North Carolina has made vaccinating all children appropriately a priority. To help reach this goal, North Carolina provides the combined tetanus, diptheria, and pertussis (Tdap), hepatitis A (Hep A), hepatitis B (Hep B), haemophilus influenzae (Hib), polio (IPV), measles, mumps, and rubella (MMR), and varicella vaccines for children ages 0-18 free of charge through the Universal Childhood Vaccine Distribution Program (UCVDP).[33] The program is designed to remove financial barriers, assure vaccination access to all children, and simplify the vaccination process for health care providers. To maintain high vaccination coverage, additional outreach is needed to ensure that adolescents receive their Tdap booster vaccine, and that all children receive other vaccines recommended by the Centers for Disease Control and Prevention (CDC) that are not currently covered through the UCVDP. The state does not currently cover vaccines for the human papillomavirus (HPV), influenza, meningococcal diseases (MCV4), or pneumococcal diseases (PCV7). Including these vaccines would require additional funding.

In addition to vaccine preventable illnesses, foodborne illnesses are among the most common infectious diseases. Foodborne diseases cause a total of approximately 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths each year in the United States.[34] Unfortunately, the current food safety and defense system is very complex and varies by agency. Oversight and enforcement of food safety standards are split between many different state agencies. Therefore, another Task Force recommendation is to strengthen our food safety system by developing a unified, proactive, scientifically-based strategy to prevent, detect, and respond to foodborne illnesses.

Action Steps to Reduce the Incidence of Vaccine Preventable Diseases and Foodborne Illness	
Individuals	Get your recommended immunizations; wash your hands often
Family/ Home	Make sure your children are immunized; make sure food is prepared and stored safely
Clinical	Offer immunizations; counsel patients to receive age-appropriate immunizations
Schools and Child Care	Ensure children are immunized; support the Coordinated School Health Program and participate in school health surveys
Worksites	Make sure foods in break rooms are properly prepared and stored; encourage employees to wash hands
Insurers	Provide first dollar coverage for all vaccines recommended by the CDC
Community	Provide outreach and education about vaccines
Public Policies	Fund outreach efforts to increase immunization rates for all recommended vaccines; strengthen laws and procedures to prevent foodborne illnesses; fund enhanced efforts to protect the food supply

Differences in health by race and ethnicity have been consistently observed across a range of health indicators. As a general rule, racial and ethnic minorities have poorer health status and experience poorer health outcomes than non-minorities.[35,36] Health disparities by race and ethnicity are also noted in health care access and quality, with minorities generally having less access to health care and health insurance and experiencing lower quality of health care than non-minorities.[36-38] These health disparities are not new, and while some disparities are slowly shrinking (e.g. life expectancy (US)), a few are actually increasing (e.g. health status as fair/poor for African Americans (US)).[38]

Risk of Mortality by Race/Ethnicity



Value greater than 1.0 indicates higher risk; value lower than 1.0 indicates lower risk.

In 2007, racial and ethnic minorities comprised approximately 29% of North Carolina's population (21% African American, 7% Latino, and 1% American Indian), with these populations steadily increasing.[37] Because of the large and growing numbers of racial and ethnic minorities in North Carolina, our state will not be able to make significant improvements in overall population health without addressing racial and ethnic health disparities.

In North Carolina, minorities are more likely to report that their health status is fair or poor compared to whites.[37] People of color in North Carolina are also more likely to engage in or be exposed to some of the preventable risk factors that contribute to poor health. Differing levels of access to health care may also affect disparities in health status and health outcomes. However, racial and ethnic disparities often persist even after controlling for factors such as insurance status, income, age, co-morbid conditions, and symptom expression.[36] This racial and ethnic disparity translates into lower life expectancies: minorities have, on average, a life expectancy of 72.1 years, versus 76.8 years for whites.[38]

Gaps in health outcomes between minorities and white populations can be partly explained by their unique social experiences. Research has indicated that perceived racial/ethnic bias contributes to health disparities even after controlling for income and education.[39,40] Further, some individuals from minority populations are distrustful of the American health system because of the history of segregation and discrimination. As a result, they may be less likely to seek care, or to follow treatment advice.[39] Strategies that promote community involvement and empowerment, such as the use of community health workers or lay health advisors, have been shown to improve health-seeking behaviors.[40] The Task Force recommends funding evidence-based programs that meet the needs of the diversity of the population being served.

Action Steps to Eliminate Racial and Ethnic Disparities	
Clinical	Take steps to ensure your practice is culturally and linguistically accessible
Community	Involve community leaders in health education initiatives; fund evidence-based programs that help meet the health needs of diverse populations in the community
Public Policies	Fund evidence-based programs that help meet the health needs of diverse populations across the state

Priority recommendations:

1. Increase Economic Security by Increasing the State Earned Income Tax Credit
2. Increase Enrollment in the Supplemental Nutrition Assistance Program
3. Increase the High School Graduation Rate

A person's income, wealth, educational achievement, workplace, and community can have profound health effects. People with higher incomes or personal wealth, more years of education, and who live in a healthy and safe environment, on average, have longer life expectancies and better overall health outcomes. Income is positively related to health, with increasing income levels corresponding to gains in health and health outcomes.[41] People living in poverty have the worst health outcomes, including higher morbidity and mortality rates.

More than one million North Carolinians lived in a family that did not earn enough money to afford basic, necessary expenses in 2008, even though 61% of adults in these families worked.[42] The federal Earned Income Tax Credit (EITC) is one of the most effective anti-poverty measures for low- and moderate-income working families in the United States, and lifts approximately 4.5 million people out of poverty each year.[43] North Carolina has a small state EITC which could be increased to support economic security for low-income working families.

Households in North Carolina with lower incomes are significantly more likely to experience food insecurity, and have limited access to nutritionally adequate foods.[44] Increasing the use of the Supplemental Nutrition Assistance Program (SNAP), which helps families with monthly incomes less than or equal to 130% of the federal poverty guideline purchase groceries, would decrease food insecurity.

Academic achievement and education are also strongly correlated with health across the lifespan. Unfortunately, 3 in 10 North Carolina students do not graduate from high school.[45] Adults who have not finished high school are more likely to be in poor or fair health than college graduates. They are also more likely to suffer from the most common health conditions.[46] Increasing the percentage of the people who graduate from high school would significantly improve population health.

Increasing the availability of affordable housing and utilities is also a recommendation.

Action Steps to Reduce Socioeconomic Health Disparities	
Individuals	Finish high school and pursue higher education
Family/ Home	Encourage everyone in the family to get their high school diploma and pursue higher education
Clinical	Advise patients to finish high school or get their GED
Schools and Child Care	Implement programs to increase the high school graduation rates; expand opportunities for high quality early childhood education and health programs
Worksites	Pay employees a living wage and help them apply for the EITC; offer health insurance coverage
Insurers	Expand health insurance coverage to small businesses and more of the uninsured
Community	Conduct outreach to help people enroll in SNAP; fund high quality childhood education and health programs; support school drop-out prevention programs
Public Policies	Increase the state EITC; increase funding to support affordable housing and utilities; expand opportunities for high quality childhood education and health programs; implement programs to increase the high school graduation rate; expand health insurance coverage to more North Carolinians

Implement Prevention Strategies in Schools, Worksites, and Clinical Settings

Priority recommendations:

1. Expand Health Insurance Coverage to More North Carolinians
2. Enhance North Carolina Healthy Schools

Multifaceted prevention efforts that promote healthy behaviors at the individual, interpersonal, clinical, community, and policy levels have a better chance of positively impacting the health of a population than solitary interventions.[2] Although most of the Task Force's work focused on evidence-based strategies to reduce specific risk factors, the Task Force also wanted to examine site-specific strategies, such as those that can be provided through schools, worksites, or clinical settings, to improve population health across multiple risk factors.

Uninsured North Carolinians are Less Likely to Receive Preventive Screenings or Have a Regular Source of Care

	Insured	Uninsured
Have one or more people who they consider to be their personal doctor or health care provider	85.3%	44.4%
Had a mammogram in the last two years (women ages 50 and older)	84.5%	57.2%
Had a Pap smear in the past three years (women ages 18 and older)	88.4%	79.8%
Received the HPV vaccine	14.0%	8.1%
Tested for diabetes	64.8%	41.8%

Primary care and other clinical settings are effective intervention points to prevent disease. Unfortunately, many people—especially those who are uninsured—lack access to preventive screenings and services, as well as primary care. Currently, there are an estimated 1.75 million non-elderly people in North Carolina who lack insurance coverage.[47] Because of the importance of having insurance coverage to obtain preventive screenings and other primary care services, the Task Force recommends that all North Carolinians have health insurance coverage, and that existing benefit packages be expanded to ensure coverage of all the recommended preventive screenings.

One of the five goals of the North Carolina State Board of Education is to ensure that North Carolina public school students will be healthy and responsible. Healthy children and adolescents are better learners and are likely to do better in school.[48] The Centers for Disease Control and Prevention promotes an integrated approach to student and staff well-being through the use of the Coordinated School Health Program (CSHP) which includes eight components: health education, physical education, health services, nutrition services, mental and behavioral health services, healthy school environment, health promotion for staff, and family and community involvement. In order for school districts to teach an effective health curriculum, and to successfully integrate health throughout schools, the CSHP needs strong leadership and infrastructure.[49]

Other recommendations include requiring the use of evidence-based curricula for the healthful living standard course of study; creating a North Carolina worksite wellness collaborative and tax incentives for small businesses; and improving provider training to promote evidence-based practices.

Improve Data Systems to Support Prevention Efforts

Throughout its deliberations, the Task Force focused on identifying evidence-based practices that would address North Carolina's most pressing health needs most effectively. Good data are critical to identify these health concerns, the health risks contributing to these problems, and evidence-based interventions, and to measure progress—or lack thereof—in improving the health of the state's population. North Carolina needs information both about the prevalence of certain types of diseases or health conditions (i.e. data on specific types of cancer), as well as the number of people engaging in certain risky health behaviors.

While North Carolina has many different data systems that collect specific health data, these data systems are not well-integrated. They often operate in silos, making it difficult to capture a complete understanding of the health problems facing the state. Additionally, there are significant gaps in the data that are collected.

The state and other community groups also need information about evidence-based interventions which have been shown to be effective in addressing certain health problems. However, evidence-based interventions do not exist for every health problem. In these instances, community groups need access to best or promising practices which they can employ or modify to address their specific health concern. More is needed to disseminate both evidence-based strategies, as well as those best or promising practices that have been identified in North Carolina. Development of a clearinghouse of options well-suited to North Carolina communities would make this information-gathering more efficient.

Recommendations include enhancing existing data systems, and identifying and disseminating effective nutrition, physical activity, obesity, and chronic disease prevention practices in North Carolina.

Conclusion

North Carolina currently ranks poorly on many health indicators, including health outcomes, health behaviors, access to care, and socioeconomic measures. However, these health problems are not intractable. Our recent success in reducing youth smoking highlights the way to make meaningful health improvements in our state. We know that health improvements take a coordinated effort of many groups working together to implement evidence-based strategies that target individuals, families, clinical care, schools, workplaces, the community at large, and public policies. Working together from a common action plan and making wise use of resources offers the greatest opportunity to improve population health in the state.

The final report, *Prevention for the Health of North Carolina: Prevention Action Plan*, includes evidence-based strategies that, if followed, will lead to improved population health. Together, we can improve the health of North Carolinians and move towards the ultimate goal of making North Carolina the healthiest state in the nation.

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Federal resources on evidence-based prevention practices:

- US Preventive Services Task Force (www.ahrq.gov/CLINIC/uspstfix.htm)
- CDC's Community Guide (www.thecommunityguide.org/index.html)
- CDC's Adolescent Health Registries of Programs Effective in Reducing Youth Risk Behaviors (www.cdc.gov/HealthyYouth/AdolescentHealth/registries.htm)
- US Department of Justice's Model Programs Guide (www2.dsgonline.com/mpg/)
- DHHS National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov/find.asp)
- National Cancer Institute's Research Tested Intervention Programs (http://rtips.cancer.gov/rtips/index.do)
- US Department of Education's What Works Clearinghouse (http://ies.ed.gov/ncee/wwc/)

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STATE OF NORTH CAROLINA

NORTH CAROLINA
GENERAL ASSEMBLY

STATE LEGISLATIVE
BUILDING
RALEIGH, NORTH CAROLINA
27601

December 28, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R Purcell
Chairman, Representative Douglas Y Yongue

SUBJECT: Meeting Notice

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY: **Tuesday** **TIME:** **10:00 a.m. – 3:00 pm**

DATE: **February 2, 2010**

LOCATION: **Room 544, Legislative Office Building**

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend.

Posted:

cc: Committee X
Record
Interested Parties X

MINUTES

LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY

Tuesday, February 2, 2010
10:00 a.m.
Room 544, Legislative Office Building

The Legislative Task Force on Childhood Obesity met Tuesday, February 3, 2010 in Room 544 of the Legislative Office Building. Co-Chair Senator Bill Purcell presided. ***(SEE ATTACHMENT: Members and Guests Present.)*** There were no opening remarks.

ACTIVE LIVING AND NUTRITIOUS FOOD IN THE COMMUNITY

PRESENTATIONS

Alice Ammerman, Ph.D. Director of the Center for Health Promotion and Disease Prevention at UNC-Chapel Hill began with the premise that childhood obesity could be dealt with on a community basis. Her presentation served as a prelude to the remainder of the scheduled presenters. ***(SEE ATTACHMENT: Ammerman)*** Contrary to recommendations that might cost money, she advocated taking the poor economic climate as a challenge, referring to the socio-ecological model with the individual considered downstream of the impact of the environment. She said her ideas dealt further upstream so that the individual would not need to give as much thought to making good food choices.

Dr. Ammerman proposed protecting the obesity prevention programs already in place without too much shifting of resources. She used the term "stealth help" to describe obesity related policies into other policies. This involves such things as bikeways, schools built with the idea of walking paths, encouraging sidewalks.

In terms of promoting wealth, she supports leveraging federal money in such programs as SNAP, the former food stamp enterprise. She aid another source of funds could come from excise taxes on soft drinks.

She told the Task Force that obesity was not a short term fix that programs would need to work long term. She suggested a Health Impact Assessment using the example of how much health benefit could come from adding a bike lane to a bridge.

She said that while per capita spending on food in the U. S, lower than most other countries, and going down, health care spending was going up.

Dr. Ammerman said it was good that the Task Force had a limited life time so that the issue could be addressed more quickly. At the same time, she said it would be good if a permanent group with particularly focus on obesity could remain in place.

In discussion, Senator Tillman said that while a tax on sweetened was a consideration, sucha tax could reduce consumption. A tax of one cent per ounce could raise prices about 17%, thus the Senator said that reduced consumption meant that the

entire 17% would not be a net figure. He did say that a soft drink tax did make an inviting target.

Co-Chair Yongue asked why North Carolina is not receiving the full amount of federal funds due the state under the SNAP program. Dr. Ammerman was not sure of the reason, but there had been a believe that the food stamp program should not grow during a tight economy even though the program actually produces revenue due to the goods bought with the stamps.

Co-Chair Purcell asked for any specific advice Dr. Ammerman might have for the Task Force. She said she would recommend promoting healthy communities as opposed to weight loss programs for a child.

Representative Grady asked for a more specific definition of healthy communities. He said with an approach that was too broad, it would be better to concentrate on a few specific things. Dr. Ammerman said that communities planned with sidewalks were one example, but Representative Grady countered that was a decision for local entities and not something the General Assembly could order. Representative Weiss pointed out that there was a legislative commission on urban growth and that there was a federal effort to work across various agencies for concerns on such multi-faceted issues.

Representative Brown recalled the time when much of the population of Russia was overweight and the government ordered products to be made with less sugar to curb the problem. He asked if having the U. S. government encourage products with less sugar would be workable. Dr. Ammerman said that perhaps the experience with the trans fat labeling could be used as an example of what the Representative spoke of. She said that the food industry was trying hard to provide nutrition information.

Representative Weiss asked what could be done with the SNAP program to get more dollars into the state, and how to use the money more effectively.

In deviation from the agenda, Dr. Nancy Creamer from the Department of Horticulture Science brought the Task Force information about the Center for Environmental Farm Systems. ***(SEE ATTCHMENT: CEFS.)*** She related work of the Center to the work to combat obesity. The Center seeks to promote environmentally friendly farms that will provide economic opportunities for both rural and urban North Carolina. The venture began in 1994 with N. C. State, N. C. A&T, the U. S. Department of Agriculture and other partners. There is a 2,000 acre site in Goldsboro for research, outreach and education in sustainable agriculture.

The Center will release an action plan in March and part of it is geared toward obesity.

She provided the Task Force with various parts of the Center's program and tied them through local farms/local products etc. to the need for nutritious food to curb obesity. In the presentation Dr. Creamer traced the history of the Farm to School national program. She outlined various Farm to School programs across the country.

North Carolina has preferential treatment laws for the purchase of local goods, but the procurement policies often create a problem in carrying through.

During discussion, Senator Tillman said there was a need for procurement laws in North Carolina to favor local producers, not just in food, but furniture and other products.

He also advocated creating gardens at state prison facilities as a way to provide more nutrition and work opportunities for the prison population.

Representative Grady recalled the presentation by Superintendent of Schools, June Atkinson that the school system provides over 300 million meals per year. His question related to the Farm to School program in the state which has been operating for 13 years and has 23 farmers participating, therefore was it worth the effort of the General Assembly to add support to the program. Dr. Creamer says there are many barriers to making Farm to School work, but that there was a greater will to make it work. Representative Grady followed with the reminder that it was North Carolina policy not to provide money for school food programs. His position was that there should be a more direct way to assure children of obtaining nutritious meals. The two decided to discuss Representative Grady's concerns later.

Co-Chair Yongue asked if the poverty figures were broken down by various demographics. Dr. Creamer said she would provide the breakdowns. Additionally, Co-Chair Yongue asked if there was a state by state comparison concerning whether the nutrition programs were better administered by the education component or the agriculture component of the government. Dr. Creamer said that both agencies should be involved.

Representative Weiss asked if the Local Food Policy Council, created by the General Assembly in 2009, could aim toward specific recommendations to the task force prior to the May Legislative Session.

Representative Brown asked about the process a farmer could follow to become a part of the Farm to School Program. Dr. Creamer deferred to Gary Gay, from the Department of Agriculture scheduled for the afternoon session.

Co-Chair Purcell asked how we get beyond the cost factor when goods that are shipped in cost less than local farmers can charge for the products. Dr. Creamer said we are up against some highly subsidized systems, even products from within the U. S.

Representative Grady said that people across the U. S. would not agree that the cost of food is cheap. He questioned if people would pay more money to get goods from a better source, closer source, etc. Dr. Creamer agreed that many people do struggle with food costs, but that it would better for the government to subsidize different food systems than some of the ones not subsidized, such as corn. Representative Grady said with the economic gloom, and 10% of the population using food stamps, he opposed subsidizing more people. Dr. Creamer said that with the subsidies for corn which goes into the high fructose syrups used in multiple products could be shifted to other systems. Representative Grady said he would ask that Dr. Creamer look at things differently. Representative Weiss said that she purchased produce at the farmer's market that was cheaper than chain grocers thus a better value and better quality. She said the work should be to remove barriers to access to the foods. Representative Grady said he agreed with Representative Weiss about the farmer's market in Raleigh in terms of price and quality. However, he said there is a farmer's market in his town (Jacksonville) which is subsidized by N. C. State, but there were only two vendors selling produce then only two days a week. He wasn't sure how to encourage more vendors, or more customers. Senator Purcell noted that Senator Walters could speak to the struggling farmer's market in Robeson County. Senator Walters said he didn't think the agriculture community had

been educated well enough concerning the possibilities. Dr. Creamer said the work involved several aspects that had to be worked on at the same time: farmers raise goods for farmer's markets work differently from those who farm for wholesale markets, consumers need to be made aware, balances and tradeoffs to be made.

In reference to farming on small plots of land, Co-Chair Yongue spoke of a personal experience: hay bale gardening which produced okra that grew 17-feet, as opposed to 7-feet on soil.

Co-Chair Purcell reminded the group of the World War II Victory Garden's that were grown out of necessity. He suggested this idea of Victory Over Obesity. Dr. Creamer said that about 40% of the food during WWII was grown in victory gardens. Senator Purcell said the gardens didn't need a lot of space.

Representative Brown said that Aberdeen Elementary School students had planted a garden on the school grounds as a way to introduce the children to fruits and vegetables they could raise.

(Note: Due to weather conditions, Sue Foerester was unable to come to North Carolina and her presentation was made by teleconference.)

Sue Foerester is the Chief of the Network for a Healthy California, and she provided information about that state's education program on food stamps SNAP-Ed. ***(SEE ATTACHMENT: Overview of SNAP-Ed.)*** She was joined on site in California by several members of her staff: Roseanne Stephenson, Chief of Operations, Valerie Quinn, head of Regional Operations and Alicia Ghirardelli.

Once again the California approach is based on the socio-ecological model. While the basic USDA guidelines are different, California uses a waiver to allow their program to serve families up to 185% of the federal poverty level. That is about 10 million people in the state: 7 million of whom are parents and children. Seniors are cashed out.

Roseanne Stephenson said that the Plan relied on two sources of funding:

1 Local Incentive Awards involving governmental bodies
2 Non-Profit Incentive Awards with food banks, hospital foundations, research foundations, etc.

Valerie Quinn said the initiatives were based on reaching the various partners that can be used in collaboration to set up priorities and actions. The regional concept allowed programs to address specific needs for specific areas.

Representative Grady asked the group how the California budget situation had impacted the programs. Teacher time which is used to leverage participation in the Local Initiatives has been reduced. The group said there had been some other constriction, but the programs were holding steady.

Daniel Rodriguez, Director of the Carolina Transportation Program at UNC spoke about the concept of physical activity to reduce the problems of obesity. ***(SEE ATTACHMENT: Linking the Built Environment and Health)*** He said that even light to moderate activity could make a difference. He also said that such activity served to reduce risks from numerous other diseases.

His data presented various trends in the decline in moderate activity in youth and adults, at the same time youth obesity is climbing and carrying over into adulthood.

He advocated off-road trails, bike ways, and bike lanes as parts of the infrastructure to promote physical activity. He presented research to show that when such methods were in place physical activity increased. One study showed that for every dollar invested in off-road trails, almost three dollars was returned in the form of avoided health care costs. He said that abandoned railroad rights of way made good trails. His data indicates that users of transit systems are more active due to walking to and from stops and destinations.

Mr. Rodriguez' data showed Charlotte was the only North Carolina city among the top 50 cities across the country that received federal funds for pedestrian and bike programs. However, the federal money only amounted to 19 cents per person, per year while others were receiving up to seven times that amount.

The presentation provided a list of policy considerations specifically geared toward working with the Department of Transportation to create an environment that encourages physical activity. Currently NCDOT can provide funds for communities to develop plans for pedestrians and bicyclists.

Mr. Rodriguez recommended re-shuffling priorities to accomplish the goal of increasing physical activity. He said to expect fear, anger and anxiety at such changes of older rules.

Carolyn Dunn, Professor and Nutrition Specialist from N. C. State University. representing Eat Smart, Move More sought to move away from relating how bad the problem of childhood obesity has gotten, or how the problem got that bad in the first place. ***(SEE ATTACHMENTS: Eat Smart Move More.)*** She said there is no silver bullet to solve problems relating to obesity, but a series of policies involving nutrition and physical activity. At the same time, she said the Arkansas Surgeon General, Joe Thompson predicts that childhood overweight will begin to decrease in five years.

She referred to the environment that we have currently as "obesigenic", where it is not only "possible to be overweight, it is probable to be overweight". She said the movement should be toward a "healthogenic" environment through political, social and cultural action.

She recommended to the Task Force the policy strategies from the CDC regarding community strategies and measures concerning obesity. Further she spoke of the Community Guide which contains data on obesity projects that have shown evidenced based success.

Representative Grady posed what he said could be a rhetorical question: How do we (legislators) make people make the right food choices. He noted that the ability of the General Assembly to deal with school meals didn't necessarily mean that children would go home after school to healthy meals, snacks, etc. Ms. Dunn moved outside the purview of the General Assembly to the community and what would the health care system do that could head off problems with overweight/obese children. What could the family afford to do for a child who might face the problem. She said the various little steps could be combined to make a difference. Representative Grady said that he had sponsored a bill to

remove soft drink machines from schools. As a result he heard from school principals that the soft drink companies offered incentives to schools such as free computers, to allow the drink machines to operate.

Jimmy Newkirk from the Public Health Division reminded the group that in June of 1944 when the Normandy invasion began America's war effort was in dire straits, but Normandy represented a foot hold. Such a foot hold was being made on the problem of obesity, he said. ***(EAT SMART MOVE MORE continued.)***

IN the past 10 years eleven rounds of grants had been made by the Eat Smart Move More organization, totaling almost $2 million. The funds have come from the CDC. He said the grants had gotten a good return. No grant is over $20 thousand. An $11,000 grant in Granville County went to pay for a greenway master plan. This sparked interest in recreation, transportation and physical activity. The community added an additional $225,000 to implement the plan. Following that the community was able to obtain $1.1 million from the federal transportation funds. He provided other examples of grants which were used to leverage other funds.

While he provided success stories, he said there were other good ideas across the state that had not been funded. He said the requests from funds ran from 3 to 5 times the amount of money available.

The General Assembly has allocated $380,000 for Childhood Obesity Prevention Demonstration Projects. Twenty-nine counties applied, grants were award to 5 counties:

1. Henderson County
2. Watauga County/Appalachian District
3. Cabarrus Health Alliance
4. Moore County
5 Dare County

Mr. Newkirk outlined the required and optional parts a program needed to participate and the evaluation process.

In the 8 months the projects have operated he pointed out several highlights:

13,801 people were affected by work site policies
6 miles of new sidewalks/greenways were built or planned
180 teachers were trained
133 health care workers were trained.

He said the effort showed a statewide approach.

Representative Hughes said that several of the presenters had mentioned gardens as a way to attack part of the problem. She said that with local special use permits sometimes gardens might be difficult to create. She said that barrier might be something that the General Assembly could address.

Emily Jackson from the Appalachian Sustainable Food Project told the Task Force she not only represented the Sustainable Food Project, but the presentation focused on the Farm to School Network. ***(SEE ATTACHMENT: Jackson)***

Ms. Jackson said the emphasis was to keep farmers farming and to give children access to fresh, locally grown, healthy products. She supported the idea of gardens for children to acquaint them with the process of growing food. She also said that in the Farm to School program children could bond with the people who were growing their food.

In her opinion, she said the problem with childhood obesity was more a problem of adults rather than children.

She said that Farm to School was more than just locally grown foods served in the cafeteria. She said the program included farm field trips, school gardens, cooking with foods. She said having access to good food required knowing what to do with the food is part of the process.

She provided these recommendations to the Task Force:

1. Develop the Farm to School fund to give nutrition directors the opportunity to purchase from the Farm to School system
2. Educate more people about locally grown foods
3. Locate farmers who are interested in selling to schools
4. N. C. Grown Week—to put products in school meals
5. Standardize the small purchase threshold to Child Nutrition
6. Eliminate the reduced price category for lunches
7. Provide pre/service education for teachers, etc.
8. Make school fund raisers use such things as seeds, not candy
9. Farmer's markets accept food stamps

Senator Dannelly asked how to overcome the barrier of cost for the healthier foods. Ms. Jackson said that school food budgets can be adjusted. She said eliminating the reducd price lunches would free up money for the Nutrition Directors to use. She said when the economy improved that the state could consider adding to the federal re-imbursements in the school lunch program. Ms. Jackson assured Senator Dannelly that she was not speaking of organic foods.

Representative Hughes asked about the prevalence of food stamps being accepted at farmer's markets. Ms. Jackson said it happened in only a few counties. Ruth Peterson from the Department of Public Health said there were some restrictions to the use of food stamps at farmer's markets which would be addressed more completely at the next meeting.

Gary Gay gave the background and aims of the Farm to School Program in North Carolina. ***(SEE ATTACHMENT: North Carolina Farm to School Program.)*** Seventy-five of the state's 117 school districts participate in the program.

Co-Chair Yongue asked if more school districts had participated at any one time. Mr. Gay said 75 was the high water mark. In answer to the question why more districts didn't participate, Mr. Gay said some times there were objections to the time involved or perhaps a distributor objected to a school using the program. The Co-Chair asked about price comparison, Mr. Gay said the schools told them the program has great prices. Co-Chair Senator Purcell asked for thoughts on getting all districts to use Farm to School. Mr. Gay said that early on there was an appropriation to set up a fund to get schools to use the program by matching an amount given by the NCDA. He said that sort of pilot effort might work again.

Senator Davis asked what efforts were made to promote the plan. Mr. Gay said that food shows, training sessions and newsletters were some of the ways the program was promoted. He also promised to provide a list of the participating school districts.

Senator Tillman asked who made the decision on participation. Mr. Gay said the authority was with the children nutrition director made those decisions.

The meeting adjourned at 2:50 p.m.

Senator William Purcell, Co-Chair Presiding

Katie Stanley, Clerk

Representative Doug Yongue, Co-Chair

Ted Harrison, Minutes

Taskforce on Childhood Obesity

AGENDA

Tuesday, February 2, 2010
10:00 am

Legislative Office Building
Room 544
Active Living and Nutritious Food in the Community

Introduction
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

Alice Ammerman, Ph.D. Director, Center for Health Promotion and Disease Prevention, University of North Carolina

Sue Foerester, Chief, Network for a Healthy California -Webinar

Nancy Creamer, Ph.D. Professor, Department of Horticultural Science, North Carolina State University

Daniel Rodriguez, Director, Carolina Transportation Program, University of North Carolina

Lunch Break

Carolyn Dunn, Professor and Nutrition Specialist, North Carolina State University

Jimmy Newkirk, Manager Physical Activity and Nutrition Branch, Division of Public Health

Emily Jackson, Appalachian Sustainable Food Project

Gary Gay, Director, Food Distribution Division, Department of Agriculture

Discussion

Future Meeting Dates:
February 11-Children's Access to Nutritious Food: Preschool to High School,
February 15- Children's Physical Activity, BMI, and Fitness
February 23- Food Industry

CHAMPIONS for CHANGE
Network for a Healthy California

Network for a Healthy California

USDA Annual Plan

Partners

Local Incentive Award Program (LIA)

- Governmental Agencies
  - School Districts
  - Office of Education
  - Local Health Departments
  - Indian Tribal Organizations
  - University Cooperative Extensions
  - Colleges
  - Parks and Recreation Districts
  - Cities
  - Counties

Partners

Non-profit Incentive Awards (NIA)

Large Associations

- **Food Banks (CAFB)**
- **Health Clinics (CVHN)**
- **Research Foundations**
- **Hospital Foundations**
- **Resource Service Centers (Catholic Charities)**

Terminology

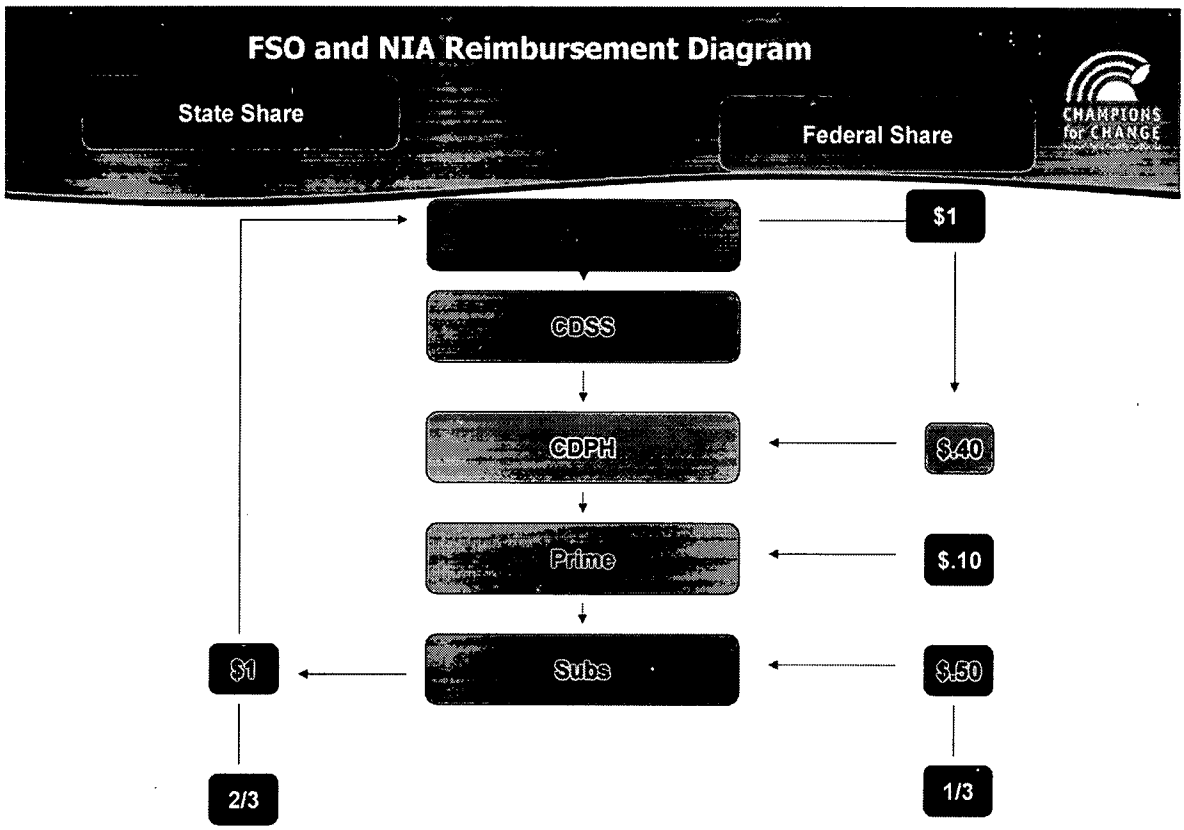
- State Share: **SNAP-Ed activities funded by your agency during the contract year**

- Federal Share: **SNAP-Ed activities reimbursed by USDA during the contract year**

Network Funding Mechanism

- LIA budgets $1 qualifying nutrition educations (State share)
- USDA gives the Network $1 (Federal Share)
- Network gives LIA 50 cents
- LIA documents $1.50 expenditures
- Network keeps 50 cents for Programs

FSO and NIA Reimbursement Diagram



What Network federal share dollars purchase

- 56% LIA NIA reimbursement
- 15% PHI Master contract
- 10% Regional Networks (11)
- 9% Media and Public Relations
- 7% Administration
- 3% Special Projects (Local Food Nutrition Education)

Public Health Institute Contract

- Staff & Services on:
- - Research and Evaluation
- -FVPA Campaigns
- -Retail, Worksites & PA Programs
- -Website, Technology & GIS
- -Leadership Projects
- -AA Faith-Based Projects
- -Training
- -Administration
- -Warehouse
- -Program Compliance
- -NECs
- -Community Development
- -Communications
- -Design, Photography & Translation

Request for Application

- Gather documentation necessary from partners to complete the plan

Timeline:

- Feb. 4, 2010 Release
- Feb. 26, 2010 Letter of Qualification and Intent
- April 5, 2010 Applications due from LIA/NIA partners
- April 5 – June 1 Negotiations
- June 15, 2010 Letter of Intent to Award
- July 15, 2010 – Plan submitted to CDSS
- August 15, 2010 – Plan submitted to WRO
- September 30, 2010 – Plan approved
- October 1, 2010 – Contracts Awarded

RFA Required Documents for LIA/NIA

- Cover Sheet
- Contractor Information Sheet
- Budget Forms (state and federal share)
- Project Synopsis
- Memo of Understanding
- Time Study Methodology

Contract Processing Steps

1. Primes recruit Subs to participate in *Network* activities
2. Sub submits application to Prime
3. Prime reviews, negotiates, & prepares overall budget
4. Prime submits one budget to *Network*
5. *Network* & Prime negotiate overall contract
6. *Network* packages contract
7. Prime signs contract
8. *Network* processes contract for full execution
   - ✓ *Network*/CMU approval: 2-4 weeks
   - ✓ DGS approval: 2-4 weeks
9. Prime sends program & finance binders to Subs

Source Documentation Reviews

Two Main Types:

- Desk reviews: **Remote fiscal & administrative evaluation, which will be conducted by *Network* of Prime & Prime of Subs**

- Site visits: **In-person fiscal, administrative, & program evaluation, which will be conducted by USDA, *Network*, and/or prime**

Resource Links

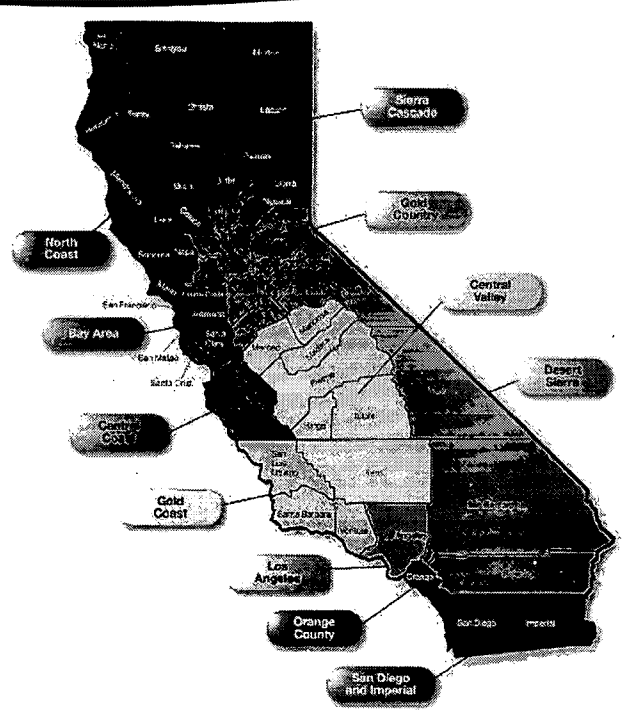
- IMPORTANT LFNE LINKS:
- Network Website:
- http://www.cdph.ca.gov/programs/CPNS/Pages/default.aspx

- USDA SNAP-Ed Guidance:
- http://www.cdph.ca.gov/programs/cpns/Documents/Network-SNAP-EdGuidance-2009-01.pdf

- LIA GUIDELINES Manual
- http://www.cdph.ca.gov/programs/cpns/Pages/GuidelinesManual.aspx

- Network Program Training
- http://www.cdph.ca.gov/programs/cpns/Pages/ProgramTraining.aspx

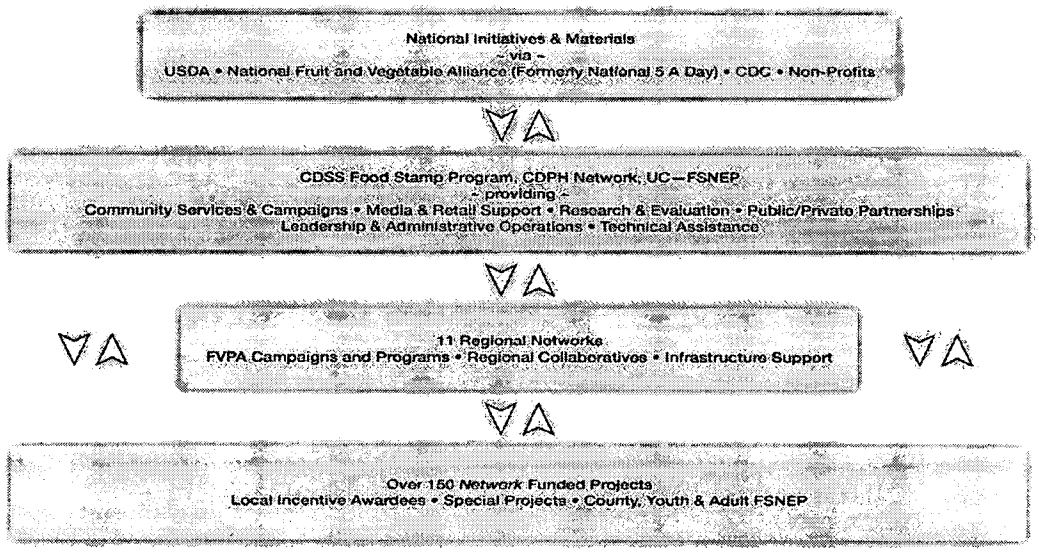
Regional Networks



CALIFORNIA

— The Golden State —

How California FSNE Puts It All Together



Regional Networks (cont.)

- What makes a region?
  - Based on media markets
  - Geographic identity
  - History of working together (or should be…)



Regional funding via Federal Share

Receives second largest slice of pie

Service & delivery oriented

3 objectives

1. **Maximize impact**
2. **Grow the Movement through Collaboratives**
3. **Reach consumers the social marketing way**

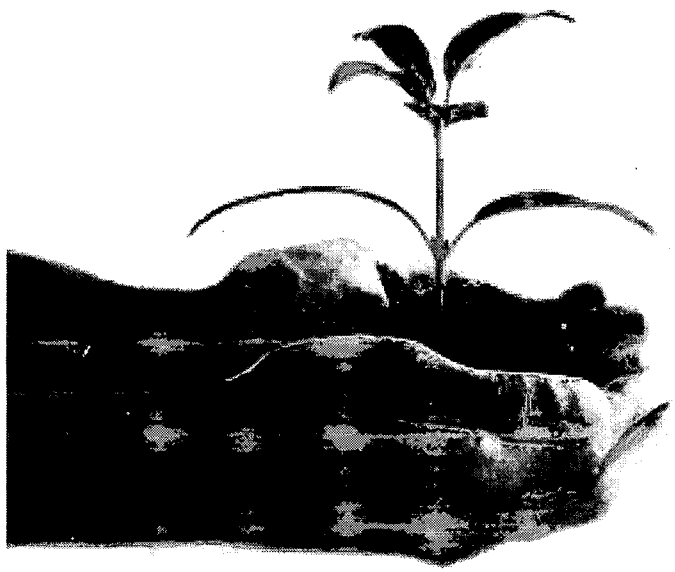
Maximize impact!



Maximize impact

1. Maintain strong infrastructure
   - Connect, coordinate among diverse <u>funded</u> projects
   - Trainings, communications systems, technical assistance
   - Media coordination!

Growing the movement



Regional Collaboratives

2. Regional Collaboratives
- Stakeholders– funded & non-funded
  - SNAP-Ed intermediaries, CBOs, WIC, agriculture, worksites, advocates, etc.
  - Majority of members, non-funded
- Address issues and challenges facing low-income populations
- Develop region-wide nutrition education initiatives

Examples of regional initiatives

Northcoast: Food insecurity – Community gardens/garden-based nutrition education

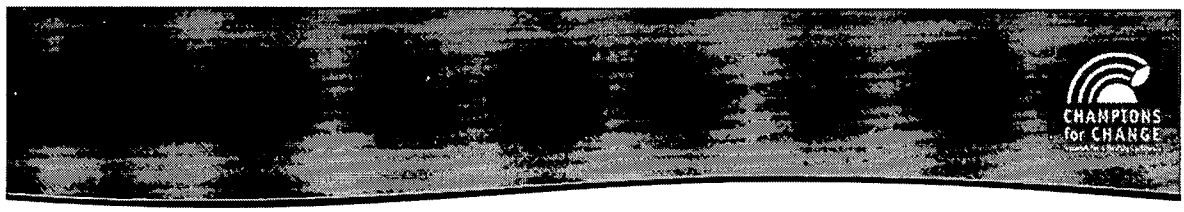
Bay Area: Rethink Your Drink & Soda Free Summer

San Diego & Imperial; Central Coast: EBT in Farmers Markets in underserved areas

Rethink Your Drink – now in 7 of 11 regions!

Regional Collaboratives

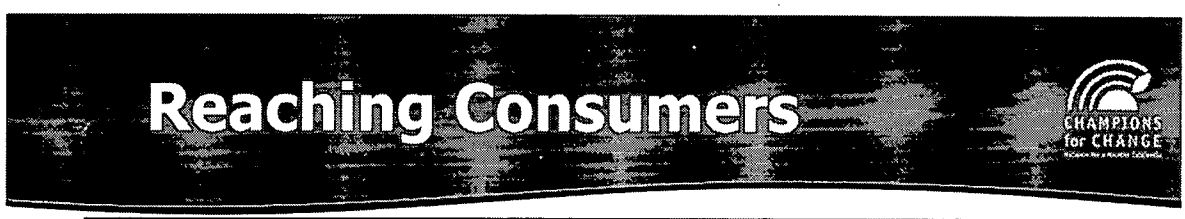
- Why Collaboratives?
  - Make more happen with other partners
  - Maximize power, extend reach, advance regional priorities
  - Go beyond funding restrictions/limits
  - Advance policy and environmental change!

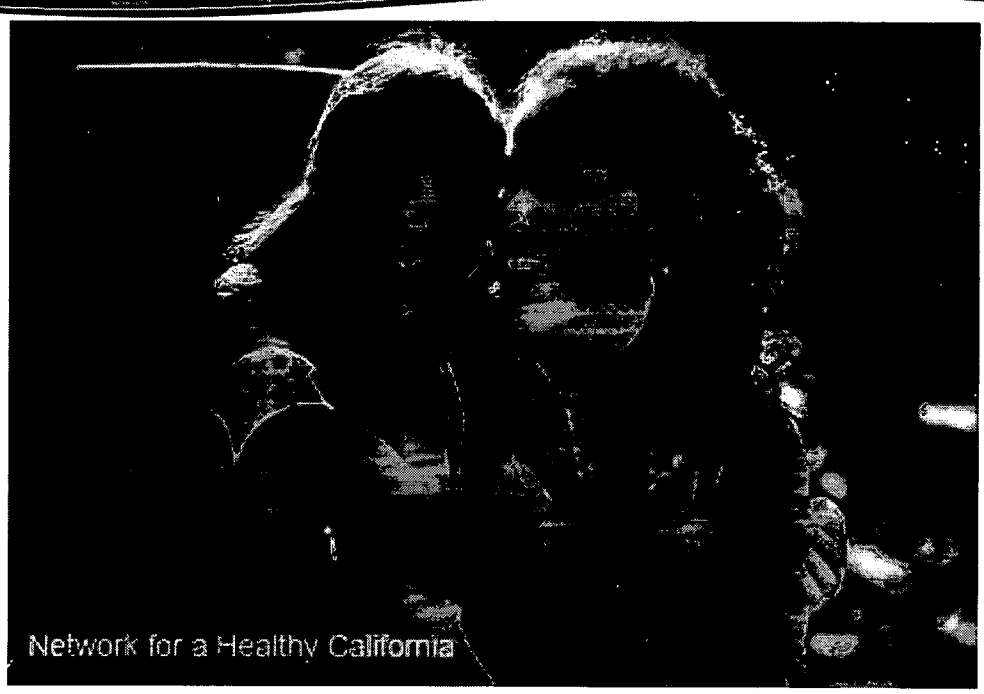


"None of us could accomplish individually what we are able to accomplish by working together."

Chris Moss, Nutrition and Fitness Collaborative of the Central Coast







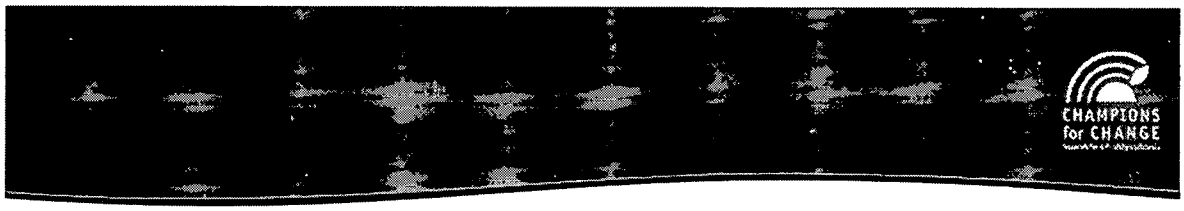
Reaching consumers

3. Regionally delivered social marketing Campaigns & Programs

- Children's Power Play Campaign (9 – 11)
- Latino Campaign
- African American Campaign
- Retail Program
- Worksite Program

Lessons learned

- Integration!!!
  - Layers of intervention~ touch points
  - FVPA Campaigns & Programs
  - More complex SoW, but important
- Media! Strategic & Proactive



Thank you!

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CEFS

CENTER for ENVIRONMENTAL FARMING SYSTEMS

NCSU | NCA&TSU | NCDA&CS

www.cefs.ncsu.edu

THE CENTER for ENVIRONMENTAL FARMING SYSTEMS

Cultivating Thriving Communities & Sustainable Farms







Local Foods and Childhood Obesity a National Perspective

Center for Environmental Farming Systems

Mission: *To develop and promote agricultural systems that protect the environment, enhance rural and urban communities, and provide economic opportunities in North Carolina and beyond*

- Partnership initiated in 1994
  - NCSU
  - NCA&T SU
  - NCDA &CS
  - Partner with other organizations

www.cefs.ncsu.edu

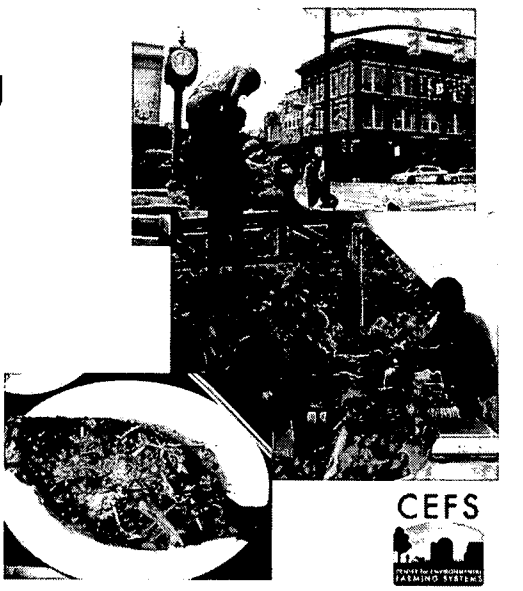


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Building a Local Food Economy in North Carolina

- What are the compelling reasons to build a local food economy?
- How does this tie-in to childhood obesity?
- National trends and initiatives



CEFS

As we address childhood obesity, what if we could also ...Grow the Economy and Grow Jobs

Average household spends $4010 per year per person on food (USDA ARS)... half spent in the home.

***If just 10%** of the $4010 was spent on **Local Foods** ($.~1.00/person/day)...With 8,8000,000 people in the state (US Census, 2006), local food sales would **total $~3.5 billion**.*

And... then there is the multiplier effect (money respent locally) University of Wisconsin data: 2.6 for local agriculture

CEFS

Around the Country

- The Governor of Illinois recently signed a bill that sets a goal of 20% of all food purchased by state-owned facilities (e.g., universities and prisons) and 10% of all food purchased by state-funded facilities (e.g., schools and hospitals) be produced in Illinois.

Around the Country

- ISU economist Dave Swenson: If Iowan's ate the recommended five servings of fruits and vegetables per day, and Iowa farmers supplied that produce for just three months of the year, the production and marketing of those additional crops would add $300 million and 4,000 jobs to Iowa's economy.

Around the County

- Doubling the sales into local markets could yield 1889 jobs with an investment of $9.5 million (approx. $5000/job as compared to national average of $15000/job)

Eat Fresh Grow Jobs (2006). Michigan Land Use Institute and CS Mott

Around the County

- Twenty-four local food enterprises studied nationally, and as reported by Washington Post, "local food enterprises are profitable startups that are key to economic growth and recovery".
- "Two to four times the income, wealth and jobs than at an equivalent nonlocal business"

Wallace Center and Business Alliance for Local Living (2009)

Where does Job Growth Come From?

- Value added agriculture
- Local processing ventures
- Prep work for schools/hospitals/institutions
- Local aggregation of product
- Local distribution channels
- Kitchen incubators



CEFS

NCSU | NCA&TSU | NCDA&CS

Around the Country

- New USDA thrust announced by Secretary Vilsack **"Know your Farmer Know your Food"**
- $65 million program will "begin a national conversation to help develop local and regional food systems and spur economic opportunity."

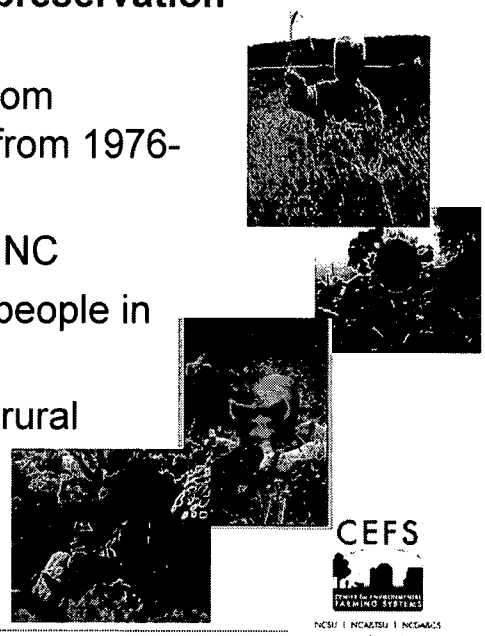
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As we address childhood obesity... what if we could also address farmland preservation

- In North Carolina, we've gone from 100,000 farms to 48,000 farms from 1976-2008.
- Average age of farmers is 57 in NC
- Nationally, there are now more people in prison than farms
- Think about the implications for rural community viability and vitality



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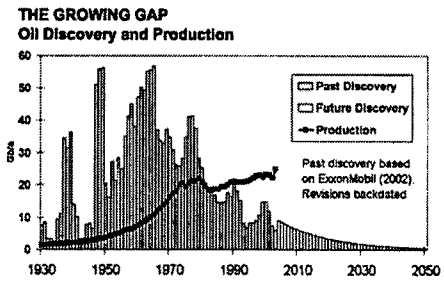
...and what if we could also address long-term health care costs

- **$147 billion** currently spent to treat obesity,
- **$116 billion to treat diabetes**
- 30 percent of the increase in health care spending over the past 20 years has been attributed to the soaring rate of obesity
- Increasing access to fresh and flavorful fruits and vegetables could significantly influence the long-term North Carolina health care costs.

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..and what if we could also address environmental quality and global warming

- ***An Iowa study found that the average distance food travels in the US from production-to-consumption is 1546 miles.***
- Currently about 10 to 15 calories of fossil fuel energy are used to create 1 calorie of food.
- Opportunities within production and distribution to impact energy use and greenhouse gas emissions.



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...and what if we can also address Food Security for all NC citizens

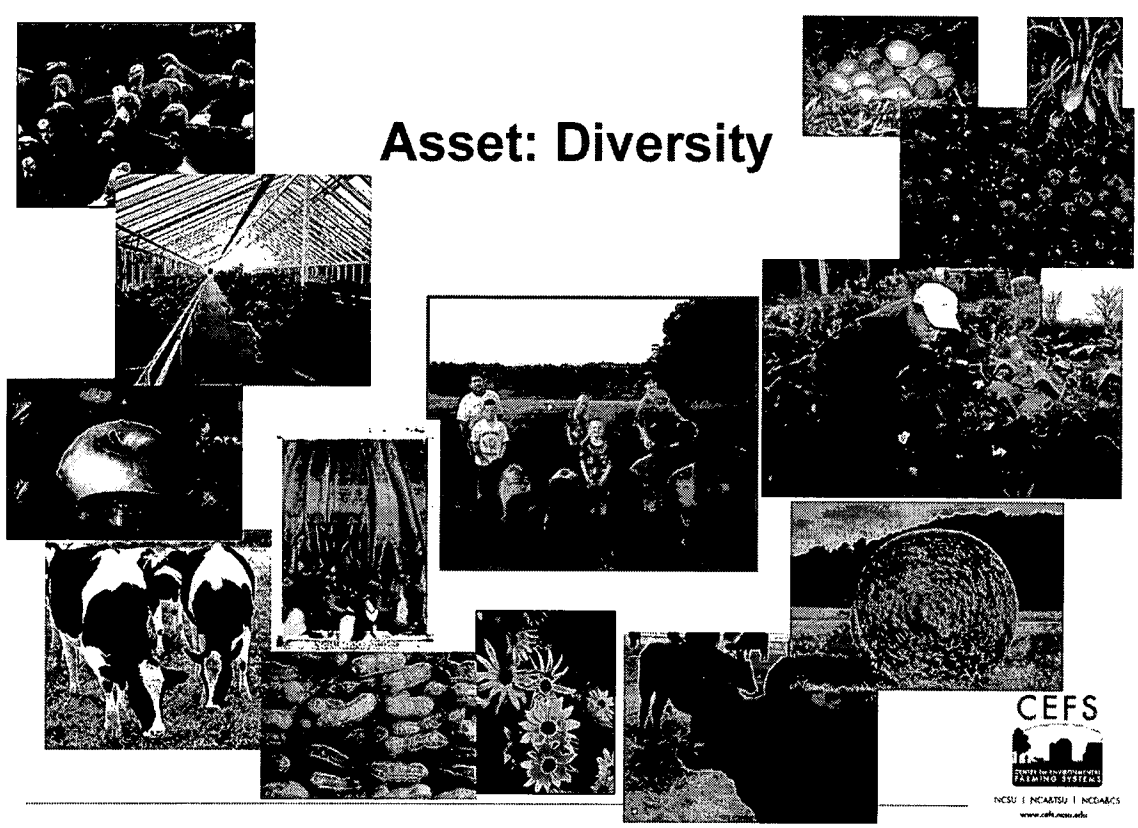
- 21 percent of children in NC live in poverty.
- Over 13 percent of residents in NC are considered food insecure (36% of children).
- Food Deserts: access to fresh foods is limited in many rural and urban communities in NC.

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Address Childhood Obesity with Local Food Systems...and we also get..

- Job Creation
- Economic Development
- Rural revitalization
- Health and Wellness, long-term
- Farmland preservation
- Environmental Quality
- Food Security

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Across the State We See:
Community Leadership, Business Entrepreneurship, Regional Planning, Public Policy



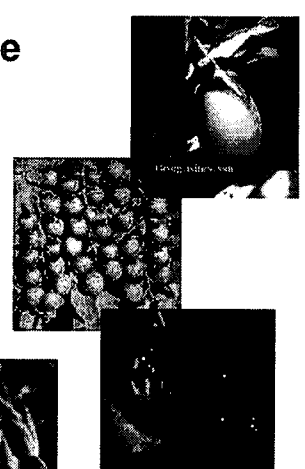
What can **Local** add beyond **Fresh**



- **TASTES GOOD: at the peak of their flavor and better varieties**
- **Fun**
- **More Nutritious**
- **Cool-Novel**







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Local Foods as part of the Solution for Childhood Obesity

- Impacts can be significant and state-wide (we ***all*** eat every day) and good habits can be lifelong
- Meets multiple NC needs at once



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Sustainable Local Food Advisory Council

SESSION LAW 2009-530, SENATE BILL 1067

- To address program and policy considerations regarding the development of a sustainable local food economy in North Carolina
- Four focus areas:

✓ **Economic development**
✓ **Health and Wellness**
✓ **Hunger and Food Access**
✓ **Preservation of Farmlands and Water Resources**

- 27 members- 3 year terms

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Local Foods and Childhood Obesity

- Farm to School (or daycare and pre-school?)
- Community Gardens and Urban Farms
- Farmers Markets
- Increase Local Foods Access

Farm-to-School

- Serve healthy meals in school cafeterias
- Hands-on educational opportunities
- Physical activity
- Support for local small farmers

Food for Thought: National Focus
Let's get prepared!

- Ag Secretary Vilsack, Feb, 09. Washington Post.

"My job is to listen to the president, who is the ultimate vision maker..."**The vision is, he wants more nutritious food in schools.** In a perfect world, everything that was sold, everything that was purchased and consumed, would be local so the economy would receive the benefit of that. One thing we can do is work on strategies to make that happen. It can be **grant programs, local programs, it can be technical assistance**".

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Food for Thought: National Focus
a little history

- 2004 National Farm to School program is authorized (but not funded)
- 2008 Farm Bill legislation allows "geographic preference".
- National Child Nutrition Act discussion is currently underway.

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Let the data speak

- Greater the exposure to farm-fresh fruits and vegetables, the greater likelihood children will eat them (ADA)
- Schools report a 3-16 percent increase in participation in school meals when farm-fresh food is served.
- Riverside County (CA): 25% of children chose the salad bar on any given day.

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Farm to School Nationally

- 43 States have operational Programs
- 2,051 Farm to School Programs in US
- 8,943 number of schools involved
- 2,065 number of school districts involved
- 19 States have passed legislation

www.farmtoschool.org

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National Examples

Farm to School Legislation: State by State Listing www.farmtoschool.org
National Conference of State Legislatures

- New staff in Depts of agriculture and education
- Communicate state's procurement preferences through policy statements
- Changes to bidding practices
- Cost-preferences for in-state products ranging from 5-25%
- Competitive grants programs
- Developed websites and databases

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Procurement Policy

- **MA:** allows purchasing agents to award contracts to local vendors whose price is not greater than 10% of lowest bidder
- **CO:** awards bid for local products whose quoted price "reasonably exceeds" the lowest bid
- **IL:** allows state purchasing to go over low bid by 10% for local products
- Many other examples
- Although **NC** has preferential treatment of local goods on the books, procurement policies can make this challenging (best value procurement).

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Oregon Example

- Has new Oregon Farm to School and School Garden Program.
- New positions in both Department of Agriculture and Department of Education: Procurement and Production
- Other states with positions focusing on farm to school: Oklahoma, Kentucky

New York example

- Comprehensive legislation in 2002
- Charges Dept of Education and Agriculture to get NY products into schools
- Establishes a Farm to School week: New York harvest for New York kids. Activities include farm-to-cafeteria, classroom tastings, farm visits, health fairs, demonstrations, scavenger hunts at farmers markets, etc...

Washington (SB 6483)

- Links school districts and local producers
- Integrates curricula and programs that demonstrate the benefits of local food
- Created Washington Grown Fresh Fruit and Vegetable grant program (*in the office of public instruction*) to encourage nutritious snacks and support farmers

Washington cont.

- Requires revision of food procurement and food contract procedures.
- School districts can develop policies to maximize purchase; can operate school gardens and farms
- Creates WA state Farmers Market Technology improvement pilot program for EBT transfer
- Creates farmers to food banks pilot program

More this afternoon..

- Current farm to school in-state activities and possible policy initiatives to support
- Integrating gardens in school
- Teacher Training
- Healthy fundraisers

Barriers of Farm-to-Institution

- Price
- Distribution and Storage
- Aggregation from several producers
- Processing capacity
- Gap certification and training
- Liability insurance
- Limited numbers of producers

Farm Incubator Programs

Providing Support for New Farmers





- Hands-on production experience
- Classroom instruction
- Business plan development
- Marketing help
- Mentoring from existing farmers
- Access to land and equipment



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Increasing Food Access

- Community Gardens
- Urban Farms
- Farmers Markets
- Supermarkets and corner stores

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Community Gardens and Urban Farms

- They offer hands-on, outdoor education about food production and stewardship, and offer physical exercise.
- They provide direct increased access and exposure to foods that can establish positive life-long health habits.



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Community Gardens

- Producing nutritious food
- Reducing family food budgets
- Providing a catalyst for neighborhood development
- Stimulating social interaction, especially for youth
- Encouraging self-reliance
- Creating opportunities for recreation, exercise, and education.



Community Garden policy

- Primarily local policy vs statewide
- Zoning ordinances

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Community Gardens: the Status in North Carolina



Networking efforts

- The Community Garden Partners Initiative established through the NC Division of Public Health, NC Agricultural Extension, and others
- The Piedmont Interfaith Network of Gardens (PING)
- The Rural Advancement Foundation International (RAFI)'s *Come to the Table*

NCPH **North Carolina Public Health**
Working for a healthier and safer North Carolina Everywhere. Everyday. Everybody.

NC State University A&T State University COOPERATIVE EXTENSION
Empowering People · Providing Solutions

COME TO THE TABLE
people of faith cultivating hunger and sustaining rural agriculture in North Carolina

ping
Piedmont Interfaith Network of Gardens

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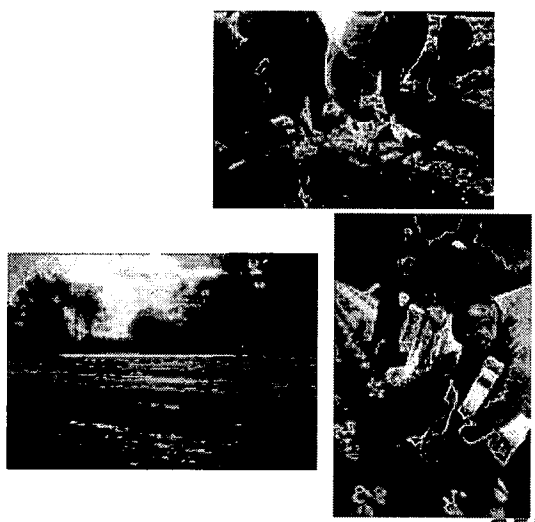
State Level Ideas:
Community gardens

- **Goal: A Community Garden in every community across North Carolina**
- Statewide coordinator for community gardens
- Development of community garden hubs in support of this goal.
- Mapping NC community gardens, tour- capable farms, and school gardening programs
- Educational resources available
- Information for local governments

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Urban Farms

- Larger scale economically viable enterprises, often with public support (for example, land), and also public payback and benefit (improving access or donation programs).



Wayne County, NC

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Will Allen: Growing Power

- 2008 MacArthur Genius Grant award winner
- Featured in NYT as leader in urban farming
- CEFS lecturer in 2009 (700 attended in Raleigh, and 500 attended in Goldsboro)



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Will Allen: Growing Power

- 2 acres in downtown Milwaukee
- 159 varieties of fresh fruits and vegetables
- Community involvement of youth, elderly, government, etc.
- Grows $250,000 worth of food and feeds 10,000 urbanites
- "Chicago has 77,000 vacant lots"
- Compost and waste recycling





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Farmers' Markets



About 2800 farmers' markets and 20,000 farmers were operating in the United States in 2000; a 63% increase from 1994. And in 2008...

4,385 farmers markets in the US

Benefits to Farmers and Consumers

Electronic Benefit Transfer at Farmers Markets

- Currently, 12 counties are equipped, and program is run through a partnership of NCDA &CS and Leaflight.
- WIC coupons for fresh vegetables are taken at some farmers markets- statewide?
- New York : WIC checks allowed at all farmers markets (Healthy Food/Healthy Communities

Farmer FoodShare

- Carrboro farmers market
- 9,810 lbs of food in 19 weeks donated to food banks, treatment centers, etc
- Volunteers collect and distribute food

Grocery Stores and Corner Stores

- Grocery stores are generally 2.5 times smaller in areas of higher poverty.
- Groceries are more expensive in smaller stores
- Ratio of fast food/convenience stores to grocery and produce markets (4:1)

Pennsylvania Example
Fresh Food Financing Initiative

- Created in 2004 to address lack of access to fresh fruits and vegetable in urban and rural areas.
- Public-private partnership
- Investment of $30 million in seed money (through loans, etc.)

Pennsylvania successes

- 68 new or improved grocery stores in underserved communities
- 400,000 residents with increased access to healthy food
- 3,700 jobs created or retained
- $540,000 increase in local tax revenue from a single store in Philadelphia
- $165 million in private investment leveraged

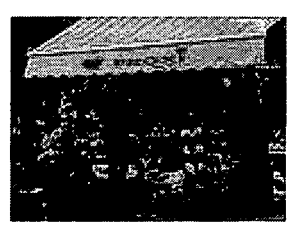
New York
Healthy Food/Healthy Communities

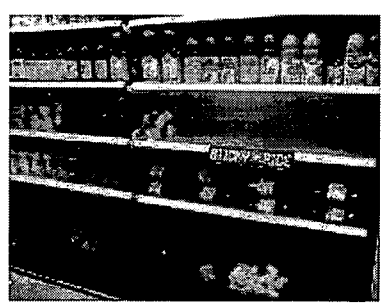
- $10 million revolving loan fund to build food markets in underserved communities
- Funding preference in New York's All-Affordable Housing Program
- Low-Cost Project Insurance
- Matching Grants program for permanent Farmers Market Infrastructure.
- Food Trust Supermarket Campaign

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In North Carolina

- Incentive programs for corner store offerings of fresh fruits and vegetables? Distribution networks to corner stores?





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I'm happy to help

- Research
- Develop
- Brainstorm
- Discuss
- Write
- Advocate for

Any creative policy initiative to help us develop local food system approaches that help to reduce child obesity.

nancy_creamer@ncsu.edu. 919-515-9447

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Eat Smart, Move More NORTH CAROLINA

Carolyn Dunn, PhD
Chair, Eat Smart, Move More, NC Leadership Team
NC Cooperative Extension

Jimmy Newkirk
Physical Activity and Nutrition Branch
NC Division of Public Health

Eat Smart, Move More NORTH CAROLINA

The shared VISION among the many partner organizations is a North Carolina where healthy eating and active living are the norm, rather than the exception.

The MISSION of Eat Smart, Move More NC is to reverse the rising tide of obesity and chronic disease among North Carolinians by helping them to eat smart, move more and achieve a healthy weight.

60+ organizations

ESMM Leadership Team Executive Committee

Carolyn Dunn, Chair
NC Cooperative Extension

Maggie Sauer, Vice Chair
NC Medical Society Foundation

Dave Gardner, Member at Large
NC Department of Public Instruction

Kevin Cain, Member at Large
John Rex Endowment

Pam Seamans, Member at Large
NC Alliance for Health

Greg Griggs, Past Chair
NC Academy of Family Physicians

What?

Children today may be the first to have a shorter life span than their parents, chiefly because of their growing weight and sedentary lifestyle.



Age 7 Age 12 Age 25 Age 40

Why?



How?

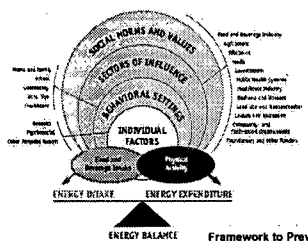
obesogenic → *healthogenic*

Unintended consequences of many economic, individual, political, and social decisions made for other reasons

Political, social, and cultural change

Carolyn_Dunn@ncsu.edu
Jimmy.Newkirk@dhhs.nc.gov

Socioecological Approach



Framework to Prevent and Control Overweight and Obesity

Adapted from *Preventing Childhood Obesity*, Institute of Medicine, 2005.

Eat Smart, Move More, North Carolina Ad hoc committees

- Key Measures
- Advocacy
- Surveillance

Eat Smart Move More Plan Released in 2006

Eat Smart, Move More: NC's State Plan to Prevent Overweight, Obesity and other Related Chronic Disease 2007-2012

ESMM Leadership Team Advocacy Survey Results

November 2008

Physical Activity Policy #1

Policy strategies to **increase availability of quality, daily physical activity and physical education in schools for all children.** (Example: requirements for increased physical education in K-8, two or more units of healthful living curriculum for grades 9-12, daily physical activity in grades 9-12.)

23 organizations working on this issue

Physical Activity Policy #2

Policy strategies to **increase safe and convenient opportunities for routine walking** (Example: increased funding for sidewalks; requiring sidewalks in commercial and/or retail developments)

16 organizations working on this issue

Carolyn_Dunn@ncsu.edu
Jimmy.Newkirk@dhhs.nc.gov

Nutrition Policy #1

Policy strategies to **provide healthy options in age-appropriate portion sizes in schools**. (Example: fully implement NC Nutrition Standards with funding/reducing indirect costs; pilot NC Nutrition Standards in Secondary Schools (and perhaps re-do elementary standards for more conclusive results); funding for equipment for schools such as steamers and walk-in refrigerators.)

20 organizations working on this issue

Nutrition Policy #2

Policy strategies to increase access to healthy foods. (Example: zoning for farmers' markets, community gardens, and open space.)

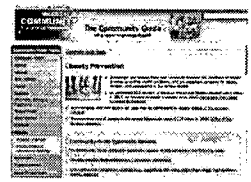
14 organizations working on this issue

Evidence-Base for Obesity Prevention

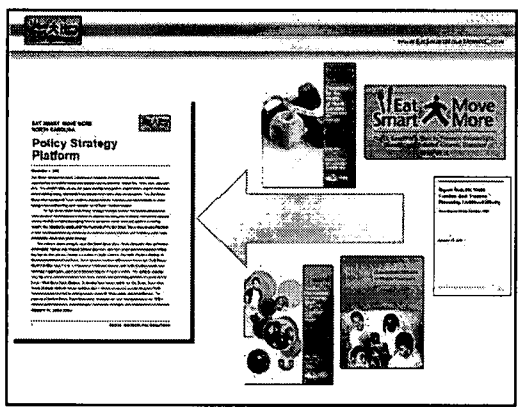


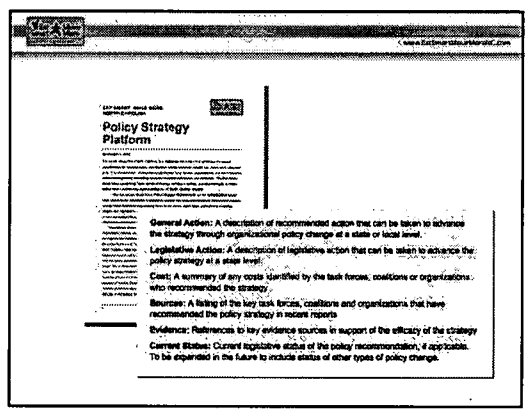
Healthy Policies → Healthy Environments → Healthy Behaviors → Healthy People

Evidence-Base for Obesity Prevention



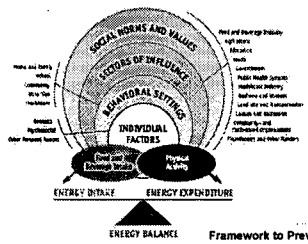
www.thecommunityguide.org





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Socioecological Approach



Framework to Prevent and Control Overweight and Obesity

Adapted from *Preventing Childhood Obesity*, Institute of Medicine, 2005

Who and what will fix this problem?

- Government?
- Policy makers?
- Medical community?
- Schools?
- Educators?
- Food industry?

YES

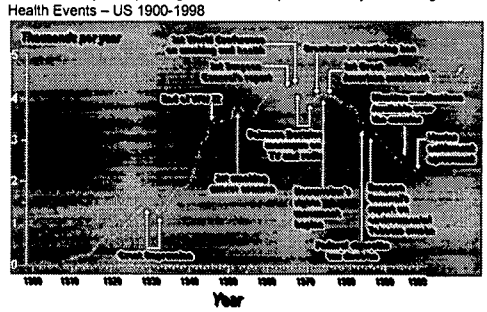
Discovery of knowledge...not enough

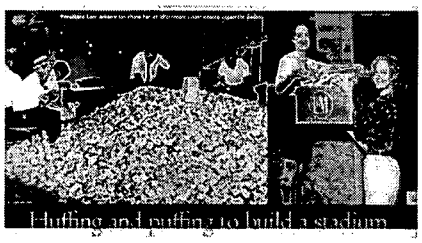
Doing the right thing...not enough

If you want more evidence-based practice you need more practice-based evidence.
Dr. Larry Green

Bridge the gap between research and practice.

Annual Adult per Capita Cigarette Consumption and Major Smoking and Health Events – US 1900-1998







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Eat Smart Move More Community Grants

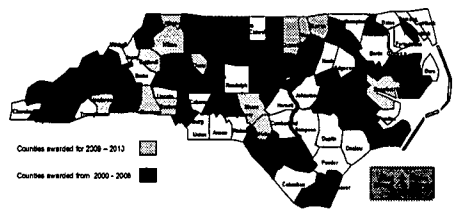
Celebrating 10 years of success!

11 rounds of funding 2000-2010

169 Grant projects funded

$1,941,660 distributed

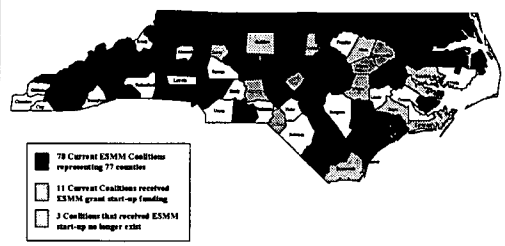
Counties Awarded Community Grants



169 grants awarded since 2000 - total funding to counties over $1.94 M

Funding provided by federal funds from the CDC Obesity Grant and state funds from the Justice Warren Heart Disease and Stroke Prevention Task Force.

Start-up funding for 14 Eat Smart, Move More Coalitions, 9 are still active



Granville County Greenway Master Plan



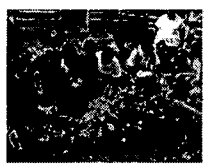
Buncombe's 2001-2002 grant project still going strong!

- 2001 – Grant for $9019 to change Worksite policies for employees to "Walkabout"
- 2007 – local businesses pooled resources to increase opportunities for staff
- 2009 – over 24 worksites, 400 participants, name changed to "Moveabout"

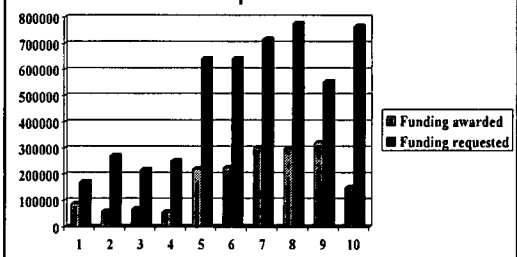
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Rockingham Co. - local non-profit trust established a school wellness grant to continue school gardens





Funding Awarded vs Funding Requested



NORTH CAROLINA

Childhood Obesity Prevention Demonstration Project

Community Approach to Preventing Obesity

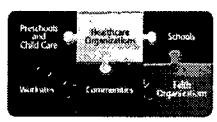
- Multi-level, multi-sector interventions
- Evidence-based or promising practices
- Environment and policy change
- **Community partnerships**, including non-traditional partners

Example: "Shape Up Somerville"

Background

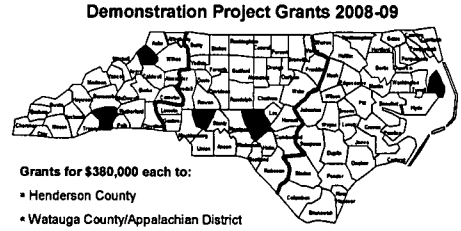
Purpose:

To reduce rates of childhood overweight and obesity



- $1.9 million (non-recurring) state funding
- 2008-09 fiscal year (8 months to implement)
- 5 counties selected through competitive application process
- 8 required components; several optional
- UNC Chapel Hill evaluation of the project

Childhood Obesity Prevention Demonstration Project Grants 2008-09



Grants for $380,000 each to:

- Henderson County
- Watauga County/Appalachian District
- Cabarrus Health Alliance
- Moore County
- Dare County

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Required Components

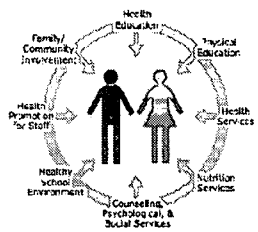
- Community Partnership Development
- Bicycle/Pedestrian Master Plan Implementation
- Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC)
- NCAAHPERD's In-School Prevention of Obesity and Disease (ISPOD) Initiative

Required Components (cont'd)

- WakeMed ENERGIZE! Program
- Clinical Pediatric Obesity Tools and Training for Medical Practices
- Hospital Worksite Wellness
- Health Communication/Social Marketing Campaign

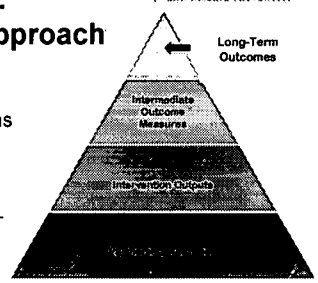
Optional Components

- Other Coordinated School Health - School Worksite Wellness
- Farmers Markets'/ Farm Stands
- Faith Community Intervention



Evaluation: 4-Tiered Approach

Identify success, challenges, lessons learned, and recommendations for implementing similar community-based programs



Results in Just Four Months*!

- 5.7% of residents improved what they ate. (Pre=27.3%, Post=33.0%)
- 3.3%of residents started exercising more. (Pre=16.2%, Post=19.5%)
- 4.5% more residents had heard of their county's Partnership. (Pre=19.0%, Post=23.5%)
- 5.7% more residents had heard of the Eat Smart, Move More NC movement. (Pre=18.8%, Post=24.5%)

* Statistically significant finding from a county-wide Health Communication Survey at pre- and post-test, N=4,000).

Project highlights

- 13,801 employee's impacted by policies
- 4000 people responded to project survey
- 2400 children, 42 participating childcare centers
- 825 members, 9 faith communities impacted
- 180 teachers trained
- 133 health care workers trained
- 14 children reduced their triglycerides to normal
- 6 miles of new sidewalks / greenways built or planned
- 1 statewide movement

Carolyn_Dunn@ncsu.edu
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Lessons Learned

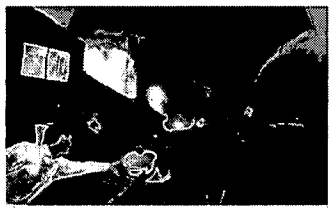
Instrumental to success:

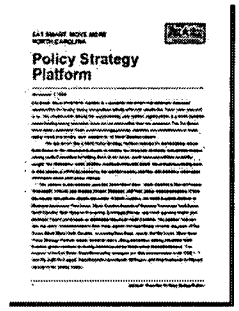
- Strong County Coordinators
- Ability to adapt project to fit the local context
- Partnerships ability to leverage resources

So if this works ...

Why do we still have a problem?

...the fire is too big for buckets!




Policy Strategy Platform

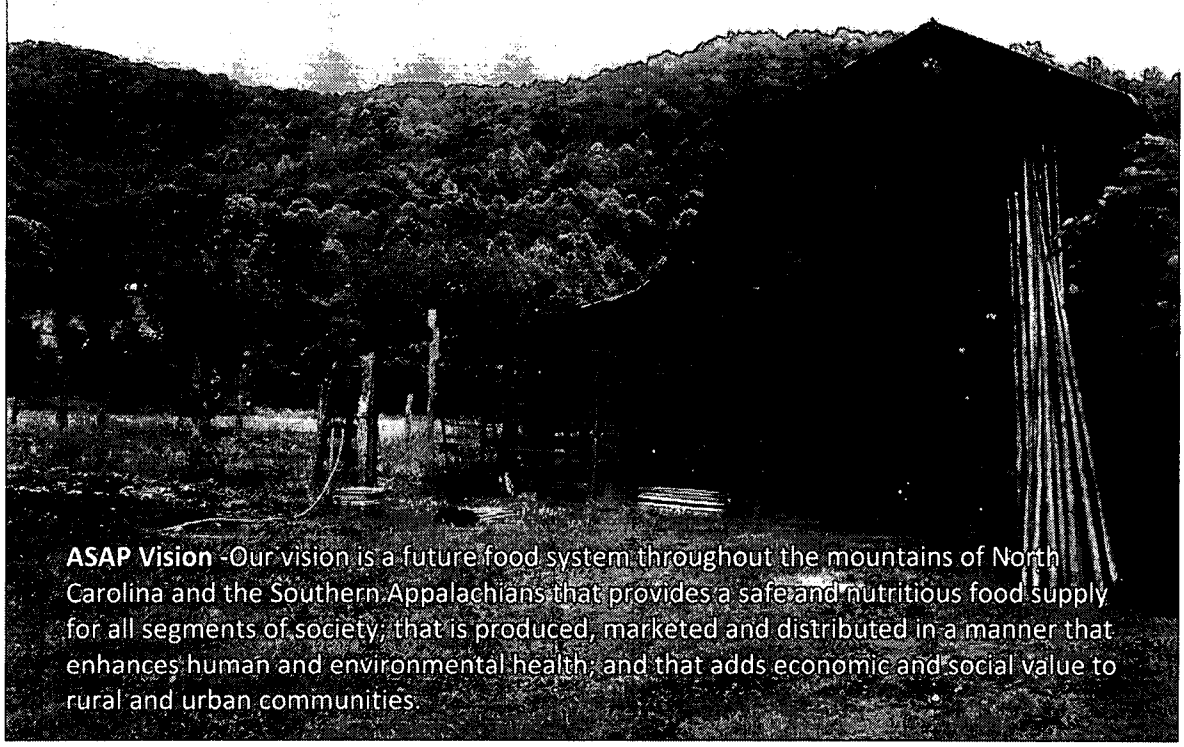
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North Carolina Legislative Task Force on Childhood Obesity

Active Living and Nutritious Food in the Community - Focus on Farm to School

Emily Jackson
Appalachian Sustainable Agriculture Project and
National Farm to School Network

ASAP Mission - Our mission is to collaboratively create and expand regional community-based and integrated food systems that are locally owned and controlled, environmentally sound, economically viable, and health promoting.

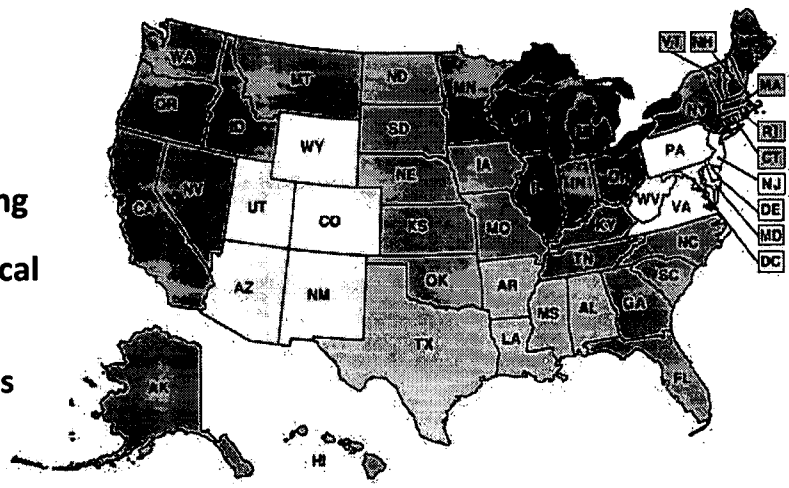


ASAP Vision -Our vision is a future food system throughout the mountains of North Carolina and the Southern Appalachians that provides a safe and nutritious food supply for all segments of society; that is produced, marketed and distributed in a manner that enhances human and environmental health; and that adds economic and social value to rural and urban communities.

National Farm to School Network

AREAS OF WORK

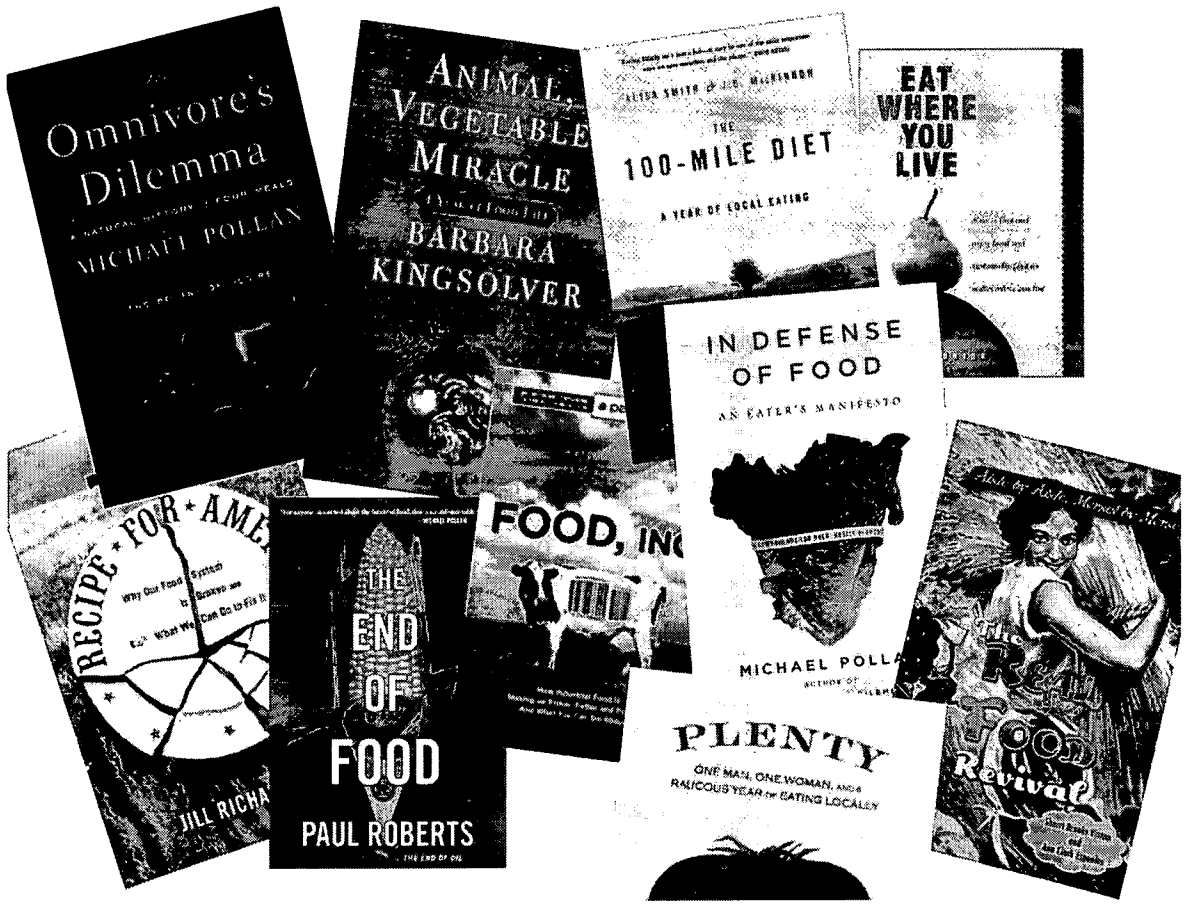
- **Policy**
- **Networking**
- **Media and Marketing**
- **Training and Technical Assistance**
- **Information Services**



WHO WE ARE

- **Eight Regional Lead Agencies**
- **Four National Staff**





Why Buy Local?

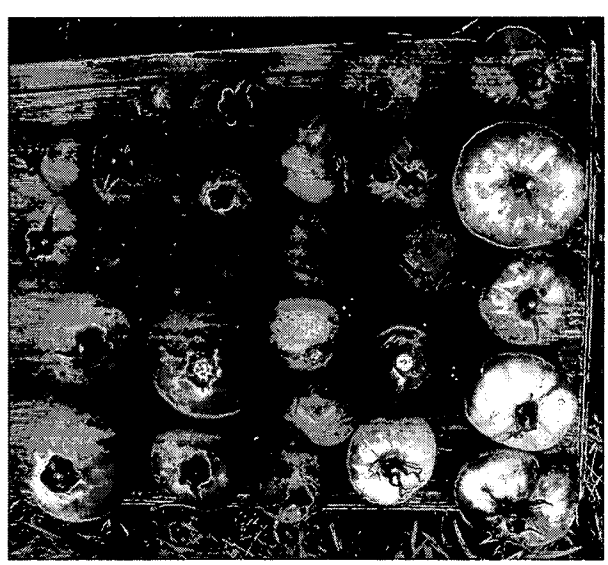
1. Eat fresher, better tasting food grown for taste rather than ability to travel.

2. Enjoy seasonal produce and regional varieties.

3. Support your farming neighbors.

4. Sustain rural heritage and lifestyles.

5. Protect natural beauty and open spaces by preserving farmland.





6. Encourage sustainable farming practices, benefiting human, animal, and environmental health.

7. Strengthen local economies and keep your food dollars close to home.

8. Maintain and build local food systems so we can feed ourselves in the future.

9. Keep farming skills alive, and farmland available.

10. Get to know who grew your food and where, so you reconnect with it, and your community.

Farm to School

Cultivating mutually beneficial relationships between farms and schools that create dynamic, wellness-focused learning environments for our children and provide markets for our local farmers

Farm field trips, farm-based nutrition education, school gardens and locally grown food served in the school cafeteria







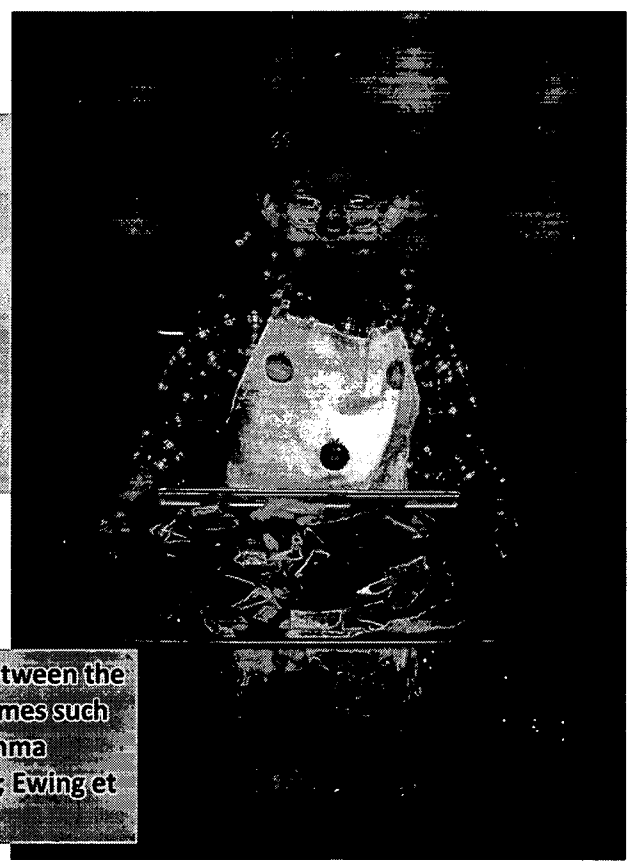
FARM TO SCHOOL ADDRESSES CHILDHOOD OBESITY

- Provides access to fresh, healthy food for ALL children
- Helps children associate positive experiences with healthy food
- Re-connects children (and their families) to where their food is grown and by whom



POSITIVE FOOD ENVIRONMENTS

Setting up our schools and communities so that children **CAN'T** make unhealthy choices



Research has demonstrated links between the built environment and health outcomes such as childhood obesity, injury and asthma (Ewing et al., 2003; Levy et al., 2004; Ewing et al., 2006).

Educational Components of Farm to School
School Gardens

Great outdoor classrooms and children will eat what they grow



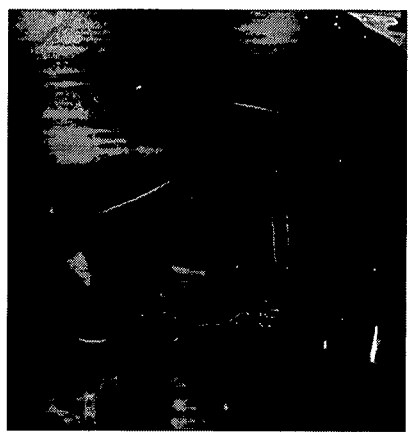


Educational Components of Farm to School
Farm-Based Nutrition Education



We find that cooking not only resonates with children but families as well!

Children that prepare the food will eat the food!



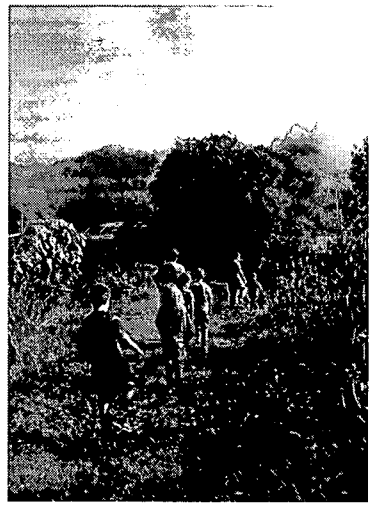
Educational Components of Farm to School
Farm field trips

Meeting the farmer that grows the food

We heard some cows go moo - I had never been that close to one when they say mool
-Sean, 2nd grader

Experiencing the place where the food is grown





NCDA Farm to School Program
An effective strategy



From recommendations from the Robert Wood Johnson Foundation to the CDC, farm to school is an effective strategy to prevent and/or combat childhood obesity. We have one of the most lauded state farm to school programs in the country and one of only three states that has the infrastructure (trucks and warehouses) for farm to school distribution).

Farm to School Pilot Program in Madison County
Parent Comments

My son was so excited about cooking and eating new things in class. Since then he tries more types of food.

My non-vegetable eating child came home saying he loved kale!

He tried new things that without having tasted them at school he probably wouldn't have had the opportunity

My daughter enjoyed these projects and bragged about eating fresh veggies at the farm. She tried more raw veggies at home after the farm trip.

I think its great for children to learn where food comes from, especially since this county once produced a large number of crops and families grew their own food.

Keep serving local grown products for lunches.

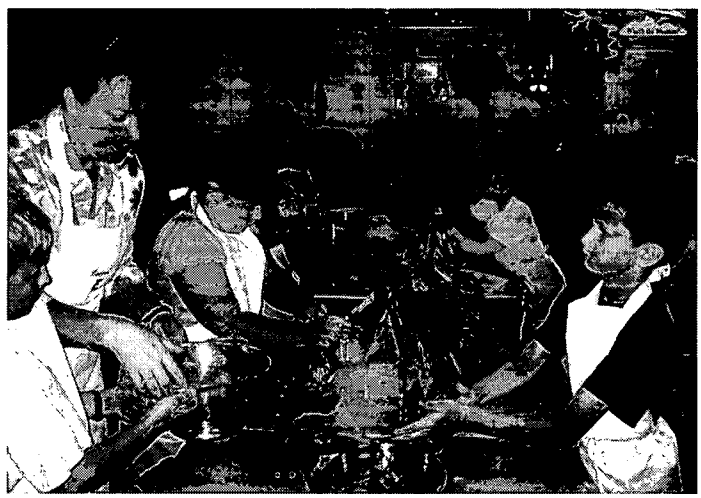


What needs to happen in North Carolina?

RECOMMENDATION

Farm to school fund

School systems could apply for funds to purchase food from local farmers/NCDA Farm to School program or to purchase kitchen equipment that would make preparation of fresh, local foods easier.



RECOMMENDATIONS

Farm to School Position

A new position created would:

1) increase the educational components of farm to school; **2)** compile information for farmers interested in selling to school systems;

3) encourage more school systems to participate in NCDA program;

4) increase awareness of USDA Fresh Fruit and Vegetable Program (and ability to utilize locally grown food)



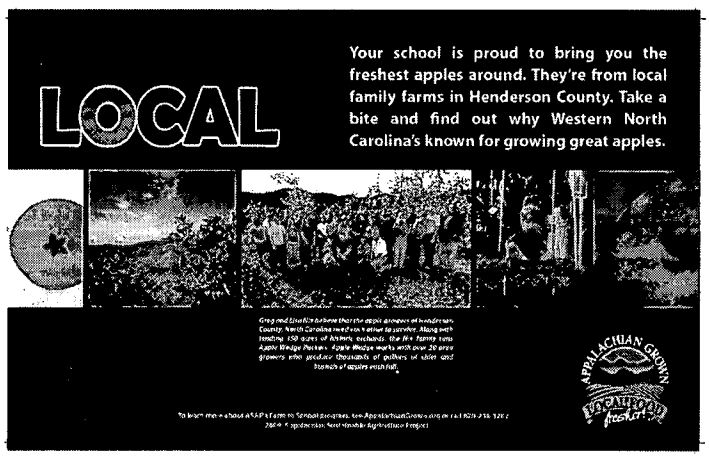
RECOMMENDATIONS

Farm to School Week

A week long celebration to learn more about North Carolina agriculture, enjoy delicious (and nutritious) locally grown fruits and vegetables and inspire healthy food choices.

Great publicity potential.

New York has a NY Harvest for NY Kids program that is very successful. Maryland has a similar program.



RECOMMENDATIONS

Procurement

Standardize the small purchase threshold for Child Nutrition.

This would make it easier for school systems to buy from local farmers (and save time, which is money!).



RECOMMENDATIONS

Eliminate the reduced price category in school breakfast and lunch programs



RECOMMENDATIONS

Farm to School or Preschool

Provide farm to school programming to Head Start centers

It Is Never Too Early

- By age 3, many children develop dislike for vegetables and are reluctant to eat or taste them (Niklas et al., 2001)
- Preference for vegetables in preschool children is a strong predictor of vegetable consumption (Birch, 1979; Harvey-Berino, et al. 1997; Morris & Zidenberg-Cherr, 2002).



RECOMMENDATIONS

Farm to School

Expand this pilot to other UNC system teacher and dietetic programs.

Jackson County Public Schools

Pre-service teacher/dietitian training and implementation

Partnership between Western Carolina University, Jackson County Public Schools and Appalachian Sustainable Agriculture Project



Other Effective Community Strategies

Ability to accept EBT (Electronic Benefits Transfer or electronic food stamps) at farmers markets



(ASAP's Asheville City Market
Accepts EBT, credit and debit
Also offers Kids Corner Market –
healthy food activities for children)



Farm to Hospital
Locally grown food served in hospitals but also CSA drops, farmers markets, cooking classes



Farm to Head Start
Starting young means you have a greater chance of establishing healthy behaviors and attitudes





Provide workplace wellness experiences for child nutrition staffs – farm field trips and CSAs!

Modeling is important!



Healthy Fundraisers

Sell Seeds or Plants

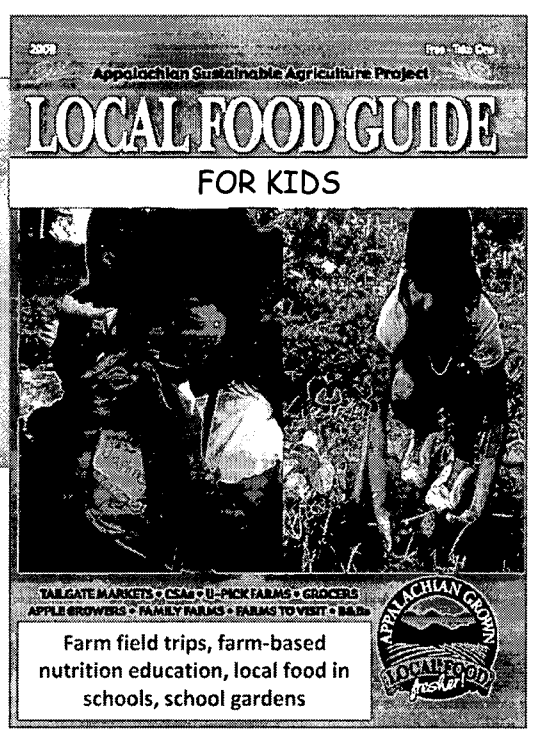


FEDCO SEEDS
Co-op Seed Packers



GET LOCAL
Harvest of the Month promotional campaign for schools, hospitals and restaurants

LOCAL FOOD GUIDE... FOR KIDS!



Farm field trips, farm-based nutrition education, local food in schools, school gardens

Questions?



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SE Regional Lead Agency for the National Farm to School Network
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Asheville, NC
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Emily @asapconnections.org

STATE OF NORTH CAROLINA
NORTH CAROLINA
GENERAL ASSEMBLY
STATE LEGISLATIVE
BUILDING
RALEIGH, NORTH CAROLINA
27601

December 28, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R Purcell
Chairman, Representative Douglas Y Yongue

SUBJECT: **Corrected Meeting Notice – Meeting Time Change to 10:00 a.m.**

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY: **Thursday** **TIME:** **10:00 a.m. – 3:00 p.m.**

DATE: **February 11, 2010**

LOCATION: **Room 544, Legislative Office Building**

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend. The agenda is attached.

Posted:

cc: Committee X
Record
Interested Parties X

MINUTES

JOINT LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY

Thursday, February 11, 2010
10:00 a.m.
Room 544, Legislative Office Building

The Joint Legislative Task Force on Childhood Obesity met Thursday, February 11, 2010 at 10 a.m. in Room 544 of the Legislative Office Building. Co-Chair Representative Yongue presided. Representative Yongue called the group's attention to an e-mail he sent to the members regarding the efforts of First Lady Michelle Obama on the issue of attacking childhood obesity. He said future information on the issue would also be passed along.

This meeting was devoted to Children's Access to Nutritious Food: PreK-12

PRESENTATIONS

Dr. Sara Benjamin from the Department of Community and Family Medicine at Duke University Medical Center spoke to the issue of preventing children in child care from developing obesity. ***(SEE ATTACHMENT: Obesity Prevention in Young Children Attending Child Care.)*** She reported that three-fourths of the children between the ages of 2 and 6 are in some form of child care: one-half of the group in a home based setting and one-half in a child care center. Her presentation followed the premise that child care tended to put children at risk of obesity because of poor diet and inadequate physical activity.

Dr. Benjamin's study took 20 model child care policies: 10 for healthy eating and 10 for physical activity and ranked the states by that criteria. North Carolina ranked in the middle when both categories were combined. Most of the states lacked adequate healthy eating and physical activity, especially in the family child care homes.

States can provide the proper policies on their own. She provided information from several states. Some examples were requiring low-fat milk, limiting juice consumption and no sugar-sweetened beverages. North Caroling children, based on an 84-county survey, showed the children in North Carolina failed to consume the proper amount of vegetables and fruit, but did rank high in nutritious milk consumption.

Dr. Benjamin referred to the Nutrition and Physical Activity Self Assessment for Children Project (NAPSACC) that began in 2006. It is a voluntary program aimed at better nutrition through such things a more fruits and vegetables, less fried foods and high fat meats, variety of menus and the like. NAPSACC promotes more physical activity and less sedentary activities such as watching television. In some locations, vending machines were moved to less visible areas, menus were revised and children were switched to low-fat milk.

In the Watch Me Grow program pre-school children planted gardens which allow them to grow the fruits and vegetables and consume the harvest.

In the discussion, Representative Brown asked how the fruits and vegetables were used: meal or snacks. Dr. Benjamin said the Watch Me Grow gardens were not intended to provide meals, but rather provide and promote healthy snacks.

In response to Co-Chairman Yongue, Dr. Benjamin said the Department of Public Instruction was not a partner in the work she had been doing, but she would like to work with the Department.

Representative England asked what would separate the state rankings on the 20 child care policies. Dr. Benjamin said if a state followed one of the policies that would score one point. Thus 10 points on one section would be a perfect score, and then the grades were averaged.

Representative Weiss asked Dr. Benjamin to narrow the focus to something that the Task Force might recommend that would have an immediate effect on the problem at hand. Dr. Benjamin said in Massachusetts the regulation that was the easiest to enact had to do with physical activity. She said a proposed North Carolina regulation for 60 minutes of active play for a full day of care would get her support. Dr. Benjamin said that abandoning sugar-sweetened beverages would not cost any money. Co-Chair Purcell asked if the Massachusetts changes were by law or by regulation. Dr. Benjamin said that most states that have a child care agency have empowered that agency to put in the regulations. Co-Chair Purcell asked if Dr. Benjamin would be working with the Division of Child Development on such changes. She said she would.

Co-Chair Yongue asked if Dr. Benjamin had knowledge of how North Carolina might stand in terms of compliance with Federal regulations. Dr. Benjamin said there was very little federal regulation in child care unless it was a Head Start program or another program that used federal funds.

Representative Weiss said she thought it would be good once there was a change in child care policies that the information be made available to the parents.

Representative England asked if states with "B" ratings had had enough time to show any change. She said that southern states tended to adhere to the new regulations faster than other states, but these are also the states with the highest rates of childhood obesity. She said it was hard to say whether the obesity brought on the new regulations or would the children be even more obese without the regulations.

Representative Grady asked if the poor nutrition environment of the home could be a factor. Dr. Benjamin said that children in child care in North Carolina consume two-thirds of their daily calories while in child care. So 75% of children under the age of 5 are in child care and eat two-thirds of their meals during child care and one-third at home. She said the issue of obesity required the cooperation of the parents and the child care providers.

Representative Hughes asked how the information that the child care providers would receive concerning better nutrition could filter up to the parents. Dr. Benjamin said for example the Cooperative Extension and the Department of Health have developed "Color Me. Healthy" that promotes healthy eating in child care. The children take the message home.

There is a CD of the children singing songs about healthy eating and when they children sing the songs at home, the parents want the CD.

Senator Davis asked if there was a relation between the Farm to School program and the Watch Me Grow initiative. Dr. Benjamin said there was a good opportunity to adapt the Farm to School system to child care, but that nothing is using that framework yet.

Anna Carter, Division of Child Development said the Child Care Commission would vote on some rule changes in March. Those changes include:

1 .60 minutes of physical activity /8-hr day
2. weekly limits on screen time
3. support to allow mothers time to breastfeed

If passed the rule changes become effective July 1. Co-Chair Yongue asked that the Child Development Division would make the draft available to the Task Force.

Representative Weiss said if the Task Force could move ahead on some changes that might be put in place sooner, with milk for instance. Dr. Benjamin said when child care providers changed to low fat milk the children did not notice any taste difference.

The next presentation came from Jessica Black, National Director of the Healthy Schools Program through the Alliance for a Healthier Generation. (SEE ***ATTACHMENT: Child Nutrition in Schools.)*** Ms. Black was snowbound in her home in Washington, D.C.

The Healthy Schools Program (HSP) operates in 30 states including North Carolina. There is a Best Practices Framework built around health and physical education, school meal programs, before and after school programs and school employee wellness.

Information provided showed that 38% of schools restricted students from buying sugar drinks in the year 2006. By 2008 63% of the schools were restricting the sugar drinks.

HSP research shows children do better in school when they follow a good nutrition program. There is also less absenteeism and tardiness. Severely overweight children miss school 4 times as much as normal weight children.

Ms. Black cited North Carolina schools which had put the Best Practices Framework into action:

1. Hyde County Schools
2. Scotland Neck Primary School
3. McIver Elementary
4. Pittman Elementary
5. Hollister Elementary
6. Inborden Elementary
7. Franklin County Schools
8. Vaughn Elementary

North Carolina's secondary schools rank between 37% and 45% of the schools that do not sell sugar sweetened drinks.

Ms. Black said research had shown schools usually overcome the financial differences that result when schools do away with the competitive school lunch system. She said there were various factors that come into play in this process.

She said that some of the North Carolina Schools had employed something called Morning Move. In this program children who were arriving at school before classes begin go to the gym and dance, march, and move around with teachers and administrators participating. Thus the students begin the day with physical activity.

Co-Chair Yongue noted that teachers and principals as role models was a method used in several foreign countries.

Representative Hughes also noted that teachers and other personnel in Franklin County are serving as role models.

Senator Dannelly said that some foreign countries can dictate what will be done and the United States is quite different. He wondered how long it will take for the U. S. to become a healthy country.

Co-Chair Yongue agreed that many of the countries did dictate activities and that he was seeking a way to change our way of living.

Dr. Lynn Harvey, Section Chief for Child Nutrition Services for the Department of Public Instruction presented a question to the committee: was the school lunch program one of healthy foods or healthy finances. ***(SEE ATTACHMENTS: School Nutrition Programs in N. C., What's for Lunch, etc.)***

The expanded version of the question concerns the purpose of the child nutrition program: is it a food service enterprise program housed on the school campus that generates enough money to support itself and/or generate revenues for the school district,

Between 1946, when President Truman signed the National School Lunch act until 1980 the lunch program was based on the idea that hungry children can not learn. In 1981, $1.8 billion in federal funds for the program were cut and a lot changed before the funds were restored nearly a decade later. From 1981 until 1989 states and charities were supposed to operate the program. Schools began to sell supplemental items and then came a la carte served. Federal funds were restored

From 1990 until 2003 the a la carte systems picked up speed and schools began to make money. At the same time the 'traditional meal' developed a stigma. The state and local funds were redirected into other areas.

Dr. Harvey said the priority has changed to how much money can be generated by the nutrition program. Perhaps as a result North Carolina has the fifth fattest student body in the nation.

A pilot program for 8 North Carolina districts provided each $25,000 for the 2004-2005 school year.

At the end of the pilot it was shown that food costs were higher, production costs were higher, schools were not adequately equipped, the districts lost 15 times the amount of allotted in less than 5 months-primarily due to decreases in a la carte sales. It was suggested that to implement the nutrition standards in elementary schools would take $20 million per year.

Meanwhile, the State Board of Education said that all elementary school were to comply with nutrition standards by the end of the 2007-2008 school year. That deadline has been extended until there is adequate funding. The State Board of Education has made it a top priority for the Legislature to provide the estimated $20 million. But the funds have not been appropriated.

Nevertheless, Dr. Harvey said that upwards of 90% of the elementary schools had hit the nutrition standards, until they began to lose money. Now the percentage is back to 85% of the schools at standard.

From 2005 to 2008 food costs to schools went up 28%. In 2009 the costs seemed to have leveled due in part to the purchasing alliance joining all the schools districts. During the same period time labor costs went up by $32 million. Those labor costs follow the state salary schedule, but the money must come from the nutrition program, since there is no Legislative appropriation.

Of the money which goes to the Child Nutrition Program, 47% goes for salary and benefits, 44% for food, and 9% for indirect costs, capital etc. The annual budget is about $615 million. At the same time revenues are decreasing. The federal share does not cover the costs of the meals. A la carte sales are down. Lack of state and local funding is a factor, too. The federal funds cover about 60% of the costs; sale of food brings in about 38%. The remainder comes from catering, grants, interests on funds on deposit etc.

In summary, Dr. Harvey had the following possible solutions:

1. School Nutrition program must become a program for the health and academic success of the student.
2. Adequate federal, state and local funds are needed. (5 cents per meal she suggested.) Funds to eliminate the meal cost for reduced price meals.
3. Achievable, affordable and appealing meals to meet the nutrition standards.
4. Adequate meal periods
5. Make behavior-focused nutrition a part of the curriculum.
6. Sale and availability based on student health not profit.

Phillip Price, Chief Financial Officer for the Department of Public Instruction explained the impact of indirect costs on the Child Nutrition Program. ***(SEE ATTCHMENT: Indirect Costs)***

Indirect costs can be considered the cost of doing business. Lights, heat, personnel and such could be charged directly to a specific service such as the Child Nutrition Program. The problems is there is no way to determined just how much of a heat cost a school can ascribe to a program such as Child Nutrition anymore than the heat cost could be ascribed to a class room.

The U. S. Department of Education develops cost rate formulae used the Department of Public Instruction. In turn the U. S. Department approves the rates set by DPI for the individual districts. The federally defined formula drives the indirect cost system.

Mr. Price provided the Task Force with responses to several previously submitted questions. ***(SEE Indirect Costs, page 6.)***

In the discussion, Senator Tillman said the system has slipped that less nutritious meals are being provided at a relatively higher cost. He asked how many school systems have to supplement the nutrition program with local funds. Dr. Harvey said there were about 67 systems operating in the red; another 45 systems so close to the edge that

something like the loss of a large cooler would be catastrophic. Senator Tillman asked how the $7.1 million federal matching money was allocated. Mr. Price said $2 million went to schools which operate the breakfast programs, and $5.4 million goes to the central office to be allocated to the districts for administrative costs.

Co-Chair Yongue asked if more low-wealth counties fell into the category of operating in the red. Dr. Harvey said that the problems were spread across the board and will provide the complete information. Mr. Price noted that there were safeguards built into the allocation process to protect the fiscal integrity of the systems.

Representative Grady asked if 76% of the students eat lunch then what about the rest. Dr. Harvey said the others were brown bagging or not eating. Representative Grady asked if children would be allowed not to eat. Dr. Harvey said the situation often fell to local board policies that said a child who could not pay could not eat.

Further, Representative Grady asked if the Department actually took $2 million dollars out of the indirect costs. Mr. Price said that was correct and that the money went to the Office of Budget and Management. Representative Grady asked if workers in local school cafeterias were state or local employees. Dr. Harvey said these were local employees. Then Representative Grady said if the Task Force was going to do something it would not be an attempt to control what children ate at home, or did with their free time at home, but the Task Force could say that money that comes to feed children has to go for food for children. Further he said that the local workers should come onto the state payroll. Saying the General Assembly was responsible for the children for several hours per day and that "we can stop food from being sold that isn't healthy and we can pay for the food to make sure they have a healthy choice. And we can do the right thing." (North Carolina is one of 10 states that do not supplement the school nutrition program.)

Co-Chair Yongue asked if the number of children who were not eating meals was a consistent figure. Dr. Harvey said the information would be provided.

Representative Weiss said if the General Assembly provided $7 million did that mean the a la carte programs would be eliminated. Dr. Harvey said that federal nutrition guidelines are being met in the districts for the reimbursable meals. The a la carte meals do not have such guidelines to meet. She said the $7 million would be a great place to start, however the total amount of local sales is $249 million, and $7 million would not eliminate a la carte meals, but it would allow those children now receiving reduced priced meals to receive meals for free. When Representative Weiss asked about nutrition standards for all a la carte items, Dr. Harvey said the districts would do what ever the General Assembly directed but it would take funds to set such a standard, otherwise the nutrition programs would fail. Representative Weiss said if only foods served were healthy foods, then the students would eat those healthy foods. Dr. Harvey said the labor costs would increase. She said the only way to eliminate the a la carte program would be adequate funding, which also includes wages.

Representative Grady asked if a la carte meals were offered for a reason for anything other than raising money. Dr. Harvey replied, "I can't think of a good one."

Representative England asked for clarification of points made concerning the results of the "no risk" pilots. ***(ATTACHMENT: School Nutrition Programs, page 3.)*** He asked specifically if the estimated cost of $20 million for nutrition programs in

elementary schools was still viable and what type of meal that would provide. Dr. Harvey said the figure still seems viable and would provide a "no sale" food program in the elementary schools.

Senator Preston asked how many high schools allowed students to go off school grounds at lunch time. Dr. Harvey said she would provide that information.

Alice Lenihan, of the Nutrition Services Branch in the Department of Public Health presented the Task Force with information on access to nutritional foods. ***(SEE ATTACHMENT: Access to Nutritious Foods.)***

A primary part of this presentation was the importance of prenatal, infancy and preschool nutrition. Ms. Lenihan's research indicates that children who are breast fed are less likely to be obese likewise the mother's pre-and post-partum diets need to be nutritious. A delay in introduction to solid food is a way to prevent early onset of obese tendencies.

Ms. Lenihan pointed out that breastfeeding promotion opportunities came in a variety of places: workplace, communities, child care facilities etc.

As children grow older, they should have menus which include reduced fat milk, limit processed meats, and no juice for those less than 12 months old.

Margaret Samuels, Executive Director of the Orange County Partnership for Young Children, provided the organizations efforts to combat obesity in that County. ***(SEE ATTACHMENT: Preventing Obesity in Orange County, also Obesity Prevention in the Child Care Setting, and Evidence-Based Obesity Prevention in other States. Etc.)*** The Orange County Partnership administers Smart State and More at Four funds in that County. The research showed that 29% of the Orange County children between 2 and 18 are overweight or obese. In the 2-4 year age range 15.8% are overweight.

The Partnership formed a group and raised about $300,000 in a 2-year period. The project started with community gardens as one of the first activities. The plan was to introduce vegetables into the diets of the children involved in the projects. Now there are 3 gardens in the Growing Healthy Kids program. At the start of the program 8 children were either overweight or at risk of becoming overweight. Post data showed 3 of these children had a body mass index classification of normal and 1 had reduced the BMI from overweight to at risk overweight. Parents reported overall increase in fruits and vegetables in the home; 126% increase in vegetables available and 88% increase in fruits available.

In another project, Move It! families participated in a physical activity program. Sixty-two children were involved, 81% of the families participating earned less that $25,000/year.

In another effort, 35 childcare teachers were provided pedometers.

Representative Hughes asked how the Growing Healthy Kids project worked. Ms. Samuels said the 7-week course was taught in Spanish and English to families with a separate child care session for children ages 2-4. She said the Cooperative Extension did the evaluation and would provide the report.

Cindy Marion, Child Nutrition Services from Stokes County, Cynthia Sevier, Child Nutrition Services, Guilford County both from the Public Policy Committee of the School Nutrition Association of North Carolina were joined by Deborah Carpenter, Hoke County Director of Child Nutrition and President of the Association presented the Association's position. ***(SEE ATTACHMENTS: 2009 Fact Sheets, Feeding North Carolina's Children.)***

The information provided said that the Child Nutrition Programs must make enough to cover 45.5% of the labor and benefits for employees, 43.6% for food and supplies, 6% of the direct costs and 5% of the indirect costs; which totaled $18 million in 2009.

The Association also supports the state match of $7.2 million to eliminate the reduced price meal category which would add an additional $5.2 million in federal dollars, allow the Child Nutrition Programs to sustain a 3 months operation balance before indirect cost can be assessed, and standardize the competitive foods regulation. While child nutrition directors' salaries can be paid out of the state matching funds, Ms. Sevier said that fewer than 50% of the salaries were paid from these funds. The most were paid out of money raised by the nutrition programs.

In the discussion, Co-Chair Senator Purcell noted that helping to balance the nutrition programs funds did not address the problem of combating obesity.

Senator Preston said the 1995-96 the General Assembly put the money into the central office budget flexibility to pay the child nutrition directors salaries. She said the current redirection of those funds needed to be changed.

Representative Weiss said the Task Force might want to consider a recommendation that would allow breastfeeding friendly policies across the state agencies. She said that might be a small step along the way.

The next Task Force meeting will be Monday, February 15, 2010.

The meeting was adjourned at 3:45 p.m.

Representative Doug Yongue,
Co-Chair Presiding.

Katie Stanley, Committee Clerk

Senator William Purcell, Co-Chari

Minutes by Ted Harrison

VISITOR REGISTRATION SHEET

Childhood Obesity — Name of Committee

02/11/10 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carolyn Dunn	NC State University
A. E. WHITE	DHHS/DPH/11
Cathy Thomas	NC DPH
Dean Simpson	DHHS / DSS
Alice Lewis	DNNS/DPN
John Dorrin	Governor's Office
RUTH PETERSEN	NC DPH
Yolanda Dickerson	AHA- Advocate
Jennifer Pack	NCAH
Peg O'Connell	CFS, Inc.

VISITOR REGISTRATION SHEET

Childhood Obesity — Name of Committee

02/11/10 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
REBECCA [illegible]	DPH
Pam Seamans	NC Alliance for Health
Greg Griggs	NCAFP / ESMM
Jennifer Howard	tomikejen@aol.com
Paula Hudson Collins	DPI/SBE
Kaye Webb	The LINKS, Inc
Kelly Kimple	UNC Pediatrics.
Cristina Stingo	UNC Pediatrics
Cindy Mahon	School Nutr. Assoc. (Stokes Co Schools
Cynthia Sevier	School Nutrition Assoc. (Guilford Co. Schools)
[illegible]	VAIO

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Linda Fairchild	Carteret Co. Schools
Gail Scalzo	Onslow County Schools
Gretchen Sharlow	Onslow County Schools
Daughn Baker	Davie County Schools/SNA-NC
Janet Johnson	DPI - Child Nutrition Services
Marjorie Wilson	NC Action for Healthy Kids

VISITOR REGISTRATION SHEET

Child Health Obesity — 2/11/10

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rob Savitt	NC Child Care Coalition
Matt Farrell	TPG
Bob Hall	McGuire Woods
Butch Gunnells	NC Beverage Ass'n
Amy McConkey	NC Beverage Ass'n
Elizabeth Roberson	NCMA
Annette Newkirk	Governor's Office
Lynn Harvey	NCDPI
[illegible]	NCICU
[illegible]	DPI
Ben Matthews	DPI

VISITOR REGISTRATION SHEET

Childhood Obesity — 2-1-10

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Margaret Samuels	Orange County Partnership for Young Children
Sara Benjamin	Duke University Medical Center
Anna Carter	DHHS / DCD
Cynthia Turner	NC Partnership for Children, Inc. (Smart Start)
Katherine Joyce	NCASA
Susan Harris	WCPSS
Emily Daye	NCPAPA
Gene Causby	NC SFSA
Marjorie Wilson	NC Action for Healthy Kids
Shaivon Simmons-Wright	Alliance for a Healthier Generation NC relationship manager
Ellen Essick	Alliance for a Healthier Generation

VISITOR REGISTRATION SHEET

Childhood Obesity — 2/11/10

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Owens	Alliance for a Healthier Generation Dare County
Kelly Mauer	11
Richard Raleigh	Be Active North Carolina
Kymm Ballard	SPARK
S Wilson	DHHS
Laura Aiken	WakeMed
Danielle Braxton	UNC-HPDP
W. Gardner Culpepper	Personal Interest
Anna Gruss	Capstrat
Jani Kozlowski	NC Partnership for Children
Nilda Cosco	Natural Learning Initiative College of Design NC State Univ.

Task Force on Childhood Obesity
AGENDA

Thursday, February 11, 2010
10:00 am
Legislative Office Building
Room 544

Children's Access to Nutritious Food: PreK-12

I. Introduction
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

II. Dr. Sara Benjamin, Assistant Professor, Department of Community and Family Medicine, Duke University Medical Center

III. Jessica Donze Black, National Director, Healthy Schools Program, Alliance for a Healthier Generation

Lunch Break

IV. Dr. Lynn Hoggard Harvey, Section Chief -Child Nutrition Services, Division of School Support, NC Department of Public Instruction

Phillip Price, Chief Financial Officer, NC Department of Public Instruction

V. Alice Lenihan, Director, Nutrition Services, NC Department of Health and Human Services

VI. Margaret Samuels, Executive Director, Orange County Partnership for Young Children

VII. Cindy Marion, Director, Child Nutrition Services, Stokes County
Co-Chair, Public Policy Committee, School Nutrition Association of NC

Cynthia Sevier, Director, Child Nutrition Services, Guilford County
Co-Chair, Public Policy Committee, School Nutrition Association of NC

Deborah Carpenter, Director, Child Nutrition Services, Hoke County
President, School Nutrition Association of NC

VIII. Discussion

Future Meeting Dates:
Monday, February 15,(9:30 am – 3:00 pm) Children's Physical Activity, BMI, and Fitness
Tuesday, February 23, (10:00 am – 3:00 pm) Food Industry

Public Schools of North Carolina

Indirect Costs

Legislative Task Force on Childhood Obesity (2009)

February 11, 2010

What Are Indirect Costs?

- Indirect costs represent the expenses of doing business that are not readily identified with a particular grant, contract, project function or activity, but are necessary for the general operation of the organization and the conduct of activities it performs.

What Are Indirect Costs?

- In theory, costs like heat, light, accounting and personnel might be charged directly if meters could record minutes in a cross-cutting manner. Practical difficulties preclude such an approach. Therefore, cost allocation plans or indirect cost rates are used to distribute those costs to benefiting revenue sources.

What Is An Indirect Cost Rate?

- An indirect cost rate is simply a mechanism for determining fairly and conveniently within the boundaries of sound administrative principle, what proportions of Departmental/organization administration costs each program should bear.

What Is An Indirect Cost Rate?

- An indirect cost rate represents the ratio between the total indirect costs and benefiting direct costs, after excluding and or reclassifying unallowable costs, and extraordinary or distorting expenditures. (i.e., capital expenditures and major contracts and subgrants).

What Is An Indirect Cost Rate?

- The indirect costs in the numerator of the equation should bear a reasonable relationship to the direct costs from the denominator. This will allow for each program or activity represented in the direct costs base to assume its fair share of indirect costs when the rate is applied.

How Are Indirect Cost Rates Determined?

- The cognizant Federal agency is responsible for approving indirect cost rates for recipients based on an indirect cost proposal submission.
- The cognizant Federal Agency for NC DPI is the Department of Education (where we get the most federal money)
- NC DPI has been delegated the authority to approve LEA rates (formula is federally approved)

Are public school systems under the same guidelines as state and local governments and subject to OMB Circular A-87?

- The standards for public schools are included in OMB Circular A-87.

Two Types of Indirect Cost Rates

- Restricted: for grants that require that the federal funds be used to "supplement and not supplant"
- Nonrestricted: no "supplement and not supplant" requirement

Restricted: "supplement and not supplant"

- ... this term means that state and local agencies have tax revenue or other financial resources of their own to finance the education program. Without the "supplement not supplant" provision, states could simply reduce their support of educational service to the extent of the newly available federal funding or could substitute federal money for tax revenue already generated to fund schools.

Calculating Indirect Cost Rate

- Per federal guidelines, all expenditures are classified into 4 categories:
  - Indirect (general costs of operations – finance, personnel, and purchasing)
  - Direct (specific delivery costs – classroom instruction)
  - Unallowed (high level administration – local board, superintendent)
  - Excluded (one-time costs like equipment)

Calculating Indirect Cost Rate

- Calculation:
  - Indirect is divided by direct + unallowed
- Rates vary by LEA (different expenditure patterns)
- LEAs can charge "up to" the approved rate

What Can Indirect Cost Funds be Used for Once Collected

- Indirect cost are reimbursements for costs already incurred. Once receipted, the indirect costs take on the identity of the agencies non-federal funding (can be expended under the same rules as):
  - DPI – State Funds
  - LEA – local funds

Where do Indirect Cost Receipts Go?

- DPI
  - OSBM receives all Indirect Cost receipts
  - DPI can request that some of the receipts be budgeted in the agency to support services
  - Collected/DPI expended
    - FY 2007-08: $5,201,733/$3,227,338
    - FY 2008-09: $4,571,265/$3,578,104

Operate
5.2 M

Where do Indirect Cost Receipts Go?

- LEAs
  - Maintained @ LEA
  - Can be expended in the same manner as local funds

Child Nutrition

- Non-Restricted Rate:
  - Child Nutrition funds do not have to supplement an existing program
  - Operation and Maintenance of Plant is considered a general cost for the program and is included in the numerator

Child Nutrition

- State Funding:
  - School Breakfast Program
    - Expenditures 2007-08 $2,017,761 and 2008-09 $1,948,728. Budget for FY 2009-10 $2,017,761
  - $7.1 million Required Match
    - House Bill 6 (1995-96) consolidated Child Nutrition Directors ($13 million) into Central Office Administration

Child Nutrition

- Match (cont).
  - Currently we expend $5.4 million from Central Office Administration for Child Nutrition Directors
  - We have met the match by identifying additional State expenditures that directly relate to the program:
    - $2 million for school breakfast

Child Nutrition

- All other costs for the Child Nutrition Program are covered with Federal, receipts, or local funds.
- Any shortage between revenue and expenditures must be covered by local funds

Child Nutrition

- Examples: How LEAs use indirect cost receipts:
  - Personnel operations to hire/manage child nutrition personnel
  - Financial operations (payroll, bills)
  - Energy costs to heat/cool cafeterias
  - Energy costs to cook/prepare/store food

Recap

- Indirect Cost is a Federally defined formula
- LEAs are authorized to charge up to the Non-Restricted rate to Child Nutrition expenditures
- LEAs use the funds to cover the general costs to support the program
- Any cost in excess of revenue must be covered by local funds – a decrease in indirect cost charges increases local charges

Response to Some Submitted Questions

- Collected Indirect Costs from the Child Nutrition Program
  - FY 2007-08 $31,416,316.99
  - FY 2008-09 $27,763,310.16
  - FY 2009-10 Budget: not known

Response to Some Submitted Questions

- How Does DPI Spend Federal Child Nutrition Funds?
  - FY 2007-08 $2,576,900
    - Salaries: $1,418,054
    - Travel: $ 225,320
    - IT Support: $ 317,218
    - Training: $ 356,370
    - Other: $ 259,938

Response to Some Submitted Questions

- How Does DPI Spend Federal Child Nutrition Funds?
  - FY 2008-09: $2,690,571
    - Salaries: $1,564,736
    - Travel: $ 230,752
    - IT Support: $ 323,252
    - Training: $ 216,020
    - Other: $ 355,811

LEA INDIRECT COST RATES
FOR USE IN STATE FISCAL YEAR
BEGINNING JULY 1, 2009

UNIT NO.	UNIT NAME	RESTRICTED	UNRESTRICTED
010	ALAMANCE COUNTY	2.293 %	12.934 %
020	ALEXANDER COUNTY	1.934	9.754
030	ALLEGHANY COUNTY	5.158	20.944
040	ANSON COUNTY	5.239	17.683
050	ASHE COUNTY	2.042	14.415
060	AVERY COUNTY	3.555	20.743
070	BEAUFORT COUNTY	3.731	18.116
080	BERTIE COUNTY	2.631	15.753
090	BLADEN COUNTY	3.335	15.838
100	BRUNSWICK COUNTY	2.873	16.599
110	BUNCOMBE COUNTY	2.913	14.152
111	ASHEVILLE CITY	3.654	21.340
120	BURKE COUNTY	2.422	13.885
130	CABARRUS COUNTY	3.601	13.570
132	KANNAPOLIS CITY	4.670	16.887
140	CALDWELL COUNTY	1.730	10.752
150	CAMDEN COUNTY	1.031	22.915
160	CARTERET COUNTY	2.264	15.313
170	CASWELL COUNTY	2.823	13.025
180	CATAWBA COUNTY	3.167	13.701
181	HICKORY CITY	3.045	17.054
182	NEWTON-CONOVER CITY	3.458	12.768
190	CHATHAM COUNTY	1.880	16.779
200	CHEROKEE COUNTY	2.108	14.853
210	EDENTON/CHOWAN	4.906	18.423
220	CLAY COUNTY	1.027	21.707
230	CLEVELAND COUNTY	3.891	13.339
240	COLUMBUS COUNTY	2.486	13.824
241	WHITEVILLE CITY	3.104	17.742
250	CRAVEN COUNTY	2.335	12.607
260	CUMBERLAND COUNTY	0.682	11.332
270	CURRITUCK COUNTY	3.880	17.327
280	DARE COUNTY	5.292	27.806
290	DAVIDSON COUNTY	2.342	12.897
291	LEXINGTON CITY	7.109	19.744
292	THOMASVILLE CITY	3.102	20.628
300	DAVIE COUNTY	1.372	11.835
310	DUPLIN COUNTY	0.369	13.236
320	DURHAM COUNTY	2.582	13.207
330	EDGECOMBE COUNTY	1.083	13.711
340	FORSYTH COUNTY	1.439	10.139

LEA INDIRECT COST RATES
FOR USE IN STATE FISCAL YEAR
BEGINNING JULY 1, 2009

UNIT NO.	UNIT NAME	RESTRICTED	UNRESTRICTED
350	FRANKLIN COUNTY	3.582 %	15.641 %
360	GASTON COUNTY	2.631	11.848
370	GATES COUNTY	3.091	15.503
380	GRAHAM COUNTY	6.130	28.238
390	GRANVILLE COUNTY	4.097	16.700
400	GREENE COUNTY	4.709	14.049
410	GUILFORD COUNTY	2.266	12.772
420	HALIFAX COUNTY	1.818	16.887
421	ROANOKE RAPIDS CITY	5.893	20.267
422	WELDON CITY	6.195	36.676
430	HARNETT COUNTY	0.584	12.507
440	HAYWOOD COUNTY	2.702	12.204
450	HENDERSON COUNTY	4.727	16.726
460	HERTFORD COUNTY	2.754	16.220
470	HOKE COUNTY	3.308	15.081
480	HYDE COUNTY	5.890	20.066
490	IREDELL-STATESVILLE	2.258	13.733
491	MOORESVILLE CITY	0.952	15.068
500	JACKSON COUNTY	1.975	16.054
510	JOHNSTON COUNTY	2.603	14.490
520	JONES COUNTY	7.835	19.961
530	LEE COUNTY	3.333	13.488
540	LENOIR COUNTY	1.835	15.698
550	LINCOLN COUNTY	2.931	13.173
560	MACON COUNTY	2.797	13.992
570	MADISON COUNTY	4.946	20.119
580	MARTIN COUNTY	2.822	14.424
590	MCDOWELL COUNTY	3.884	13.585
600	MECKLENBURG COUNTY	2.311	12.798
610	MITCHELL COUNTY	6.305	24.225
620	MONTGOMERY COUNTY	4.565	15.722
630	MOORE COUNTY	2.269	17.037
640	NASH-ROCKY MOUNT	3.099	14.596
650	NEW HANOVER COUNTY	5.535	19.104
660	NORTHAMPTON COUNTY	2.909	19.554
670	ONSLOW COUNTY	4.017	15.613
680	ORANGE COUNTY	2.822	14.704
681	CHAPEL HILL-CARRBORO	3.142	15.866
690	PAMLICO COUNTY	5.039	24.498
700	PASQUOTANK COUNTY	0.994	14.282
710	PENDER COUNTY	2.718	16.021

LEA INDIRECT COST RATES
FOR USE IN STATE FISCAL YEAR
BEGINNING JULY 1, 2009

UNIT NO.	UNIT NAME	RESTRICTED	UNRESTRICTED
720	PERQUIMANS COUNTY	2.882 %	20.473 %
730	PERSON COUNTY	2.636	18.667
740	PITT COUNTY	2.889	15.702
750	POLK COUNTY	3.354	16.909
760	RANDOLPH COUNTY	3.174	12.968
761	ASHEBORO CITY	4.938	19.029
770	RICHMOND COUNTY	0.506	11.346
780	ROBESON COUNTY	0.276	11.837
790	ROCKINGHAM COUNTY	3.641	15.048
800	ROWAN-SALISBURY	3.153	13.525
810	RUTHERFORD COUNTY	2.755	16.721
820	SAMPSON COUNTY	2.612	14.556
821	CLINTON CITY	0.581	12.129
830	SCOTLAND COUNTY	2.593	14.139
840	STANLY COUNTY	3.333	12.121
850	STOKES COUNTY	1.132	14.701
860	SURRY COUNTY	2.784	13.795
861	ELKIN CITY	5.680	24.813
862	MOUNT AIRY CITY	3.533	16.805
870	SWAIN COUNTY	0.064	20.520
880	TRANSYLVANIA COUNTY	2.370	15.037
890	TYRRELL COUNTY	5.416	25.592
900	UNION COUNTY	2.715	15.508
910	VANCE COUNTY	3.797	14.469
920	WAKE COUNTY	2.585	11.087
930	WARREN COUNTY	4.890	21.758
940	WASHINGTON COUNTY	2.394	19.454
950	WATAUGA COUNTY	7.332	21.858
960	WAYNE COUNTY	1.196	11.542
970	WILKES COUNTY	3.476	13.859
980	WILSON COUNTY	1.006	10.775
990	YADKIN COUNTY	4.041	14.041
995	YANCEY COUNTY	2.381	16.932

Prepared by: Financial and Business Services
School Business Services
Monitoring & Compliance Section
10/14/2009

Restricted Indirect Cost Rate
Classification of Purpose Codes Summary

Purpose Code	Description	Indirect Costs	Disallowed/ Direct Costs	Excluded
5100	Regular Instructional Programs	No	**Yes**	Note 1
5200	Special Populations Services	No	**Yes**	Note 1
5300	Alternative Programs and Services	No	**Yes**	Note 1
5400	School Leadership Services	No	**Yes**	Note 1
5500	Co-Curricular Services	No	**Yes**	Note 1
5800	School-Based Support Services	No	**Yes**	Note 1
5850	School Resource Officer Services	No	**Yes**	Note 1
6110	Regular Curricular Support & Development Services	No	**Yes**	Note 1
6120	CTE Curricular Support & Development Services	No	**Yes**	Note 1
6200	Special Population Support & Development Services	No	**Yes**	Note 1
6300	Alternative Programs & Services Support & Dev Services	No	**Yes**	Note 1
6400	Technology Support Services	**Yes**	No	Note 1
6510	Communication Services	No	**Yes**	Note 1
6520	Printing & Copying Services	**Yes**	No	Note 1
6530	Public Utility and Energy Services	No	**Yes**	Note 1
6540	Custodial/Housekeeping Services	No	**Yes**	Note 1
6550	Transportation Services	No	**Yes**	Note 1
6560	Warehouse & Delivery Services	**Yes**	No	Note 1
6570	Facilities Planning, Acquisition and Construction Services	No	**Yes**	Note 1
6580	Maintenance Services	No	**Yes**	Note 1
6610	Financial Services	**Yes**	No	Note 1
6620	Human Resource Services	**Yes**	No	Note 1
6710	Student Testing Services	No	**Yes**	Note 1
6720	Planning, Research Development and Program Evaluation	**Yes**	No	Note 1
6800	System-wide Pupil Support Services	No	**Yes**	Note 1
6910	Board of Education	No	**Yes**	Note 1
6920	Legal Services	**Yes**	No	Note 1
6930	Audit Services	**Yes**	No	Note 1
6940	Leadership Services	No	**Yes**	Note 1
6950	Public Relations and Marketing Services	No	**Yes**	Note 1
7100	Community Services	No	**Yes**	Note 1
7200	Child Nutrition	No	**Yes**	**Note 2**
7300	Adult Services	No	**Yes**	Note 1

Notes:

1) In all purpose codes, equipment object codes (5XX) are excluded.

2) In Child Nutrition (7200), costs for Supplies & Materials (4XX) are excluded.

3) Disallowed cost is added to the base (denominator) for computation purposes.

Updated August 2009

Unrestricted Indirect Cost Rate
Classification of Purpose Codes Summary

Purpose Code	Description	Indirect Costs	Disallowed/ Direct Costs	Excluded
5100	Regular Instructional Programs	No	**Yes**	Note 1
5200	Special Populations Services	No	**Yes**	Note 1
5300	Alternative Programs and Services	No	**Yes**	Note 1
5400	School Leadership Services	No	**Yes**	Note 1
5500	Co-Curricular Services	No	**Yes**	Note 1
5800	School-Based Support Services	No	**Yes**	Note 1
5850	School Resource Officer Services	**Yes**	No	Note 1
6110	Regular Curricular Support & Development Services	No	**Yes**	Note 1
6120	CTE Curricular Support & Development Services	No	**Yes**	Note 1
6200	Special Population Support & Development Services	No	**Yes**	Note 1
6300	Alternative Programs & Services Support & Dev Services	No	**Yes**	Note 1
6400	Technology Support Services	**Yes**	No	Note 1
6510	Communication Services	No	**Yes**	Note 1
6520	Printing & Copying Services	**Yes**	No	Note 1
6530	Public Utility and Energy Services	**Yes**	No	Note 1
6540	Custodial/Housekeeping Services	**Yes**	No	Note 1
6550	Transportation Services	No	**Yes**	Note 1
6560	Warehouse & Delivery Services	**Yes**	No	Note 1
6570	Facilities Planning, Acquisition and Construction Services	No	**Yes**	Note 1
6580	Maintenance Services	**Yes**	No	Note 1
6610	Financial Services	**Yes**	No	Note 1
6620	Human Resource Services	**Yes**	No	Note 1
6710	Student Testing Services	No	**Yes**	Note 1
6720	Planning, Research Development and Program Evaluation	**Yes**	No	Note 1
6800	System-wide Pupil Support Services	No	**Yes**	Note 1
6910	Board of Education	No	**Yes**	Note 1
6920	Legal Services	**Yes**	No	Note 1
6930	Audit Services	**Yes**	No	Note 1
6940	Leadership Services	**Yes**	No	Note 1
6950	Public Relations and Marketing Services	No	**Yes**	Note 1
7100	Community Services	No	**Yes**	Note 1
7200	Child Nutrition	No	**Yes**	**Note 2**
7300	Adult Services	No	**Yes**	Note 1

Notes:
1) In all purpose codes, equipment object codes (5XX) are excluded.
2) In Child Nutrition (7200), costs for Supplies & Materials (4XX) are excluded.
3) Disallowed cost is added to the base (denominator) for computation purposes.

Updated August 2009

Obesity Prevention in Young Children Attending Child Care

Sara E Benjamin PhD, MPH, RD

Department of Community and Family Medicine
and
Duke Global Health Institute

2.11.10



Child care attendance in the US

- Nearly 3/4 of children ages 2 to 6 years are in some form of child care
  - Close to half attend child care centers
  - Other half in home-based settings
    - Family child care home
    - Family, friend, neighbor care

Child care attendance and obesity

1. Children who attended part-time child care ages 3 to 5 years had decreased risk of obesity between ages 6 to 12 compared to no child care

Lumeng JC GK, Appugliese D, Cabral HJ, and ZuckermanB. Preschool child care and risk of overweight in 6-to-12year-old children. *International Journal of Obesity and Related Metabolic Disorders.* 2005;29:60-66.

Child care attendance and obesity

2. Children who attended child care the year prior to kindergarten had ↑ risk of obesity at start of kindergarten compared to no child care

    - Children at greatest risk were cared for in home of family, friend, or neighbor

Maher EJ, Li G, Carter L, Johnson DB. Preschool child care participation and obesity at the start of kindergarten. *Pediatrics.* Aug 2008;122(2):322-330.

Child care attendance and obesity

3. Infants in child care first 6 months of life
   - Heavier at 1 year and still at 3 years
   - Children at greatest risk cared for in someone else's home

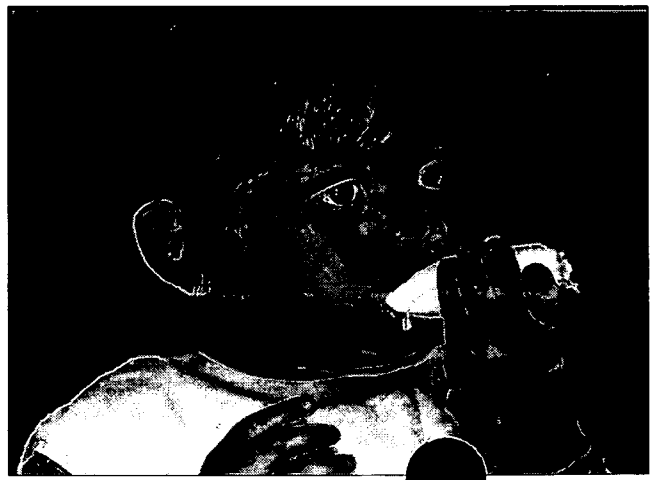
4. Infants cared for by a relative first 9 months of life
   - Less likely to have been breastfed
   - More likely to eat solid foods too early
   - Greater weight gain in first 9 months

Benjamin SE, Rifas-Shiman SL, Taveras EM, Finkelstein J, Haines J, Kleinman K, Gillman MW. Early child care and adiposity at 1 and 3 years. *Pediatrics*. 2009 Aug; 124: 555-562 .

Kim J, Peterson, K.E. Association of infant child care with infant feeding practices and weight gain among US infants. *Archives of Pediatric and Adolescent Medicine.* 2008;162(7):627-633.

Does child care attendance contribute to childhood obesity?

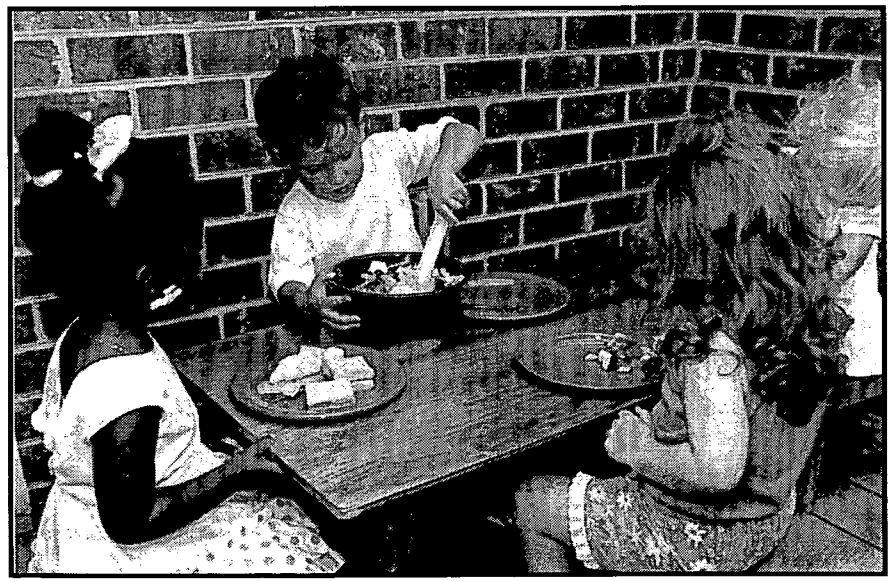
- Poor dietary intake of children in child care
  - *Low fruits, vegetables, fiber*
- Inadequate physical activity in child care
  - *Insufficient time for active play*



Two approaches to promoting healthy eating and physical activity in child care

1. Policy

2. Intervention



Regulation of child care in the US

- Each US state has own policies for child care facilities, including DC, Puerto Rico, Virgin Islands, and Dept Of Defense

- Most states regulate 2 main types of facilities: child care centers ("centers") and family child care homes ("homes")

CHAPTER 9 - CHILD CARE RULES
Effective July 1, 2008

		PAGE
SECTION	.0100 DEFINITIONS	1
.0101	RESERVED FOR FUTURE CODIFICATION	
.0102	DEFINITIONS	
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.0201	INSPECTIONS	
.0202	RESERVED FOR FUTU	
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.0204	CHANGES REQUIRIN	
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.0206	CAPACITY OF THE CI	
.0207	RESERVED FOR FUTU	
SECTION	.0300 PROCEDURES	
.0301	PRE-LICENSING REQ	
.0302	APPLICATION FOR A	
.0303	RESERVED FOR FUTU	

10A NCAC 09 .1718 REQUIREMENTS FOR DAILY OPERATIONS

The operator shall provide the following on a daily basis for all children in care:

(1) Meals and snacks which comply with the Meal Patterns for Children in Child Care standards which are based on the recommended nutrient intake judged by the National Research Council to be adequate for maintaining good nutrition. The types of food and number and size of servings shall be appropriate for the ages and developmental levels of the children in care. The Meal Patterns for Children in Child Care nutrition standards are incorporated by reference and include subsequent amendments. A copy of these standards is available free of charge from the Division at the address in Rule .0102 of this Chapter.

(2) No child shall go more than four hours without a meal or a snack being provided.

(3) Drinking water shall be freely available to children and offered at frequent intervals.

(4) When milk, milk products, or fruit juices are provided by the operator, only pasteurized products or products which have undergone an equivalent process to pasteurization shall be used. Any formula which is prepared by the operator shall be prepared according to the instructions on the formula package or label, or according to written instructions from the child's health care provider.

(5) Each infant shall be held for bottle feeding until able to hold his or her own bottle. Bottles shall not be propped. Each child shall be held or placed in feeding chairs or other age-appropriate seating apparatus to be fed.

(6) The parent or health care provider of each child under 15 months of age shall provide the operator an individual written feeding schedule for the child. This schedule shall be followed at the home. This schedule shall include the child's name, be signed by the parent or health care provider, and be dated when received

Model child care policies

Model Healthy Eating Regulations

- High fat*, high sugar, and high salt foods are served less than one time per week or are not served
- Sugar sweetened beverages are not served
- Children older than two years are served reduced fat milk (skim or 1%)
- Clean, sanitary drinking water is available for children to serve themselves throughout the day
- Nutrition education is offered to child care providers at least one time per year
- Juice is limited to a total of 4-6 ounces or less per day for children over one year of age
- Child care providers do not use food as a reward or punishment
- Nutrition education is offered to children at least three times per year
- At least one child care provider sits with children at the table and eats the same meals and snacks
- Providers encourage, but do not force, children to eat

*saturated fat and trans fat

Model Physical Activity Regulations

- Children are provided with 60 minutes of physical activity per day, a combination of both teacher led and free play
- Television, video, and computer time are limited to one time per week or less and not more than 30 minutes each time
- Child care providers do not withhold active play time as punishment
- Children with special needs are provided opportunities for active play while other children are physically active
- Children are provided outdoor active play time at least two times per day
- Physical activity education is offered to child care providers at least one time per year
- At least one provider joins children in active play at least one time per day
- Shaded area provided during outdoor play
- Children are not seated for periods longer than 30 minutes except when sleeping or eating
- Physical activity education is offered to children at least three times per year

State Rankings for Healthy Eating and Physical Activity Regulations

Georgia	B
Nevada	B
Colorado	B-
Illinois	B-
Mississippi	B-
Ohio	B-
South Carolina	B-
Tennessee	B-
Alaska	C+
Delaware	C+
Hawaii	C+
Maine	C+
Missouri	C+
New Jersey	C+
New Mexico	C+
Oklahoma	C+
Rhode Island	C+
Texas	C+
Vermont	C+
Virginia	C+
Washington	C+
West Virginia	C+
Alabama	C
Arizona	C
Arkansas	C
California	C
Florida	C
Indiana	C
Iowa	C
Kansas	C
Maryland	C
Massachusetts	C
Michigan	C
Minnesota	C
Montana	C
New Hampshire	C
New York	C
North Carolina	C
Oregon	C
Pennsylvania	C
Utah	C
Wisconsin	C
Wyoming	C
Washington DC	C
Connecticut	C-
Kentucky	C-
Louisiana	C-
Nebraska	C-
North Dakota	C-
Virgin Islands	C-
Department of Defense	C-
South Dakota	D
Puerto Rico	D
Idaho	F

State Rankings for Healthy Eating and Physical Activity Regulations

Georgia	B
Nevada	B
Colorado	B-
Illinois	B-
Mississippi	B-
Ohio	B-
South Carolina	B-
Tennessee	B-
Alaska	C+
Delaware	C+
Hawaii	C+
Maine	C+
Missouri	C+
New Jersey	C+
New Mexico	C+
Oklahoma	C+
Rhode Island	C+
Texas	C+
Vermont	C+
Virginia	C+
Washington	C+
West Virginia	C+
Alabama	C
Arizona	C
Arkansas	C
California	C
Florida	C
Indiana	C
Iowa	C
Kansas	C
Maryland	C
Massachusetts	C
Michigan	C
Minnesota	C
Montana	C
New Hampshire	C
New York	C
North Carolina	C
Oregon	C
Pennsylvania	C
Utah	C
Wisconsin	C
Wyoming	C
Washington DC	C
Connecticut	C-
Kentucky	C-
Louisiana	C-
Nebraska	C-
North Dakota	C-
Virgin Islands	C-
Department of Defense	C-
South Dakota	D
Puerto Rico	D
Idaho	F

State Rankings for Healthy Eating and Physical Activity Regulations

Georgia	B
Nevada	B
Colorado	B-
Illinois	B-
Mississippi	B-
Ohio	B-
South Carolina	B-
Tennessee	B-
Alaska	C+
Delaware	C+
Hawaii	C+
Maine	C+
Missouri	C+
New Jersey	C+
New Mexico	C+
Oklahoma	C+
Rhode Island	C+
Texas	C+
Vermont	C+
Virginia	C+
Washington	C+
West Virginia	C+
Alabama	C
Arizona	C
Arkansas	C
California	C
Florida	C
Indiana	C
Iowa	C
Kansas	C
Maryland	C
Massachusetts	C
Michigan	C
Minnesota	C
Montana	C
New Hampshire	C
New York	C
North Carolina	C
Oregon	C
Pennsylvania	C
Utah	C
Wisconsin	C
Wyoming	C
Washington DC	C
Connecticut	C-
Kentucky	C-
Louisiana	C-
Nebraska	C-
North Dakota	C-
Virgin Islands	C-
Department of Defense	C-
South Dakota	D
Puerto Rico	D
Idaho	F

State Rankings for Healthy Eating and Physical Activity Regulations

Georgia	B
Nevada	B
Colorado	B-
Illinois	B-
Mississippi	B-
Ohio	B-
South Carolina	B-
Tennessee	B-
Alaska	C+
Delaware	C+
Hawaii	C+
Maine	C+
Missouri	C+
New Jersey	C+
New Mexico	C+
Oklahoma	C+
Rhode Island	C+
Texas	C+
Vermont	C+
Virginia	C+
Washington	C+
West Virginia	C+
Alabama	C
Arizona	C
Arkansas	C
California	C
Florida	C
Indiana	C
Iowa	C
Kansas	C
Maryland	C
Massachusetts	C
Michigan	C
Minnesota	C
Montana	C
New Hampshire	C
New York	C
North Carolina	C
Oregon	C
Pennsylvania	C
Utah	C
Wisconsin	C
Wyoming	C
Washington DC	C
Connecticut	C-
Kentucky	C-
Louisiana	C-
Nebraska	C-
North Dakota	C-
Virgin Islands	C-
Department of Defense	C-
South Dakota	D
Puerto Rico	D
Idaho	F

Preventing Obesity In The Child Care Setting:
Evaluating State Regulations



Role Of Child Care In Obesity Prevention

Over the past few decades, the prevalence of childhood obesity has risen dramatically in the US. Today, 24.4% of children ages two through five years are classified as either overweight or obese.[1] The preschool period is a critical time for growth and
active play
In the U
to six are in
just over h
With such
care, child c
to support
promote ph
In the U
is the respo
each has a
and enforc
result, regu
considerabl

Evaluation Of State Child Care Regulations

For this study, experts in nutrition, physical activity, early care and education, and policy and regulation reviewed a number of standards and recommendations that were developed to help child care facilities prevent obesity in young

NORTH CAROLINA OVERALL GRADE: C

Healthy Eating Grades		Physical Activity Grades	
Centers	Homes	Centers	Homes
C-	C-	B-	C-

To view the full report or individual state report cards, please visit:
http://cfm.mc.duke.edu/childcare

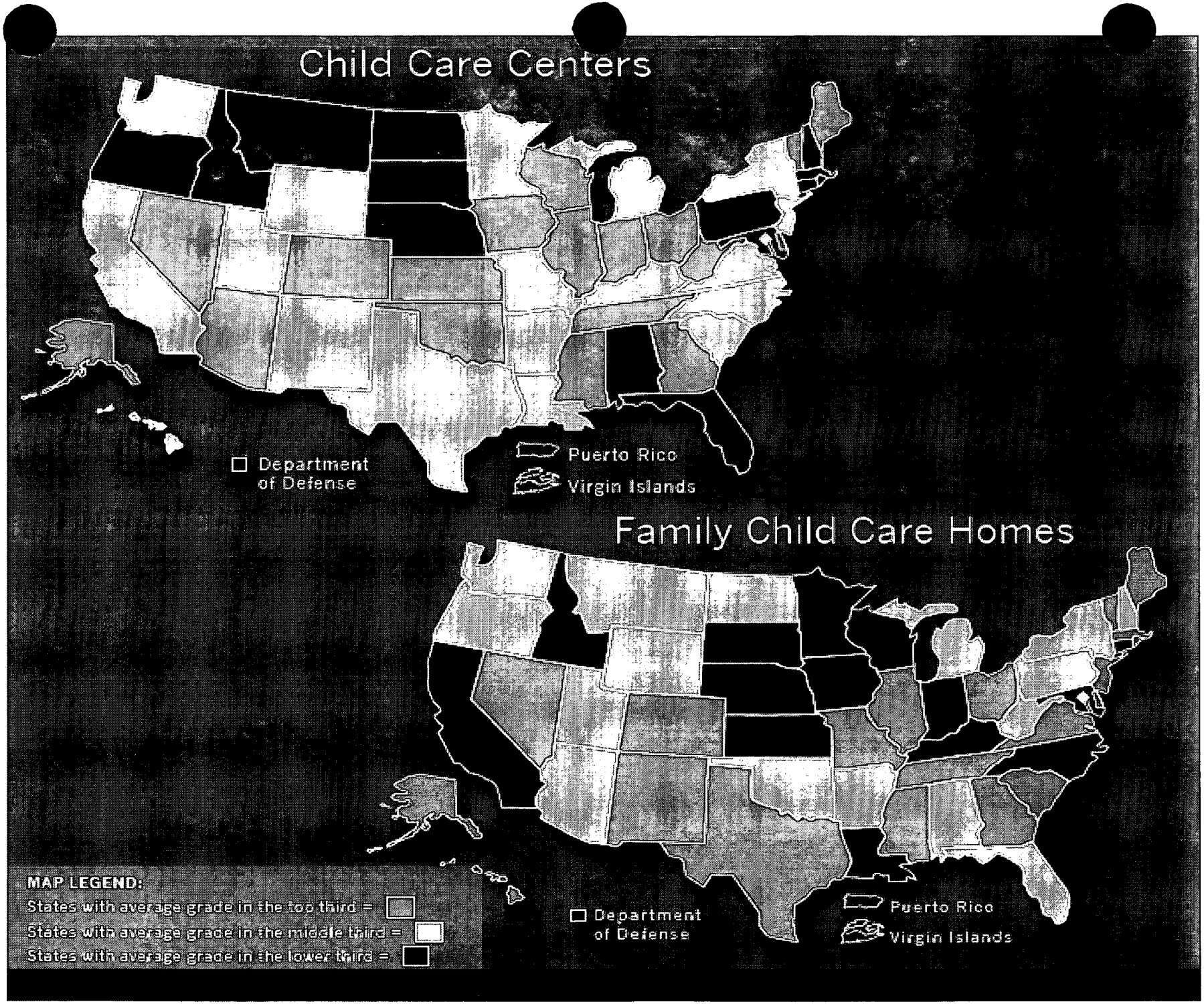
NC child care regulations

Centers	Homes	Healthy Eating Regulations in North Carolina
✓		Foods of low nutritional value are served infrequently
		Sugar sweetened beverages are not served
		Children older than two years are served reduced fat milk
✓	✓	Clean, sanitary drinking water is available for children to serve themselves throughout the day
		Nutrition education is offered to child care providers
		Juice is limited to a total of 4-6 ounces per day for children over one year of age
	✓	Child care providers do not use food as a reward or punishment
		Nutrition education is offered to children
		At least one child care provider sits with children at the table and eats the same meals and snacks
		Providers encourage, but do not force, children to eat

*Checkmark indicates presence of state regulation

Centers	Homes	Physical Activity Regulations in North Carolina
✓	✓	Children are provided with physical activity daily
		Television, video, and computer time are limited
		Child care providers do not withhold active play time as punishment
		Children with special needs are provided opportunities for active play while other children are physically active
✓	✓	Children are provided outdoor active play time
✓		Physical activity education is offered to child care providers
		At least one provider joins children in active play
✓		Shaded areas are provided during outdoor play
✓		Children are not seated for long periods of time
		Physical activity education is offered to children

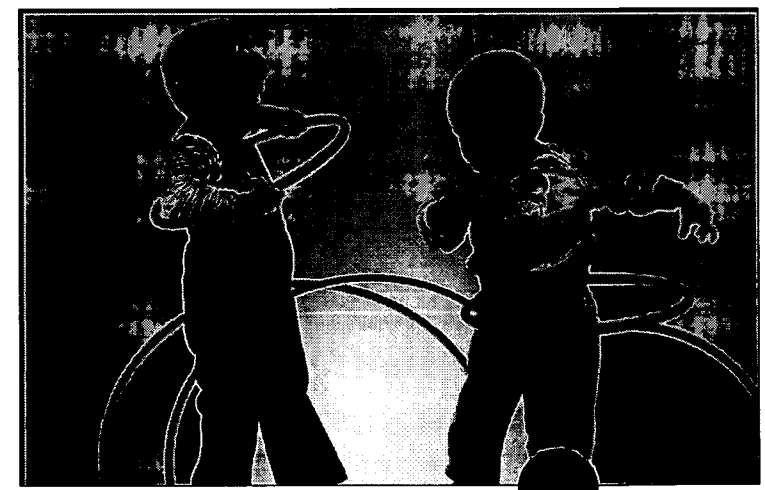
*Checkmark indicates presence of state regulation


Child Care Centers
Department of Defense
Puerto Rico
Virgin Islands
Family Child Care Homes
Department of Defense
Puerto Rico
Virgin Islands
MAP LEGEND:
States with average grade in the top third =
States with average grade in the middle third =
States with average grade in the lower third =

Conclusions

- Most states lacked adequate healthy eating and physical activity policies, esp. for family child care homes

- North Carolina average scores for child care centers and low scores for family child care homes



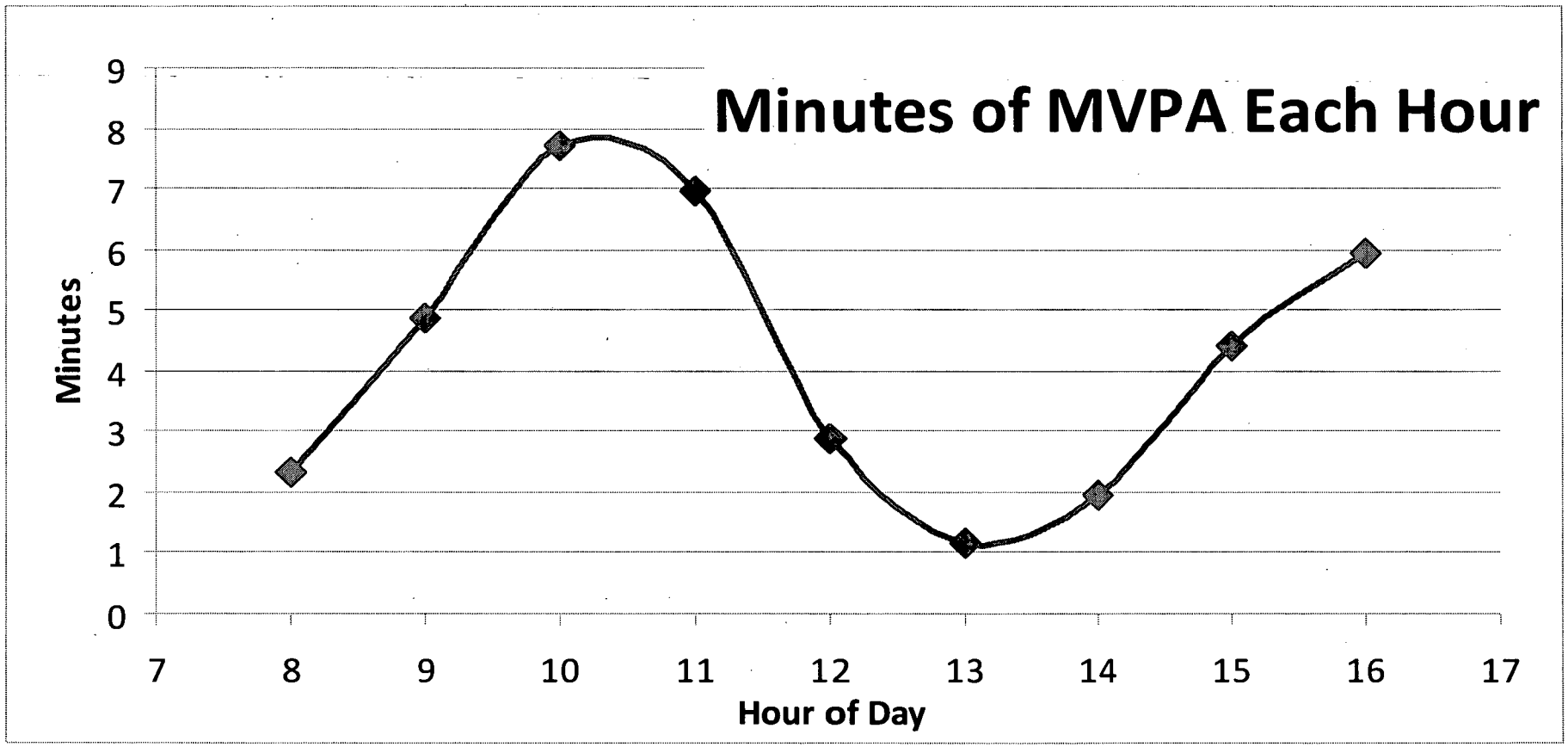
Physical activity policy

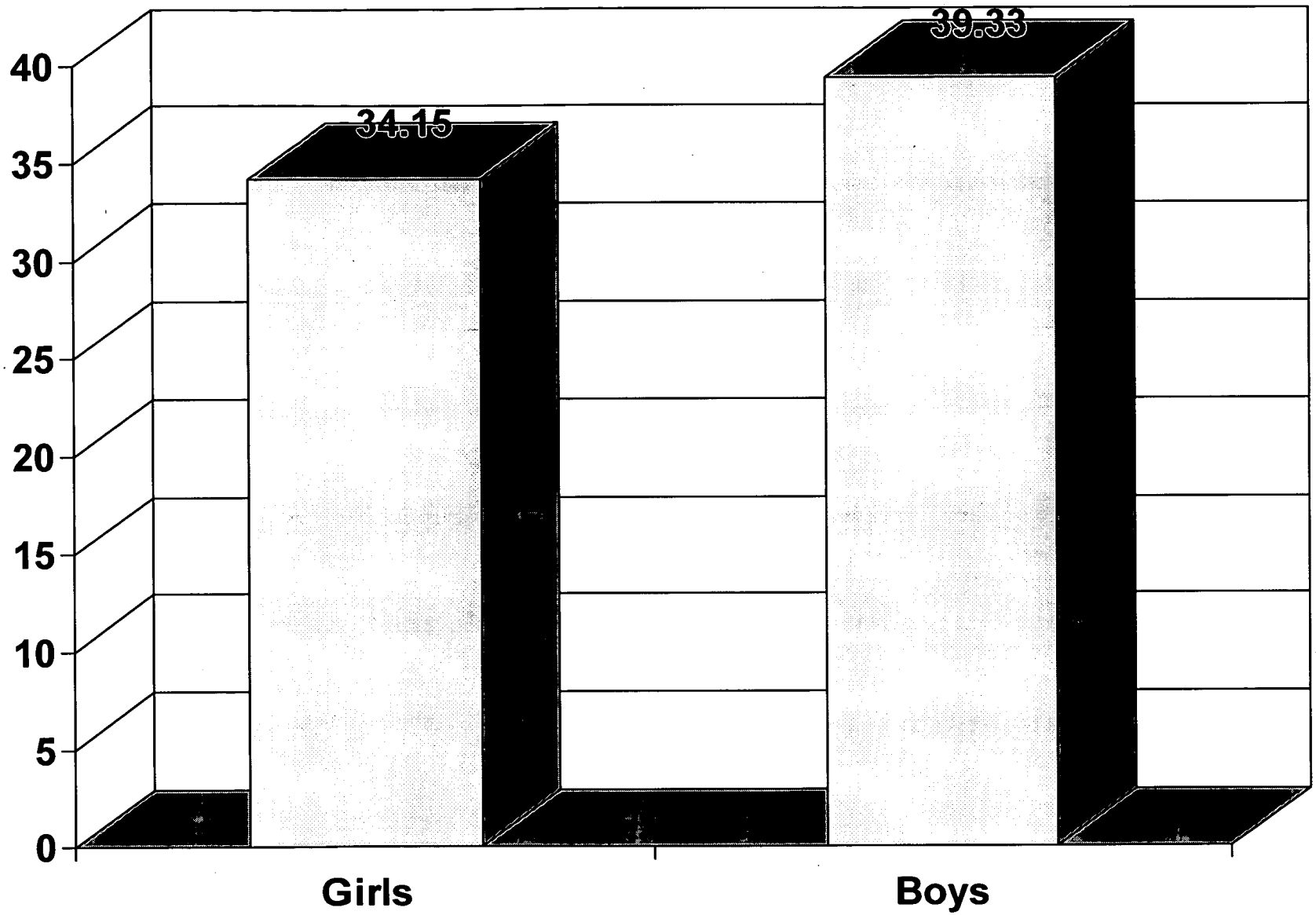
- Delaware, Alaska, and Massachusetts require specific amount of time for physical activity
  - 20-30 minutes for half day care
  - 60 minutes for full-day care

Physical activity in child care

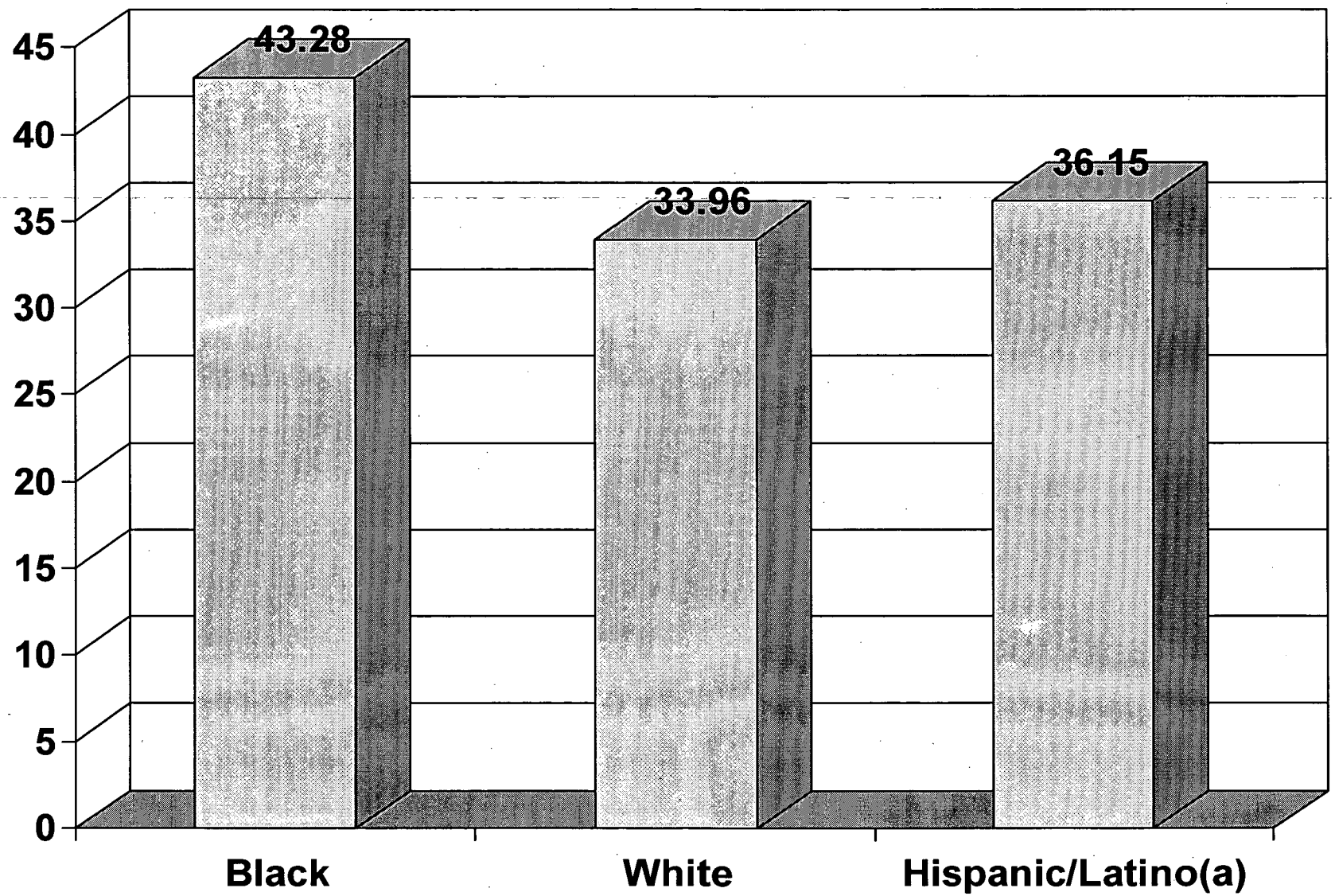
State	Sedentary activity,* minutes	Moderate/vigorous activity, minutes
	Mean (SD, range)	
MA	150 (91-178)	42 (6-88)
RI	165 (93-243)	29 (1-66)
NC	206	43

***Does not include minutes of slow and easy movement or minutes children spent eating and sleeping**


Minutes of MVPA Each Hour
Minutes
0
1
2
3
4
5
6
7
8
9
7
8
9
10
11
12
13
14
15
16
17
Hour of Day



Minutes of MVPA per day accumulated while in child care for girls and Boys. Control for race, how long monitor worn, age, and center. P < 0.0001



Minutes of MVPA time per day accumulated while in child care. Control for gender, how long monitor worn, age, and center. P<0.0001

Healthy eating policy

- Delaware enacted new regulations requiring
  - Low-fat milk for children over 2 years
  - Majority of grains to be whole grains
  - Limit juice (no juice for infants)
  - No sugar-sweetened beverages

Dietary intake in NC child care

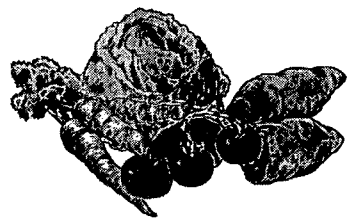
- Children consumed less than recommended for all food groups except milk
- Children consumed 1/3 cup fruit and 1/4 cup vegetables (21% of recommended amount fruit and 16% vegetables)

Table 1. Foods served to and consumed by 3 to 5 year old children (n=117) in NC child care centers, compared to

		Amt. Served		Amt. Consumed	
Food/Group	**MyPyramid Rec,[a] Daily**	**Amount**	**% Rec**	**Amount**	**% Rec**
Vegetables, total	1.5 C	0.37 C	24.7	0.25 C	16.7
Vegetables, dark[b]	0.5 C	0.07 C	14	0.04 C	7
Fruit	1.5 C	0.48 C	32	0.32 C	21.3
100% Fruit Juice	≤6 oz	3.48 oz	58	2.80 C	46

[a]Based on 1400 kcal diet for 4-year-old girl active 30-60 minutes/day

[b]Based on amounts recommended weekly



The Nutrition and Physical Activity Self Assessment for Child Care Project (NAP SACC)

Promoting healthy eating and physical activity in child care and preschool settings



NAP SACC Nutrition Areas

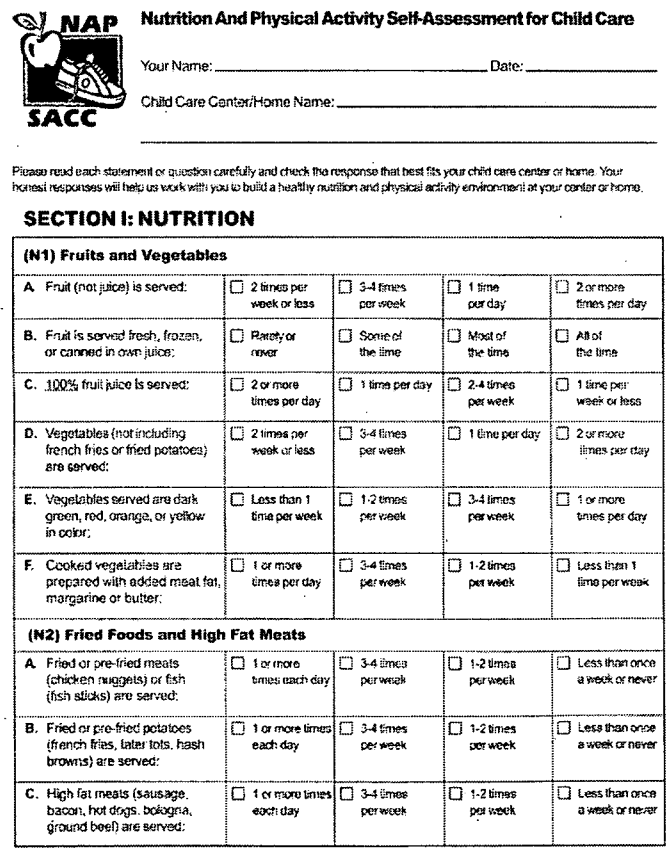
1. Fruits and Vegetables
2. Fried Foods/High Fat Meats
3. Beverages
4. Menus and Variety
5. Meals and Snacks
6. Foods Outside of Meals and Snacks
7. Modeling
8. Nutrition Education
9. Nutrition Policies

NAP SACC Physical Activity Areas

1. Active and Inactive Play
2. TV Use and Viewing
3. Play Environment
4. Modeling
5. Physical Activity Education
6. Physical Activity Policies

NAP SACC Self-Assessment

- **Child care providers self-assess their nutrition and physical activity environments**
- **Providers work with a trained health professional to identify goals for improvement**



Nutrition And Physical Activity Self-Assessment for Child Care

Your Name: _____ Date: _____

Child Care Center/Home Name: _____

Please read each statement or question carefully and check the response that best fits your child care center or home. Your honest responses will help us work with you to build a healthy nutrition and physical activity environment at your center or home.

SECTION I: NUTRITION

(N1) Fruits and Vegetables				
A. Fruit (not juice) is served:	☐ 2 times per week or less	☐ 3-4 times per week	☐ 1 time per day	☐ 2 or more times per day
B. Fruit is served fresh, frozen, or canned in own juice:	☐ Rarely or never	☐ Some of the time	☐ Most of the time	☐ All of the time
C. 100% fruit juice is served:	☐ 2 or more times per day	☐ 1 time per day	☐ 2-4 times per week	☐ 1 time per week or less
D. Vegetables (not including french fries or fried potatoes) are served:	☐ 2 times per week or less	☐ 3-4 times per week	☐ 1 time per day	☐ 2 or more times per day
E. Vegetables served are dark green, red, orange, or yellow in color:	☐ Less than 1 time per week	☐ 1-2 times per week	☐ 3-4 times per week	☐ 1 or more times per day
F. Cooked vegetables are prepared with added meat fat, margarine or butter:	☐ 1 or more times per day	☐ 3-4 times per week	☐ 1-2 times per week	☐ Less than 1 time per week
(N2) Fried Foods and High Fat Meats				
A. Fried or pre-fried meats (chicken nuggets) or fish (fish sticks) are served:	☐ 1 or more times each day	☐ 3-4 times per week	☐ 1-2 times per week	☐ Less than once a week or never
B. Fried or pre-fried potatoes (french fries, tater tots, hash browns) are served:	☐ 1 or more times each day	☐ 3-4 times per week	☐ 1-2 times per week	☐ Less than once a week or never
C. High fat meats (sausage, bacon, hot dogs, bologna, ground beef) are served:	☐ 1 or more times each day	☐ 3-4 times per week	☐ 1-2 times per week	☐ Less than once a week or never

NAP SACC

The Intervention Process

Step 1

Centers self-assess nutrition and physical activity environments

Step 2

Centers identify areas for improvement and map out strategies with NAP SACC Consultant

Step 3

NAP SACC Consultants conduct continuing education workshops for center staff

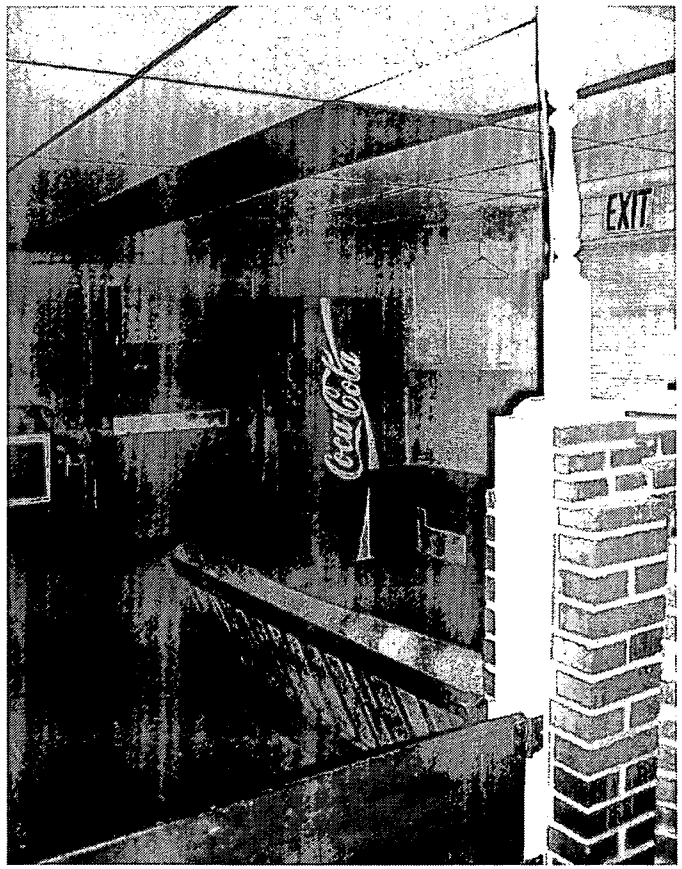
Step 4

NAP SACC Consultants provide monthly technical assistance

Step 5

Centers self-assess nutrition and physical activity environments

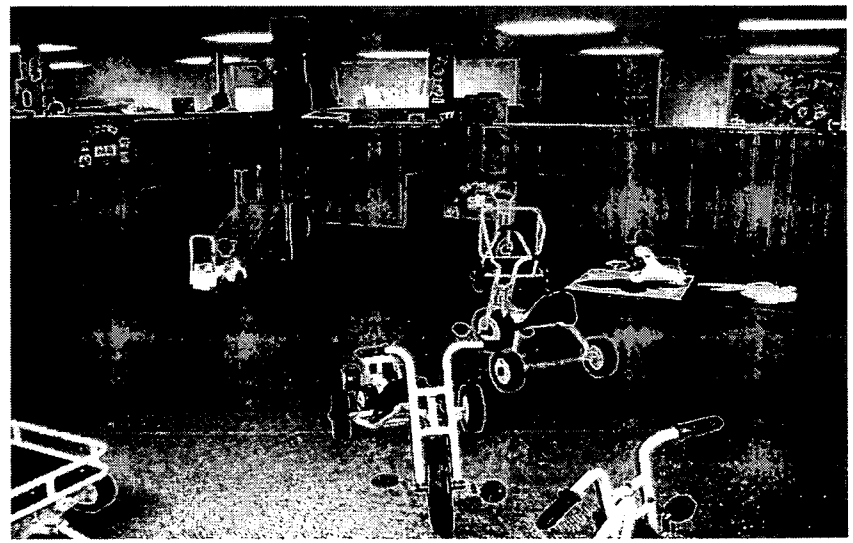
NAP SACC
Nutrition Improvements



- Moved vending machine from lobby to less visible area
- Wrote nutrition policies
- Revised menus
- Switched to low-fat milk for children over two years

NAP SACC
Physical Activity Improvements

- Wrote physical activity policies
- Created indoor play space



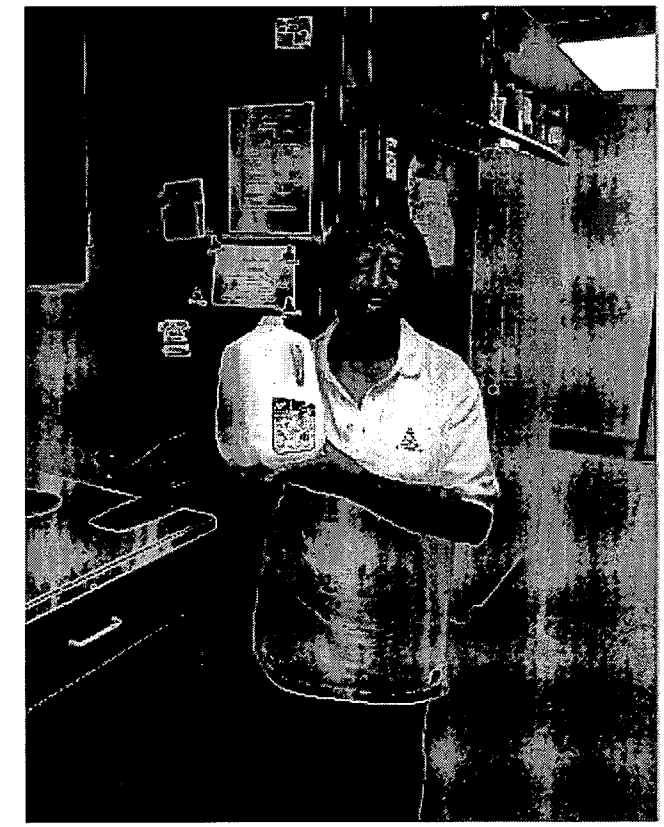
What Providers Said About NAP SACC

"We started looking at our menus more closely."

"Until this program some of the staff did not realize that fat free milk was ok for children."

"It was surprisingly easy to make these changes."

"The only change that cost money was adding more vegetables to the menu"



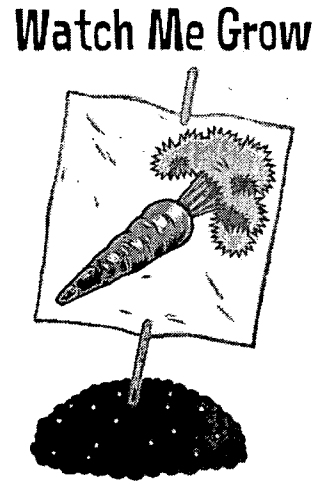
Children will eat fruits and vegetables

- Providing greater amounts of fruits and vegetables to children increases their consumption
  - Spill and colleagues found that increasing amount of carrots served to preschool children resulted in greater consumption
  - Fisher et al. doubled portion of fruit and vegetables (75g to 150g) served to 4 to 6 year old children and found intake increased by 70% and 38%, respectively

Watch Me Grow Intervention

- Watch Me Grow (WMG) is a preschool garden program rooted in the community

- Worked with Duke Center for Community Research to engage 3 community partners in Durham County, NC to help deliver the WMG intervention:
    1. SEEDS
    2. Child Care Services Association
    3. Durham County Health Department



Watch Me Grow Intervention

- Establish gardens in child care to grow fruits and vegetables over the course

- Child Care Nutritionists deliver a coordinated Watch Me Grow curriculum planned around harvest of month.
  - Activity
  - Book
  - Recipe



Collaborators

Jonathan Finkelstein, MD, MPH (Harvard Medical School)
Matthew Gillman, MD, SM (Harvard Medical School)
Dianne Ward, EdD (UNC-Chapel Hill)
Derek Hales, PhD (UNC-Chapel Hill)

State Partners

MA Early Education and Care
MA Department of Public Heath
Rhode Island Department of Health

Thank you!



Child Nutrition in the Schools

Jessica Donze Black RD, MPH

February 11, 2010

Alliance for a Healthier Generation

Reversing the Trend

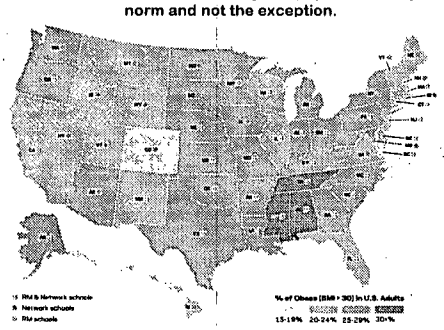
To eliminate childhood obesity and inspire all young people in the United States to develop lifelong, healthy habits

American Heart Association

Clinton Foundation

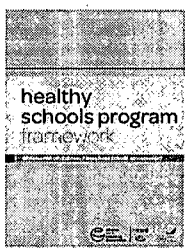
Alliance for a **Healthier Generation**

Healthy Schools Program is working to support a culture where schools that promote healthy eating and physical activity are the norm and not the exception.



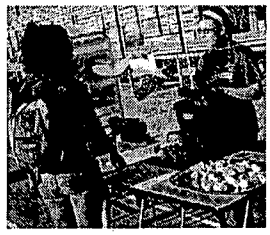
Best Practices Framework

- Policy / Systems
- Health Education
- Physical Education
- School Meals Programs
- Competitive Foods & Beverages
- Physical Activity
- Before & Afterschool Programs
- School Employee Wellness



The School Nutrition Landscape

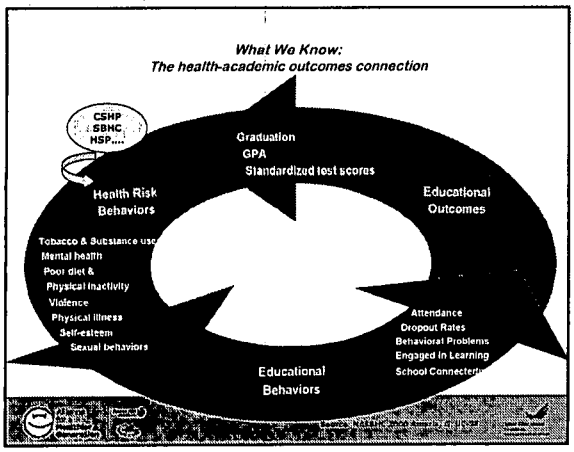
- School Breakfast
- School Lunch
- Competitive foods (a la carte, vending, school stores, fund raisers, parties, etc.)
- After school snacks
- Summer feeding program



The National Picture

- 2004 Child Nutrition Reauthorization
  - Wellness Policies
  - School Meal updates
- State Policy change
  - States with nutrition standards for competitive foods grew from 6 in 2004 to 27 in 2009.
  - In 2006, only 38% of schools restricted students from purchasing sugar sweetened beverages such as regular soda and fruit drinks. In 2008, 63% of schools report restricting sugar sweetened beverages. (CDC School Health Profiles, 2008)
- 2009 IOM guidance to USDA on school meals and 2005 Dietary Guidelines
- 2010 (?) Child Nutrition Reauthorization
  - USDA Priorities
  - Additional priorities

Why Focus on Nutrition in Schools?

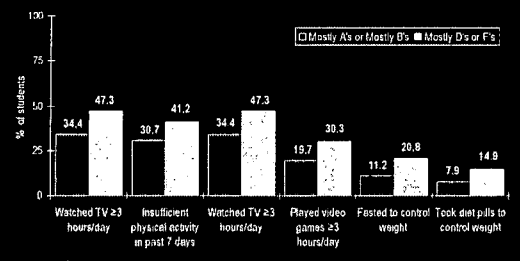


Growing body of research suggests...

- Good nutrition is linked to improved student behavior, lower absenteeism, and reduced tardiness
- Eating breakfast at school is linked to greater improvements in standardized text scores and math grades.
- Physical fitness levels predict for better math performance
- Participation in physical activity is consistently related to lower levels of anxiety and stress
- Participation in high activity physical education program may strengthen scores for elementary-age children on standardized tests.
- Physical activity can positively affect concentration, memory, and classroom behaviors.
- Severely overweight children miss 4 times as much school as normal weight children.



Percentage of U.S. High School Students Getting Mostly A's or B's and Mostly D's or F's* Who Engage in Selected Health Risk Behaviors



*As reported by students.
Unpublished analyses of CDC, National Youth Risk Behavior Survey, 2001

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Participation in the School Breakfast Program and Academic Performance

- Compared to peers who do not participate in the School Breakfast Program, low-income elementary school students who do participate have:
  - greater improvements in standardized test scores and math grades
  - reduced rates of absenteeism, tardiness, and psychosocial problems

Murphy et al. Arch Pediatr Adolesc Med 1998; Meyers et al. Am J Dis Child 1989

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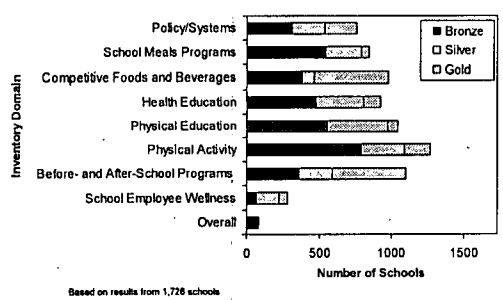
Greater Access to Low-Nutrient, Energy Dense Competitive Foods at School is Associated With:

- ↑ intake of total calories, soft drinks, total fat, and saturated fat
  Cullen K et al. *JADA* 100(12): 1482-1486, Cullen K & Thompson D. *JADA* 105(12): 1952-1954
- ↓ intake of fruits, vegetables, milk, and key nutrients
  Cullen K & Zakeri I. *AJPH* 94(3): 463-467
- ↑ BMI among middle school students
  Fox MK et al. *JADA* 109(2):S108-S117; Kubik M et al. *AJPH* 93(7): 1168-1173;

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The Data

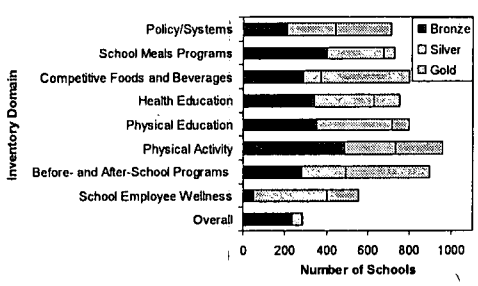
HSP Inventory Results at Baseline



Based on results from 1,726 schools

14

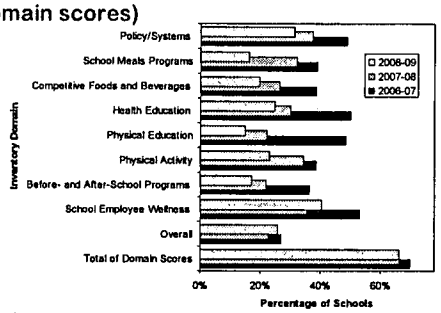
Inventory Results at Follow-Up



Based on results from 1,104 schools after 1, 2, or 3 years in program

15

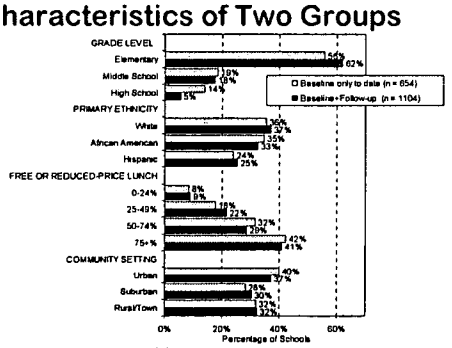
Schools Reporting Improvement
(Domain scores)



Results included for 132 2008-07 schools, 717 2007-08 schools, and 237 2008-09 schools.
About two thirds improved at least 1 recognition level across the domains.

16

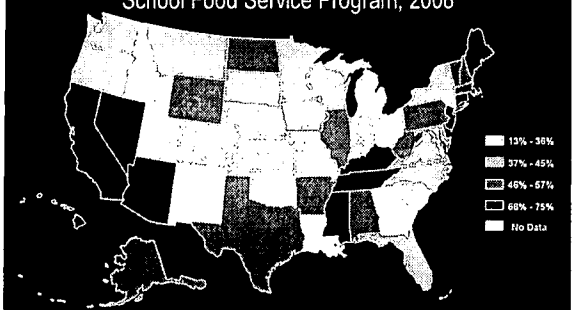
Characteristics of Two Groups



Source: National Center for Education Statistics Common Core of Data

17

Percentage of Secondary Schools That Did Not Sell Less Nutritious Foods and Beverages* Anywhere Outside the School Food Service Program, 2008

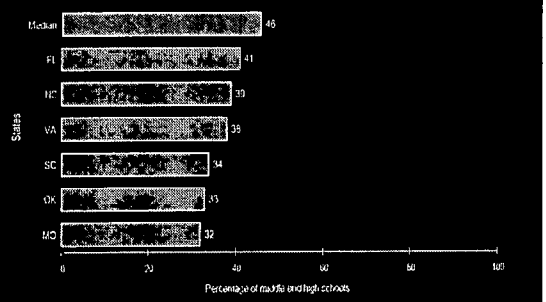


*Baked goods not low in fat, salty snacks not low in fat, chocolate candy, other kinds of candy, and soda pop or fruit drinks that are not 100% juice

School Health Profiles, 2008

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Percentage of Secondary Schools That Did Not Sell Less Nutritious Foods and Beverages* Outside the School Food Service Program—Selected Southern States and Median Among 47 States, 2008

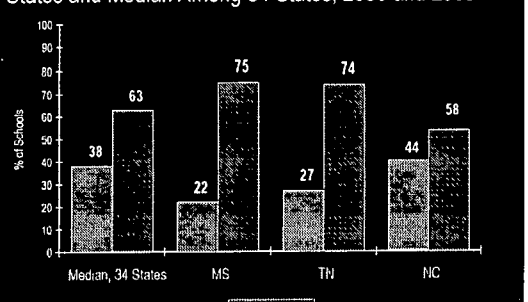


*Baked goods and salty snacks not low in fat, chocolate and other kinds of candy, and soda pop or fruit drinks that are not 100% juice

CDC, School Health Profiles

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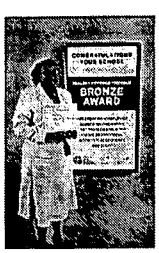
Percentage of Schools in Which Students Could Not Purchase Soda Pop or Fruit Drinks That Are Not 100% Juice—Selected States and Median Among 34 States, 2006 and 2008



CDC, School Health Profiles

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North Carolina Schools are achieving change!



Congratulations to our Award Winners!!

Halifax County Schools

- **Scotland Neck Primary School: 07-08 Bronze; 08-09 Silver**
- **McIver Elementary School: 07-08 Bronze**
- **Pittman Elementary School 07-08 Bronze**
- **Hollister Elementary School: 08-09 Bronze**
- **Inborden Elementary School: 08-09 Silver**

Franklin County Schools

- **Long Mill Elementary School: 08-09 Bronze**

Warren County Schools

- **Vaughn Elementary School: 08-09 Bronze**

(and a HUGE thank you to all the state and local champions who have worked to help schools achieve these standards!!)

Examples from the Field

Overall Healthy Schools Program Lessons learned

- Strong state policy does facilitate healthier school environments. (CO, VT, MS, and OR modeled after HSP guidelines)
- Revenue success can be better achieved with students' participation and support- they are the customer base and target audience for healthy foods and beverages.
- Kids love to see their teachers, principal, or cafeteria staff making the same healthy changes they are and building their support is also critical. Modeling also reinforces the behavior and can convince other kids to try it out.
- Comprehensive wellness councils with representation from all stakeholder groups are important for keeping communication open and maximizing support to help overcome obstacles and institute and enforce policies.

QUESTIONS?

Jessica Donze Black RD, MPH
jessica.donzeblack@healthiergeneration.org

What's for Lunch in North Carolina's Public Schools–Healthy Foods or Healthy Finances?

Lynn Hoggard, EdD, RD, LDN, FADA

Imagine for a moment a dining room designed for students: inviting, comfortable, and relaxing, with brightly colored walls decked with age-appropriate décor that promotes healthy foods and beverages. The room is filled with the slightly sweet aroma of school-baked whole grain yeast rolls and the fragrance of fresh fruits. Picture the vivid colors of recently washed fresh vegetables: red, green, yellow, orange, and purple. You can still see the tiny water droplets on their surfaces. Now imagine children who have just come in from recess or other physical activities; they are filled with laughter, excitement, and a healthy appetite. After stopping to wash their hands, the students proceed in an orderly manner into the dining room, which is one of their favorite places on the school campus. Upon entering, students are greeted by school nutrition personnel who know their names and who speak to each child in a tone that is uplifting and encouraging. As children begin to select their favorite foods from a wide variety of healthful, student-appealing options, they are reminded of what they learned earlier in the day about making healthy food choices when the teacher included a mini-nutrition lesson while covering the unit on fractions. Teachers and other school personnel are available in the dining room to encourage healthful choices by making positive comments about school meals and by subtly reminding students to practice what they learned in the classroom. Teachers praise students' healthful food and beverage choices, and they also serve as role models for students by making healthful food choices themselves. In this dining room, all students have the same food and beverage choices; there is no meal service for children who receive free meals and another for children who purchase their meals. All children are treated equally and respectfully. Once they make their food and beverage choices, students are seated with their peers where they are encouraged to socialize with each other in the full 20 to 30 minutes they have to enjoy their meal. They eat slowly and thoughtfully and display appropriate table manners. When they finish their meals, they return to their classrooms, well-nourished, satisfied, and prepared to learn.

What you have just imagined is the vision of thousands of child nutrition professionals for an optimal school meals environment in all of North Carolina's public schools. This vision would transform the institutional cafeterias of yesteryear into centers for the development of lifelong healthful eating habits where all foods and beverages available to students are wholesome, nutritious, appealing, and affordable.

Some of the conditions described above are already present in North Carolina's public schools. Many newly-constructed schools have dining rooms that are inviting, staffed by competent, caring school nutrition personnel who are committed to preparing and serving the highest quality, most nutritious meals possible. Every day, in every school dining room in the state, students have the option to make healthful food and beverage choices. When students select the "reimbursable meal" they are assured of having a meal that is consistent with the recommendations reflected in the *Dietary Guidelines for Americans*.[1] Unfortunately, the choice is not that simple. Favorites such as double cheeseburgers, french fries, big cookies, and sweetened iced tea compete with healthful foods like fresh salads topped with locally grown vegetables and low-fat dressing; sandwich wraps made with whole grain tortillas; pizza made with a hearty whole grain crust, low-fat mozzarella cheese, and an abundance of vegetable toppings; fresh fruits in season; and low-fat or skim milk.

"Some may ask why healthy foods have to compete with less healthful ones. The answer is simple: finances. The expectation for most Child Nutrition Programs in North Carolina is to be financially self-supporting."

Lynn Hoggard, EdD, RD, LDN, FADA, is the section chief of Child Nutrition Services in the Division of School Support at the North Carolina Department of Public Instruction. She can be reached at lhoggard@dpi.state.nc.us.

Some may ask why healthy foods have to compete with less healthful ones. The answer is simple: finances. The expectation for most Child Nutrition Programs in North Carolina is to be financially self-supporting. This means the program has to generate revenues from the sale of foods and beverages to students to purchase food and food preparation/service supplies, to pay salaries and benefits of school nutrition personnel, to purchase and/or repair commercial food service equipment, and to pay indirect costs to the school district. Essentially, the program has to generate enough revenue to pay for every expense borne by the program.

It hasn't always been this way. The National School Lunch Act[2] (NSLA) was signed into law in 1946 shortly after World War II. Military leaders were convinced the nation was vulnerable because many of its youth were malnourished and consequently were rejected for military service. To address the problem of malnutrition among the nation's youth while protecting the health and well-being of the nation, the National School Lunch Program (NSLP) was created. When President Harry S. Truman signed the NSLA, he read from the preamble of the Act which stated, "the program shall be a partnership of federal, state, and local governments." For the first four decades the NSLP was in operation, decisions made in the Child Nutrition Program were based on one guiding principle: what is in the best interest of the child? Food and beverage selections were made based on this principle; the amount of time for students to consume their meals was based on this principle; the time of day the meal was served was based on this principle. Federal, state, and local funds or in-kind support were available to support the program based on this principle.

In the early 1980s a massive federal budget-cut threatened to shut down the school meals program nationwide. Schools looked for creative ways to generate revenues to enable the program to continue to serve meals to students despite inadequate funds. Fortunately, in North Carolina, no school cafeteria closed its doors to students during this time; all continued to operate. They did so by selling extra servings of foods and beverages to students who could afford to purchase them. What was originally known as "supplemental school meal sales" that were needed to sustain the program through a budgetary crisis evolved into what is today known as the *a la carte* program. With greater emphasis placed on *a la carte* meals instead of reimbursable meals, the guiding principle for the Child Nutrition Program shifted. The principle of "doing the right thing for children" was gradually replaced with the principle "what will generate the most revenue?"

As a result of this shift in decision-making that placed the generation of revenues over the nutrition needs of students, several types of meals are offered to students in North Carolina's public schools. There are reimbursable meals, *a la carte* meals/snacks, and snacks that are vended on the school campus (which constitute meals for many students).

Reimbursable meals are prepared and served under the regulations of the federally-funded National School Lunch Program and School Breakfast Program (SBP). These meals are referred to as "reimbursable" because the US Department of Agriculture (USDA) reimburses school districts for a portion of the cost of each meal served to students. In addition to cash subsidies, school districts participating in the NSLP and SBP receive commodity foods from the USDA to support the service of reimbursable meals. In return for the cash subsidies and commodities, participating schools must serve breakfasts and lunches at no cost or at a reduced price to students whose household incomes make them eligible for the meal benefits. In addition, breakfasts and lunches that are reimbursable must meet federal nutrition requirements.

A typical reimbursable school lunch may include an entrée, two or more servings of fruits and vegetables, a serving of a grain product, and eight ounces of low-fat or non-fat milk. Reimbursable school meals are healthy meals. Over the course of a week, reimbursable school meals must meet the nutrition standards outlined in the *Dietary Guidelines for Americans*.[1] In North Carolina, reimbursable school meals must contain no more than 35% of calories from fat and less than 10% from saturated fat. School breakfasts must provide one-fourth of the Recommended Dietary Allowance (RDA) for protein, Vitamin A, Vitamin C, iron, and calcium, while school lunches must provide one-third of the RDA for these nutrients.

Everyone benefits when children select the reimbursable school meal. Students benefit because they receive a wholesome, nutritious meal that is planned to contribute to their optimal growth, development, and success in the classroom. Research suggests that students who select reimbursable school meals consume less total and saturated fat, eat more fruits and vegetables, drink more milk, are less likely to drink sweetened beverages, and are more likely to be a healthy weight than students who select school meals from other venues. Parents benefit because the reimbursable school meal offers a convenient method of providing nutritionally balanced meals for children at school at the lowest possible price. Schools benefit because when students are adequately nourished, their academic performance improves, they have fewer attendance and discipline problems, and are more attentive in class.

In addition to reimbursable meals, students may select from a variety of foods and beverages sold *a la carte*. Unlike the reimbursable meal that is priced as a unit for all meal components, thus providing a balanced meal, *a la carte* items are priced and sold individually. Foods and beverages sold *a la carte* are often referred to as "competitive foods" because they compete with reimbursable meals for students' appetites and for their lunch money. These items are available at a much higher cost to students than the reimbursable meal. A single item may cost twice the amount of an entire meal. Nonetheless, schools generate significant revenues from these foods and beverages. In North Carolina, the most popular *a la carte* items include specialty sandwiches, french fries, pizza, cookies, snack cakes, fruit punch, chips, ice cream, sports drinks, and sweetened iced tea. Unlike the reimbursable meal, there are no nutrition standards for *a la carte* foods and beverages

In addition to reimbursable and *a la carte* meals made available to students in the school cafeteria, there are many other food and beverage options available to students on the school campus. These options include school-operated vending machines, school stores and snack bars, school fundraisers, and school

concessions. There are no nutrition standards for foods and beverages available to students in these areas of the school campus. Like *a la carte* items, foods and beverages sold in these venues compete with the federally-funded NSLP and SBP and often undermine the nutritional, financial, and operational integrity of the NSLP and SBP.

Food and beverages are not the only competing factors in the school day. There is also competition for students' time. With increased emphasis on in-class time, the amount of time students have for breakfast and lunch is shrinking. The average time for breakfast is 12 minutes and for lunch it is only 17 minutes. When pressed, students turn to vending machines for breakfast and lunch, even when healthful foods and beverages are available in the school meals program.

When students consistently replace healthy reimbursable school meals with less nutritious foods and beverages, such as *a la carte*, vending, or other meal/snack options, there is a risk their diets will lack key nutrients needed for optimal growth and academic performance. Likewise, when competitive foods are purchased in large quantities, there is likelihood of over-consumption and the potential for unhealthy weight gain.

Concerns about the soaring rates of childhood obesity have drawn attention to the importance of healthy school meals and snacks. In 2005, the North Carolina General Assembly (NCGA) enacted legislation to require the State Board of Education (SBE) to adopt nutrition standards for all meals and snacks served in public schools. Shortly thereafter, the SBE adopted nutrition standards for foods and beverages in elementary schools. Before the standards were adopted, they were tested in 124 elementary schools. The test of nutrition standards in elementary schools revealed their implementation would require an investment of $20 million annually or approximately $25 dollars per student per year. For two consecutive years, the SBE has placed funding for healthier school meals among their top five priorities in their budget request to the NCGA. Unfortunately, funds have not been appropriated to support healthier school meals in elementary schools. As a result, the mandatory requirement to implement the standards has been delayed until 2010.

Despite the lack of funding, Child Nutrition Administrators who are committed to restoring the guiding principle of "doing the right thing for children" to the Child Nutrition Program began to implement the SBE-adopted nutrition standards in elementary schools. They also gradually removed less healthful foods and beverages from middle and high schools. Sweetened beverages, cookies, desserts, salty snacks, and fried foods were among the items that were disappearing from *a la carte* menus. Currently, over 95% of elementary schools have successfully implemented the SBE-adopted nutrition standard even without the necessary financial support to do so.

Unfortunately, the cost of implementing nutrition standards in elementary schools, combined with the increased operating costs (including escalating food, fuel, labor, equipment, and indirect costs) has proven to be cost prohibitive. Currently, the majority of school districts in the state are operating at a significant financial loss. In order to generate revenues to support the program, most districts have had no options but to include less healthful foods and beverages into their school meals programs. With no other funding sources, schools have to resort to selling foods and beverages that will generate revenues for the district. This means low-cost, high calorie foods and beverages like french fries, cookies, fruit punch, and other sweetened beverages are returning to North Carolina's school cafeterias. Once again, healthy school foods have taken a back seat to healthy school finances.

Despite this setback, many student advocates remain committed to the vision of an optimal school nutrition environment, an environment where students receive consistent, reliable information about healthful food and beverage choices and have the opportunity to use the information when making food and beverage selections; where school administrators, teachers, and support staff provide the same clear and consistent messages that reinforce healthy eating habits; where foods and beverages offered to students in the school meals program, in vending machines, in school stores, and at student events reflect and model these messages; where lessons in the classroom are reflected in food choices available in the dining room; and where school personnel are role models for healthy lifestyle behaviors, including the development of healthful eating habits.

I believe the vision can become the reality in North Carolina's public schools. But achieving the vision will require the following actions:

- Students, parents, educators, and community leaders must take an active role in supporting an optimal school nutrition environment.
- Adequate federal, state, and local funds must be provided to ensure the total school environment supports the availability of healthful foods and beverages for students.
- Nutrition standards must be established for all foods and beverages available on the school campus; those standards must be achievable, affordable, and appealing to a diverse student population.
- Students must have a designated meal period of sufficient length to enjoy eating healthy foods, and meal periods should be scheduled at reasonable times during the day.
- Behavior-focused nutrition education must be integrated into the curriculum from pre-K through grade 12 and teachers who provide nutrition education must have appropriate training to do so.
- Decisions regarding the sale and availability of foods and beverages on the school campus must be based on student health and well-being, not on making a profit.

Please consider embracing the vision for an optimal school nutrition environment in our public schools and becoming advocates for making the vision become a reality. I think you will agree it's the right thing to do for children. **NCMJ**

The Child Nutrition Services Section of the North Carolina Department of Public Instruction administers the eighth largest Child Nutrition Program in the nation. Each day, school nutrition personnel in 115 school districts prepare and serve meals for nearly 1.4 million students, half of whom are economically disadvantaged and qualify for free or reduced-price meals at schools. A healthy school lunch is available to all students every day; the majority of elementary and middle schools provide school breakfast and many elementary schools provide an after school snack for students.

REFERENCES

1 US Department of Health and Human Services and US Department of Agriculture. *Dietary Guidelines for Americans 2005*. Washington, DC: Government Printing Office; 2005.

2 Public Law 79-396. Stat. 281, Sect. 2. National School Lunch Act (1946).

Eat Smart, Move More Health Tip



Enjoy More Fruits and Veggies

What are low in calories, full of essential nutrients and can help reduce your risk for chronic diseases? Fruits and vegetables! Make fruits and vegetables half your plate at every meal and for every snack. Fresh, frozen, dried, canned—it all counts. Shake things up by enjoying a variety of colors to stay healthy and fit. Your body will thank you.

For more tips on how to eat your fruits and veggies every day where you live, learn, earn, play and pray, visit

www.EatSmartMoveMoreNC.com

Eat Smart Move More NORTH CAROLINA

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School Nutrition Programs in North Carolina

Legislative Task Force
on Childhood Obesity

February 11, 2010

Lynn Harvey, Ed.D, RD, LDN, FADA
Child Nutrition Services, NCDPI

What is the purpose of the Child Nutrition Program?

A nutrition program that promotes the optimal growth, development and health of students while supporting their academic success?



What is the purpose of the Child Nutrition Program?



A food service enterprise program housed on the school campus that generates enough money to support its operations and/or generate revenues for the district?

Today's discussion

- ✓ Programs administered by NCDPI
- ✓ Brief "snapshot" of the history of the School Meals program in NC
- ✓ Current Challenges facing the School Meals Program
- ✓ Possible Solutions
- ✓ Important Decision

Child Nutrition Programs administered by the NCDPI

School Breakfast and Lunch Programs

- ✓ 8th largest program in the nation
- ✓ 1.8 million meals served daily
- ✓ Available to all students enrolled in public school
- ✓ 50% of students qualify for free or reduced price meals (by household income)
- ✓ Governed by Federal regulations



Child Nutrition Programs administered by the NCDPI

After School Snack Program – provides snacks for students who attend after school enrichment programs

Summer Seamless Option – provides meals to students when school is out of session (summer and year-round track out periods)



Fresh Fruit and Vegetable Program – provides funds for free fresh fruits and vegetables for in-school snacks



How School Nutrition Programs Operate

Congress

⇕

US Department of Agriculture

⇕

State Education Agency/Board of Education

⇕

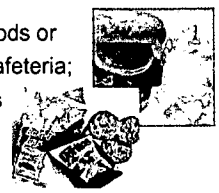
School District/Local Board of Education

Terminology



Reimbursable Meal – A meal that qualifies for Federal reimbursement because it meets requirements for food components or nutrients; must meet USDA nutrition standards

A la Carte items – Individual foods or beverages sold in the school cafeteria; there are no nutrition standards and no reimbursement for these items



How did we get here?



President Harry S. Truman signs the National School Lunch Act into law on June 4, 1946

"Today as I sign the National School Lunch Act, I feel that Congress has acted with great wisdom in providing the basis for strengthening the nation through better nutrition for our school children…I hope that all state and local authorities will cooperate fully…in establishing the cooperative school lunch in every possible community."

1946 – 1980
Child Nutrition Programs thrive
"this is the right thing to do for children"

- Educators/administrators viewed CN program as part of total education program
- Nutrition education was a component of state curricula
- *"Hungry children can not learn"*
- Child Nutrition Act of 1966 – expanded and strengthened the program
- School Breakfast program and summer food program
- Funding to states increases; more funding available for high need areas

1981 - 1989
Massive Federal Budget Cut
funding crisis closes some programs

- Program is devastated by $1.8 billion budget cut
- Federal budget cuts proposed annually
- Shift responsibility to states and charities
- States struggle to keep program operational
- Schools begin to sell supplemental items
- A la carte service begins; offers relief from budget cuts
- 1987 – federal program funds restored…

1990 - 2003
Priority for the Program Shifts

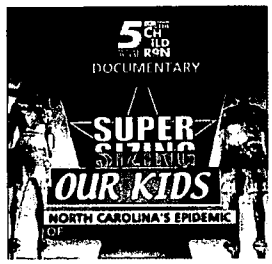
- *A la carte* program is thriving; schools are making money
- Stigma associated with the "traditional meal"
- Children develop appetite for *a la carte* items
- Schools develop appetite for revenues from *a la carte* foods and beverages
- State and local funding support allocated elsewhere
- Direct and indirect costs assessed to CN program

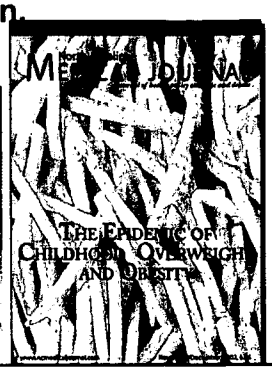
Shift in Priorities

Over the past 30 years, there has been a cultural, nutritional, operational and financial shift in priorities surrounding the Child Nutrition Program.

In many NC school districts, the philosophy of "What is the right thing to do for children" has been replaced with the administration's priority of "How much revenue can be generated?"

NC has the fifth fattest student body in the nation.





It's a Fact...

Reimbursable school meals are not the cause of the epidemic, but schools and School Nutrition Programs can be part of the solution and the national commitment to end childhood obesity in this generation.

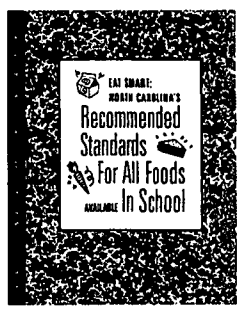




NC pilots nutrition standards

"Healthful School Food Choices Pilot Program"
(July, 20 2004)

Legislation provides $25,000 for "no risk" pilots in eight NC LEAs in grades K – 5 for the 2004 – 2005 school year



Results of the "No-Risk Pilots"

- ✓ Food costs were higher, especially whole grains, fresh fruits and vegetables
- ✓ Production costs were higher
- ✓ Schools were not adequately equipped
- ✓ Districts lost fifteen times the amount that was appropriated for the pilot in less than 5 months due to decreased *A la Carte* sales
- ✓ The anticipated cost of implementing nutrition standards in elementary school is $20 million annually



NC General Statute mandates nutrition standards (G.S. 115C-264)

In October, 2006, the SBE adopted nutrition standards for elementary schools that are consistent with the *Dietary Guidelines for Americans*.* All elementary schools were to comply with the nutrition standards by the end of the 2007 – 2008 school year. Time for implementation has been extended until funding is available.

*SBE Policy #EEO-S-002

NC's Child Nutrition Programs have made tremendous progress

- ✓ Achieving USDA's School Meals Initiative
- ✓ Increasing fresh fruits and vegetables
- ✓ Increasing whole grain foods
- ✓ Limiting fried foods
- ✓ Limiting high fat, high sugar foods
- ✓ Eliminating whole milk
- ✓ Emphasized the reimbursable meal
- ✓ Formed a state-wide purchasing alliance
- ✓ Implemented Farm-to-School Program
- ✓ 95% of elementary schools achieved nutrition standards...until they lost money



Philosophy versus Reality

While the philosophy suggests the school nutrition program is a program that promotes the optimal growth, development and health of students while supporting their academic success...



Philosophy versus Reality



The reality is that the program is a food service enterprise program housed on the school campus that generates enough money to support its operations and/or generate revenues for the district.

Current challenges in the Child Nutrition Programs

Programs expected to operate as enterprise business on the school campus and must produce revenues to cover:

- ➢ Food and supplies
- ➢ Equipment and technology
- ➢ Salaries for all staff
- ➢ Benefits (health, longevity, retirement, workers' compensation)
- ➢ State-mandated pay raises and salary schedules
- ➢ Indirect costs
- ➢ Other costs assessed by district

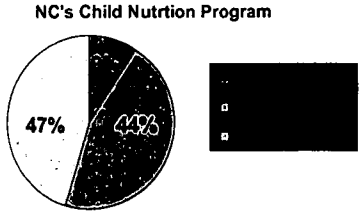
Operating costs are increasing

- ✓ Food Costs
- ✓ Fuel/Delivery Costs
- ✓ Service/maintenance
- ✓ Labor Costs
- ✓ Employee Benefits
- ✓ Equipment Costs
- ✓ Indirect Costs
- ✓ Other Costs



Where does the money go?

Expenses in NC's Child Nutrtion Program

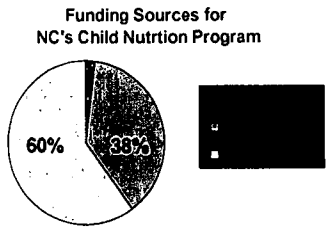


Program revenues are decreasing

- Federal Reimbursement does not cover the cost of preparing/serving the meal
- Commodity entitlement remains limited
- *A la Carte* sales have plummeted as less healthful foods and beverages have been replaced with more healthful options
- There is a diminished profit margin for more healthful foods
- There are no state or local funds to support the program



What are the sources of funds to operate NC's Child Nutrition Program?



Current perception of NC's Child Nutrition Programs

"The Child Nutrition Program is a Federal Program and is *required, by law,* to be financially self-supporting. Consequently, there is little "ownership" of the program by state and local decision-makers."

The local Board of Education is ultimately responsible for operating the program.

Economics of North Carolina's School Meals Program

Example:

$3.20	average cost to produce a school lunch
$2.68	Federal reimbursement for "free" meal
$ .52	

$3.20	average cost to produce a school lunch
$1.95	average cost to a paying student
$ .25	Federal reimbursement for "paid" meal
$1.00	

Economics of North Carolina's School Meals Program

Example:

$3.20	average cost to produce a school lunch
$2.28	Federal reimbursement for "reduced price"
$ .40	Amount owed by student
$ .52	

But what if the child does not have the $ .40 to pay for the meal? In some districts, Board-approved meal charge policies deny meals to students who do not have money for their meals.

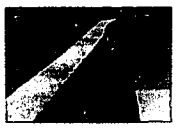
Meal participation drives Federal reimbursement

Breakfast participation is low
- 34% in Elementary School
- 19% n Middle School
- 12% in High School

Lunch Participation is moderate
- 76% in Elementary School
- 69% in Middle School
- 42% in High School

Some ask...is the answer to increase the cost of the meal to paying children?

We must consider economies of scale and the loss of meal participation when meal prices increase significantly. If the meal is unaffordable for working families, children in elementary schools will bring food from home; middle and high school students will buy items from vending machines/school stores or skip meals altogether.



Another challenge...the sale and availability of competitive foods and beverages

Competitive foods are foods and/or beverages that **are sold or offered to students** in competition with the Child Nutrition Program. Competitive foods and beverages erode the nutritional, operational and financial integrity of the school meals program.



As a result of these challenges, CN Programs have been required to:

- Return to and increase the sale of high calorie (fat and sugar) foods and beverages
- Return to the sale of fried foods in elementary, middle and high schools
- Cut labor to the exclusion of Meal quality and safety
- Decreased the amount of fruits and vegetables
- Considered eliminating the school breakfast program



Philosophy versus Reality

A nutrition program that promotes the optimal growth, development and health of students while supporting their academic success

OR

A food service enterprise program housed on the school campus that generates enough money to support its operations and/or generate revenues for the district

Healthy School Foods vs. Healthy School Finances

These challenges in the CN Program <u>are NOT</u> the result of poor program management. NC leads many states in its qualified, certified Child Nutrition Directors. Most are academically well-prepared, experienced, and competent. Most have a passion for serving the LEA to promote student's optimal growth, development and academic achievement. The time has come to re-define the criteria for a "successful" Child Nutrition Program in our state.

Barriers to Optimal Nutrition Environment that supports Obesity Prevention

- Inadequate funds
- Administrative and policy support
- Nutrition not valued as part of the instructional day
- Limited time/space for school meals
- Too little nutrition education to influence children's eating habits
- Conflicting messages
- Student taste preferences

What is the purpose of the Child Nutrition Program?

Until such time as we start measuring the success of the Child Nutrition Program based on re-shaping students' waistlines instead of the bottom line

 OR 

It will not be possible to make huge strides in the Nutritional integrity of School Meals

What is the solution?

- ✓ The CN Program MUST become a nutrition program that supports the optimal health, well-being and academic success of students.
- ✓ Adequate Federal, State and local funds must be available to ensure the total school community supports healthful school meals.
- ✓ School meals must be nutritious, affordable, achievable and appealing to students.

What is the solution?

- ✓ Students must have a reasonable meal period with sufficient time to consume healthful meals and snacks.
- ✓ Nutrition education must be part of the curriculum; students must be healthy to learn and they must learn to be healthy.
- ✓ Decisions regarding foods and beverages must be based on student health and well-being, not profits.

NC's Child Nutrition Administrators have the will and know the way...

The need you to lead the way and set the pace.

Thank you for your support of healthy school meals.

Do you have questions?

The Economics of NC's School Nutrition Program

Federal Reimbursement for Lunch

Free meal	$2.68
Reduced Price meal	$2.28
Paid meal	$ .25

Example:

$3.20	average cost to produce a school lunch
$2.68	Federal reimbursement for "free" meal
$ .52	

$3.20	average cost to produce a school lunch
$1.95	average cost to a paying student
$ .25	Federal reimbursement for "paid" meal
$1.00	

$3.20	average cost to produce a school lunch
$2.28	Federal reimbursement for "reduced price"
$ .40	amount owed by student
$ .52	

But what if the child does not have the $ .40 to pay for the meal? In some districts, Board-approved meal charge policies deny meals to students who do not have money for their meals. Other districts have Board-approved policies that allow students to charge meals when they do not have money; if these meal charges are uncollected at the end of the year, they must be paid by the district's general fund.

What are some possible solutions?

Collaborate with the State Board of Education to address the following priorities:

(1) The School Nutrition Program MUST become a nutrition program that supports the optimal health well-being and academic success of students.

- Students, parents, educators, and community leaders must take an active role in supporting an optimal school nutrition environment.
- Establish health policies that encourage school personnel to become role models for students.
- Establish policies that promote student participation in the reimbursable school meals.

(2) Adequate federal, state, and local funds must be provided to ensure the total school environment supports the availability of healthful foods and beverages for students.

- Consider a per-meal supplement ($ .05 per meal is a good start).
- Consider appropriating funds for the required State Revenue Match to eliminate the meal cost for students that qualify for reduced price meals ($ .70) per day; this would eliminate "denied" meals to these students, would prevent meal charges (where allowed) and would enable the districts to draw down over $5 million in additional Federal reimbursement.
- Strengthen competitive foods regulations.

(3) Nutrition standards must be established for all foods and beverages available on the school campus; those standards must be achievable, affordable, and appealing to a diverse student population.

- Change the paradigm about school foods; thanks to efforts by Industry, student-appealing foods are healthful choices.
- Recognize School Nutrition Programs that achieve nutrition standards.

(4) Students must have a designated meal period of sufficient length to enjoy eating healthy foods, and meal periods should be scheduled at reasonable times during the day.

- Establish policy to require adequate meal times during the school day.
- Establish incentives to encourage alternative meal approaches (ex: breakfast in the classroom, grab n' go boxed lunches).

(5) Behavior-focused nutrition education must be integrated into the curriculum from pre-K through grade 12 and teachers who provide nutrition education must have appropriate training to do so.

- Require 2 – 3 nutrition-related questions on state-mandated tests that document student progress.
- Provide incentives for school personnel to engage in personal positive health practices.

(6) Decisions regarding the sale and availability of foods and beverages on the school campus must be based on student health and well-being, not on making a profit.

- Make it a reality that the school nutrition program IS a nutrition program that promotes the optimal growth, development and health of students while supporting their academic success.
- Allocate resources and develop policies to support a healthy school environment.

FEEDING NORTH CAROLINA'S CHILDREN



SCHOOL NUTRITION ASSOCIATION OF NORTH CAROLINA

Making the right food choices, together.

Legislative Timeline

- 2004-School Nutrition Association requested and received funding to pilot nutrition standards in diverse districts representing all of North Carolina
- 2005-Nutrition Standards were legislated for all elementary schools
- 2007-School Nutrition Association requested funding to implement standards
- 2008 –School Nutrition Association requested funding to implement standards
- 2009-School Nutrition Association requested state match funds to be used to eliminate the reduced price category

SCHOOL NUTRITION ASSOCIATION OF NORTH CAROLINA

Making the right food choices, together.

This apple represents revenues generated by Child Nutrition Programs in North Carolina.

Costs are cutting our programs away...

Child Nutrition Programs must generate enough funds to cover the cost of **labor and benefits** for their employees. These costs add up to 45.5% of all revenue generated by the program.

45.5%

Child Nutrition Programs must generate enough funds to cover the cost of **food and supplies**. These costs add up to 43.6% of all revenue generated by the program.

43.6%



Child Nutrition Programs must generate enough funds to cover **direct costs**, such as equipment, travel, and computers. These costs add up to 6.0% of all revenue generated by the program.

6.0%

Child Nutrition Programs must generate enough funds to cover **indirect costs**, which are paid to the school district. These costs add up to 5.0% of all revenue generated by the program. This totaled over $18 million in 2009.

5.0%

...What's left?

Addressing Challenges

- Formation of state-wide purchasing Alliance for food purchases
- Purchase of produce from Farm-to-School Program
- Reconfiguration of labor –bare minimum of employees and hours required
- Implementation of food monitoring and safety programs
- Increase in meal prices
- "Less" healthy food choices added back to menus including a la carte
- Decline in number of food choices in some districts
- Move back to more canned and frozen fruits and vegetables instead of fresh because of cost

SCHOOL NUTRITION ASSOCIATION OF NORTH CAROLINA

Making the right food choices, together.

Program Goals

Short Term

- Invest state match (7.2 million currently) to eliminate reduced price category resulting in an additional 5.2 million in federal funds.
- Allow Child Nutrition Programs to achieve and sustain a three months operation balance before indirect cost can be assessed.
- Strengthen the competitive foods regulation (115C-264)to make it consistent with State Board of Education Policy EEO-S-002.

SCHOOL NUTRITION ASSOCIATION OF NORTH CAROLINA

Making the right food choices, together.

Program Goals

Long Term

- Invest in per plate reimbursement to sustain long term viability of quality nutrition programs
- Explore the options to fund benefits and/or salaries for Child Nutrition employees.
- Strengthen nutrition education curriculum requirement in standard course of study.

SCHOOL NUTRITION ASSOCIATION OF NORTH CAROLINA

Making the right food choices, together.

Questions

We thank you for this opportunity on behalf of our children!

Deborah Carpenter, President

Cindy Marion, Public Policy and Legislation Co-Chair

Cynthia Sevier, Public Policy and Legislation Co-Chair

SCHOOL NUTRITION ASSOCIATION OF NORTH CAROLINA

Making the right food choices, together.

LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY

February 2, 2010

ACCESS TO ACTIVE LIVING AND NUTRITIOUS FOOD IN THE COMMUNITY

BACKGROUND

Nutritious Food in the Community

Many low-income urban and rural populations—whose rates of obesity are among the highest—lack easy access to healthy, fresh and affordable foods.[1] Compared to wealthier areas, communities with a lower socioeconomic status have been found to have fewer supermarkets per person, farther distances to travel to the nearest major food store and decreased availability of healthy foods such as low-fat milk, high-fiber bread and fresh fruits and vegetables.[1]

Access to nutritious foods plays an important role in preventing disease and reducing the risk for overweight and obesity, yet many low-income urban and rural populations continue to have a hard time finding affordable fresh fruits and vegetables in their neighborhoods.

FARMERS' MARKETS

Farmers' markets, community gardens and food cooperatives provide consumers with access to locally grown fresh produce, grains and other nutritious foods. Direct consumer access to food benefits not only the grower, but also the community and consumer—especially in urban communities where fresh foods are scarce. Farmers' markets, community gardens and food cooperatives also help to promote nutrition education and encourage wholesome eating habits.

Subsidizing fruit and vegetable purchases at farmers' markets has been shown to make a big difference in the eating habits of low-income people. One report found that weekly $10 vouchers permitted low-income women to shop at local farmers' markets and increase their families' fruit and vegetable consumption.[2] Families who received the vouchers ate about three additional servings of fruits and vegetables a day compared to those receiving supermarket-only vouchers, who consumed an additional 1.5 servings daily.[2]

In addition to the supermarket aisles, rising commodity prices have also impacted low-income consumers' ability to shop at farmers' markets this year. Because small farmers selling their produce at local markets do not enjoy the economies of scale associated with larger growers who typically supply supermarkets, rising energy prices are passed more

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[1] Black Jennifer L and Macinko James. "Neighborhoods and Obesity." *Nutrition Reviews,* 66(1): 2–20 2008.
[2] Jenks E. "Effect of a Targeted Subsidy on Intake of Fruits and Vegetables Among Low-Income Women." Special Supplemental Nutrition, *American Journal of Public Health,* 98(1): 98–105 (Jan. 2008).

directly onto the consumer. As a result, price inflation at farmers' markets this year has exceeded that of supermarkets.[3]

GROCERY STORE AND SUPERMARKET DEVELOPMENT AND ACCESS

There is a direct correlation between supermarket access and diet-related diseases, such as obesity.[4] Access to a supermarket is one of the strongest predictors of whether people will eat a healthy diet rich fruits and vegetables.[5] [6] The addition of just one supermarket is associated with a 32 percent increase in fruits and vegetable intake among nearby residents.[5]

Low-income rural and urban areas are less likely to have convenient supermarkets. An analysis of 21 major U.S. metropolitan areas found there were 30 percent fewer supermarkets in low-income areas than in higher-income areas.[7] Furthermore, low-income consumers are less likely to own cars, further limiting access to food stores outside of their neighborhoods.[7]

A lack of neighborhood supermarkets means that residents must shop at local convenience and corner stores. Prices at such markets can exceed those at chain supermarkets by as much as 48 percent, and smaller stores are also unlikely to offer the variety of healthy products carried by major supermarkets.[8] Diets that rely on food from convenience stores often include more unhealthy foods that contribute to obesity.[4]

Active Living in the Community

Active living is a way of life that integrates physical activity into daily routines.[9] The distance from a person's home to commercial centers, the safety of roads for pedestrians and bicyclists, the availability of recreation facilities and the time spent in cars all contribute to how often a person walks, bikes or recreates. By these measures, the majority of American communities currently do not support active living.[10]

An association has been demonstrated between higher levels of physical activity and lower average body mass index (BMI) and neighborhoods with mixed land use, improved

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[3] Chaya Harris. Farmers' Markets Provide Nutrition Boost for Low-Income Residents," *Medill News Service*, June 16, 2008, available at http://www.windycitizen.com/news/humboldt-park/2008/06/16/chicagos-farmers-markets-can-provide-nutrition-boost-for-low-income-re.

[4] The Food Trust. *The Need for More Supermarkets in Philadelphia: Food for Every Child* (March 2005), available at http://www.thefoodtrust.org/pdf/supermar.pdf.

[5] Morland K, Wing S and Diez Roux A. "The Contextual Effect of the Local Food Environment on Residents' Diets: The Atherosclerosis Risk in Communities Study," *American Journal of Public Health,* 92: 1761–1767 (2002).

[6] Yale University Rudd Center for Food Policy and Obesity. *Eating Behavior*, available at http://yaleruddcenter.org/what/communities/topic_built_environ_eating.html.

[7] RW Cotterill and AW Franklin. *The Urban Grocery Store Gap,* Food Marketing Policy Center, University of Connecticut, Food Marketing Policy Issue Paper No. 8, 1995.

[8] Weinberg Z. "No Place to Shop: Food Access Lacking in the Inner City." *Race, Poverty & the Environment,* Winter 2000.

[9] *Healthy Community Design: Success Stories From State and Local Leaders,* The Robert Wood Johnson Foundation, Dec. 2004.

[10] *A Primer on Active Living for Government Officials,* Active Living Leadership, Oct. 2005, available at http://www.activelivingleadership.org/uploads/PDFs/brief_ALL_ActiveLivingPrimer_Oct2005.pdf.

walkability, better access to facilities and lower perceived hazards.[12] Residents in highly walkable neighborhoods have also been shown to engage in 52 more minutes of weekly physical activity and weigh less than residents of less-walkable neighborhoods.[11]

Low-income communities—which also have higher rates of obesity—are disproportionately affected by barriers to physical activity. Residents in low-income urban areas are most likely to report greater neighborhood barriers to physical activity, such as limited opportunities for daily walking or physical activity.[12]

BICYCLE LANES, WALKING PATHS AND PARKS

The creation and maintenance of bicycle lanes, walking paths and parks can promote and support increased physical activity for people of all ages and abilities. Studies show that fewer people—especially children—are physically active outdoors. Since the late 1980s, the percentage of Americans taking part in outdoor activities—as measured by tracking national and state park admissions, hiking permits and surveys of leisure activities—has declined at a rate of slightly more than 1 percent a year.[13]

COMMUNITY DESIGN AND ZONING

Careful planning and construction of communities has the potential to promote more active lifestyles. Well-designed neighborhoods make it practical to choose walking, bicycling and mass transit, especially for short trips.

Many Americans live in car-centric neighborhoods far removed from commercial, school and recreation areas. A dependence on automobiles for everyday living makes it difficult to get the exercise needed to stay healthy and maintain an optimal weight. Studies have demonstrated that the more time people spend in the car, the more obese they tend to be.[14] Conversely, the more time people spend walking, the less obese they are.[15]

State and local policies have a profound impact on growth patterns, community design, and, ultimately, environmental quality. Since most zoning and planned growth decisions are made at the local level, state initiatives generally center upon facilitating a dialogue between affected parties to encourage investment and collaboration around active living opportunities.

TRANSPORTATION INFRASTRUCURE

The state and municipal transportation infrastructure can either promote or discourage physical activity. State departments of transportation regulate the highway and

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[11] Saelens BE, Sallis JF, Black JB, Chen D. "Neighborhood-Based Differences in Physical Activity: An Environment Scale Evaluation." *American Journal of Public Health,* 93:1552–1558 (2003).
[12] Black Jennifer L and Macinko James. "Neighborhoods and Obesity." *Nutrition Reviews,* 66 (1): 2–20 (2008).
[13] R. Oliver, W. Pergams and Patricia A. Zaradic. *Evidence for a Fundamental and Pervasive Shift Away From Nature-Based Recreation,* Proceedings of the National Academy of Sciences, Feb. 4, 2008.
[14] Frank LD. "Obesity Relationships With Community Design, Physical Activity, and Time Spent in Car." *American Journal of Preventive Medicine,* 27(2): 87–96 (Aug. 2004).
[15] Ben Harder. Weighing in on City Planning: Could Smart Urban Design Keep People Fit and Trim? *Science News,* Jan. 20, 2007.

transportation systems. Current transportation systems are skewed to best accommodate car travel.
Designing roads with pedestrians and bicyclists in mind—known as complete-streets design—requires giving greater attention to the installation of sidewalks, curb ramps and crosswalks. However, the overall design and operational elements of the roadway are just as important.[16] Roadway width, number of lanes, traffic speed and traffic volume all impact the overall functionality of a road and how it meets its goals of providing access and mobility to all users.[16] Elements such as street width affect the time pedestrians need to cross the street, while traffic direction (one-way versus two-way) affects the number of potential conflicts between motorists and crossing pedestrians.

Our Speakers today

1. Alice Ammerman, Ph.D. Director, Center for Health Promotion and Disease Prevention, University of North Carolina

2. Sue Foerester, Chief, Network for a Healthy California
    a. Through a Webinar Presentation

3. Nancy Creamer, Ph.D. Professor, Department of Horticultural Science, North Carolina State University

4. Daniel Rodriguez, Director, Carolina Transportation Program, University of North Carolina

Following Lunch

1. Carolyn Dunn, Professor and Nutrition Specialist, North Carolina State University
   And
   Jimmy Newkirk, Manager Physical Activity and Nutrition Branch, Division of Public Health

2. Emily Jackson, Appalachian Sustainable Food Project

3. Gary Gay, Director, Food Distribution Division, Department of Agriculture

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[16] Active Living Research. *Healthy Community Design: Success Stories from State and Local Leaders*, Dec. 2004, available at http://www.activeliving.org/files/HealthyCommunityDesign_ALL.pdf.

Child Nutrition in the Schools

Jessica Donze Black RD, MPH

February 11, 2010

Alliance for a Healthier Generation

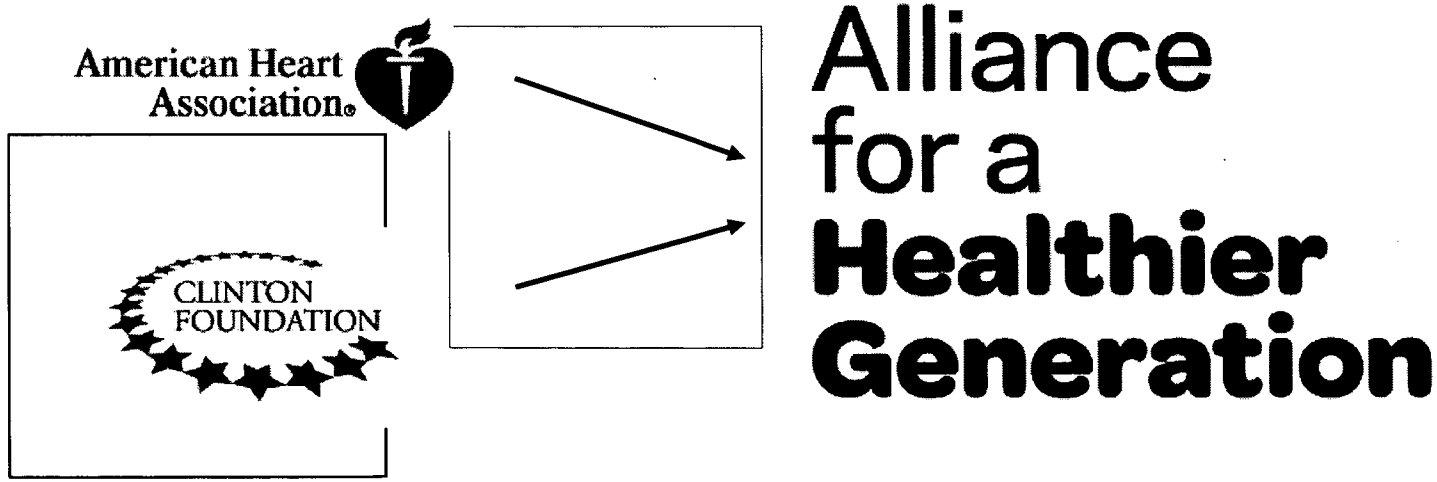
American Heart Association.

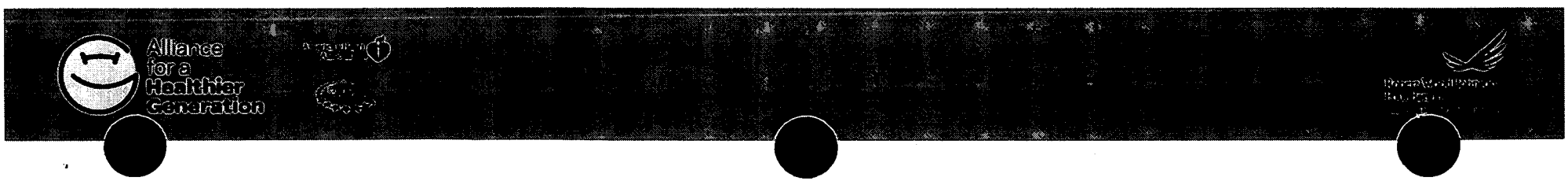
CLINTON FOUNDATION

Robert Wood Johnson Foundation
Supporting healthy schools nationwide

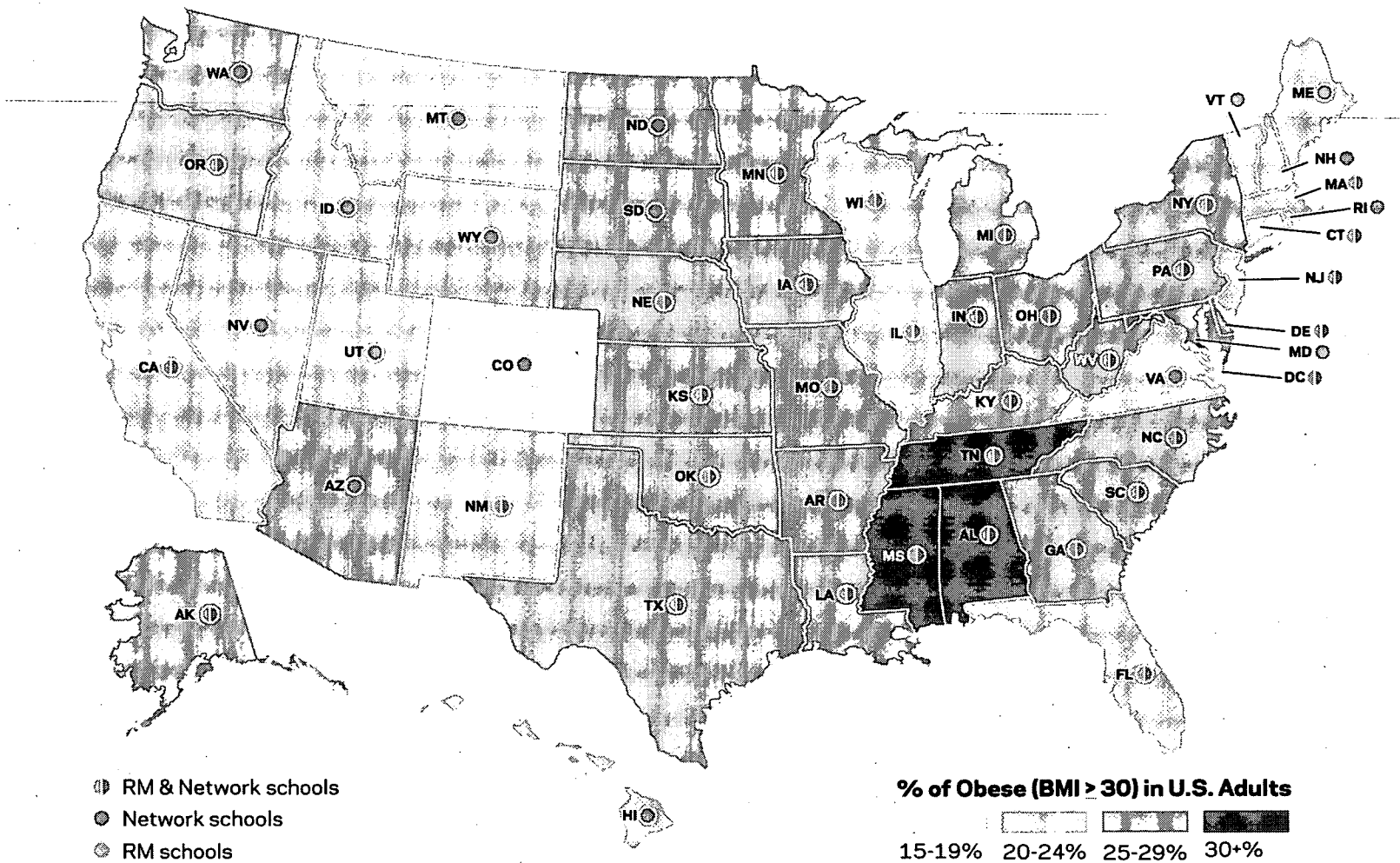
Reversing the Trend

To eliminate childhood obesity and inspire all young people in the United States to develop lifelong, healthy habits





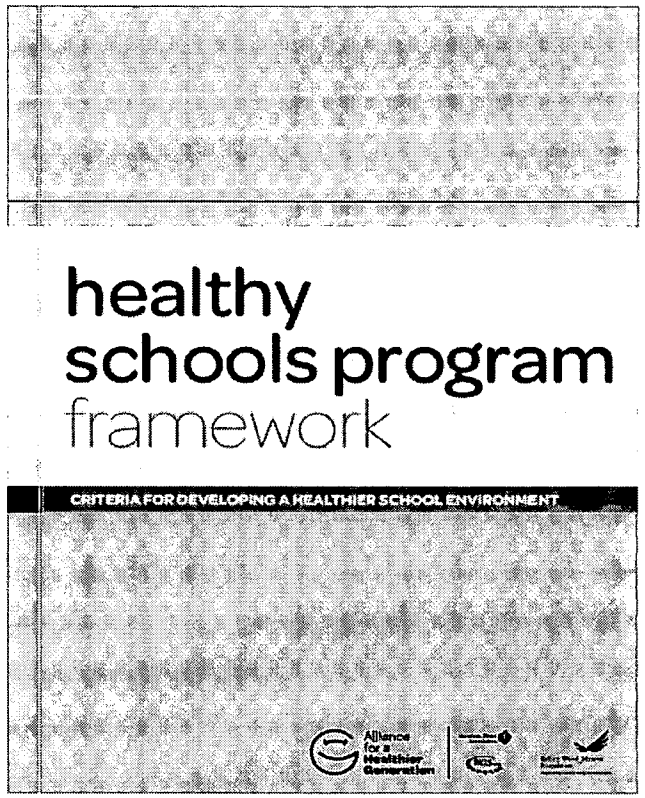
Healthy Schools Program is working to support a culture where schools that promote healthy eating and physical activity are the norm and not the exception.



Alliance for a Healthier Generation
American Heart Association
Robert Wood Johnson Foundation

Best Practices Framework

- Policy / Systems
- Health Education
- Physical Education
- **School Meals Programs**
- **Competitive Foods & Beverages**
- Physical Activity
- Before & Afterschool Programs
- School Employee Wellness





The School Nutrition Landscape

- School Breakfast
- School Lunch
- Competitive foods (a la carte, vending, school stores, fund raisers, parties, etc.)
- After school snacks
- Summer feeding program



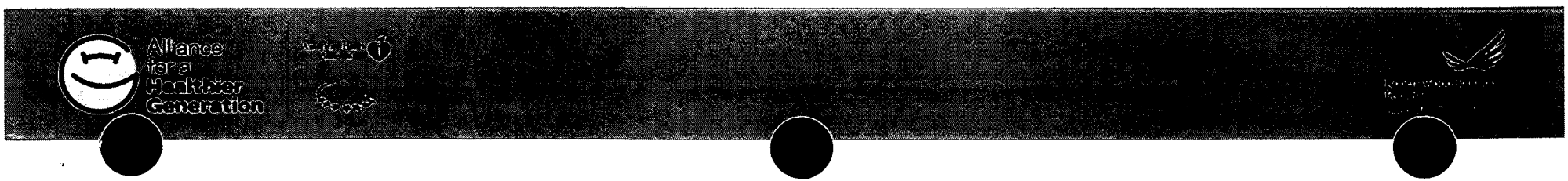
The National Picture

- 2004 Child Nutrition Reauthorization
  - Wellness Policies
  - School Meal updates

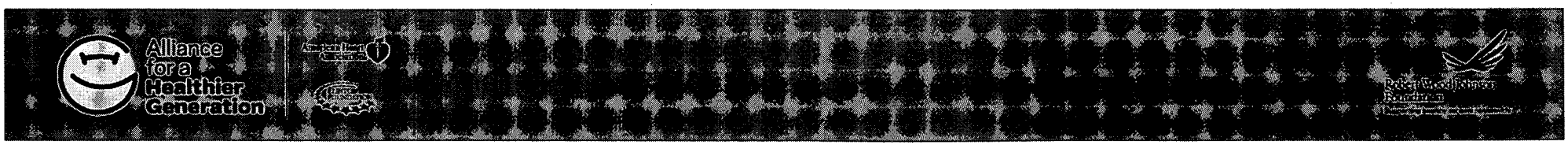
- State Policy change
  - States with nutrition standards for competitive foods grew from 6 in 2004 to 27 in 2009.
  - In 2006, only 38% of schools restricted students from purchasing sugar sweetened beverages such as regular soda and fruit drinks. In 2008, 63% of schools report restricting sugar sweetened beverages. (CDC School Health Profiles, 2008)

- 2009 IOM guidance to USDA on school meals and 2005 Dietary Guidelines

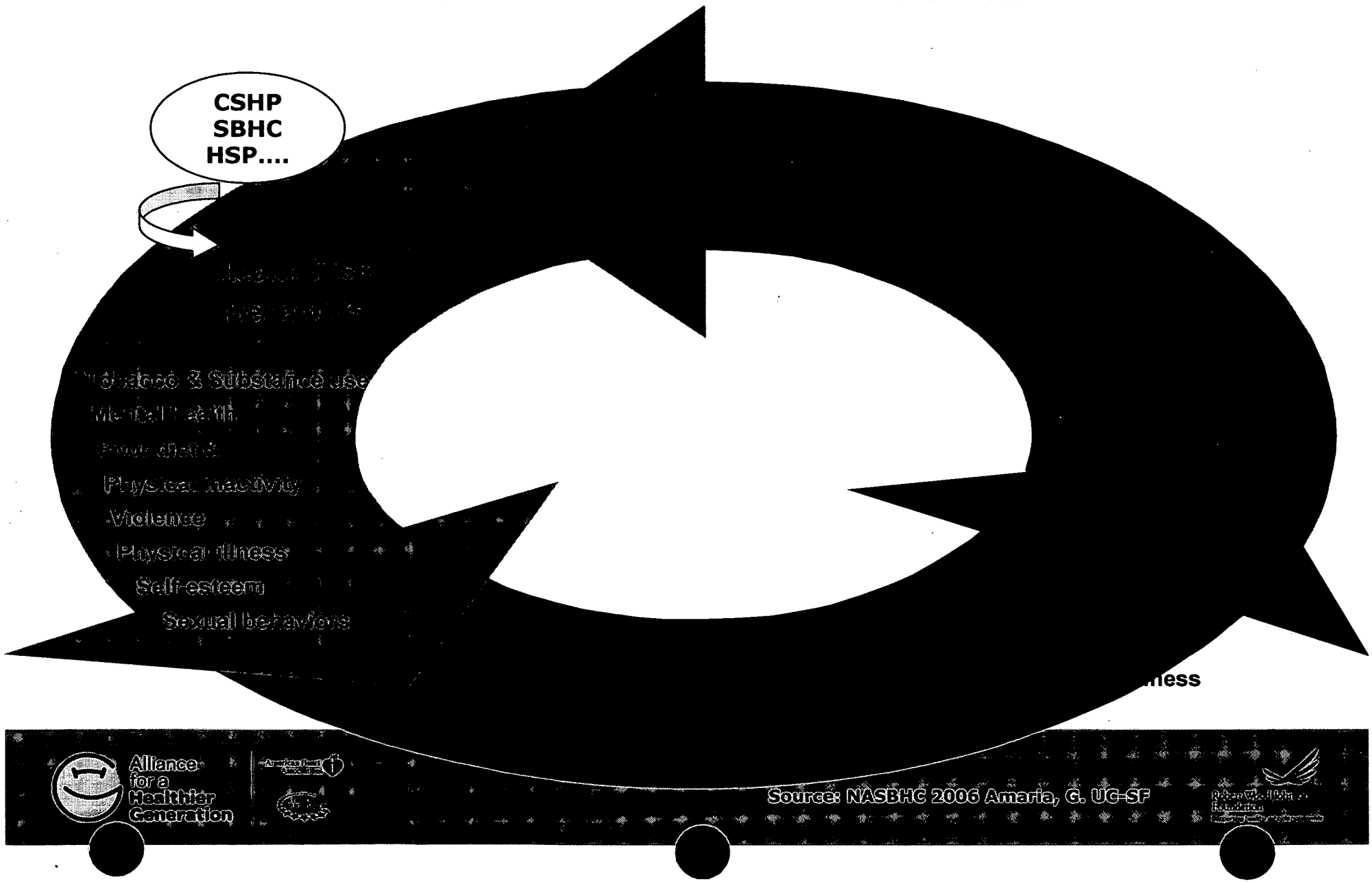
- 2010 (?) Child Nutrition Reauthorization
  - USDA Priorities
  - Additional priorities



Why Focus on Nutrition in Schools?



What We Know:
The health-academic outcomes connection

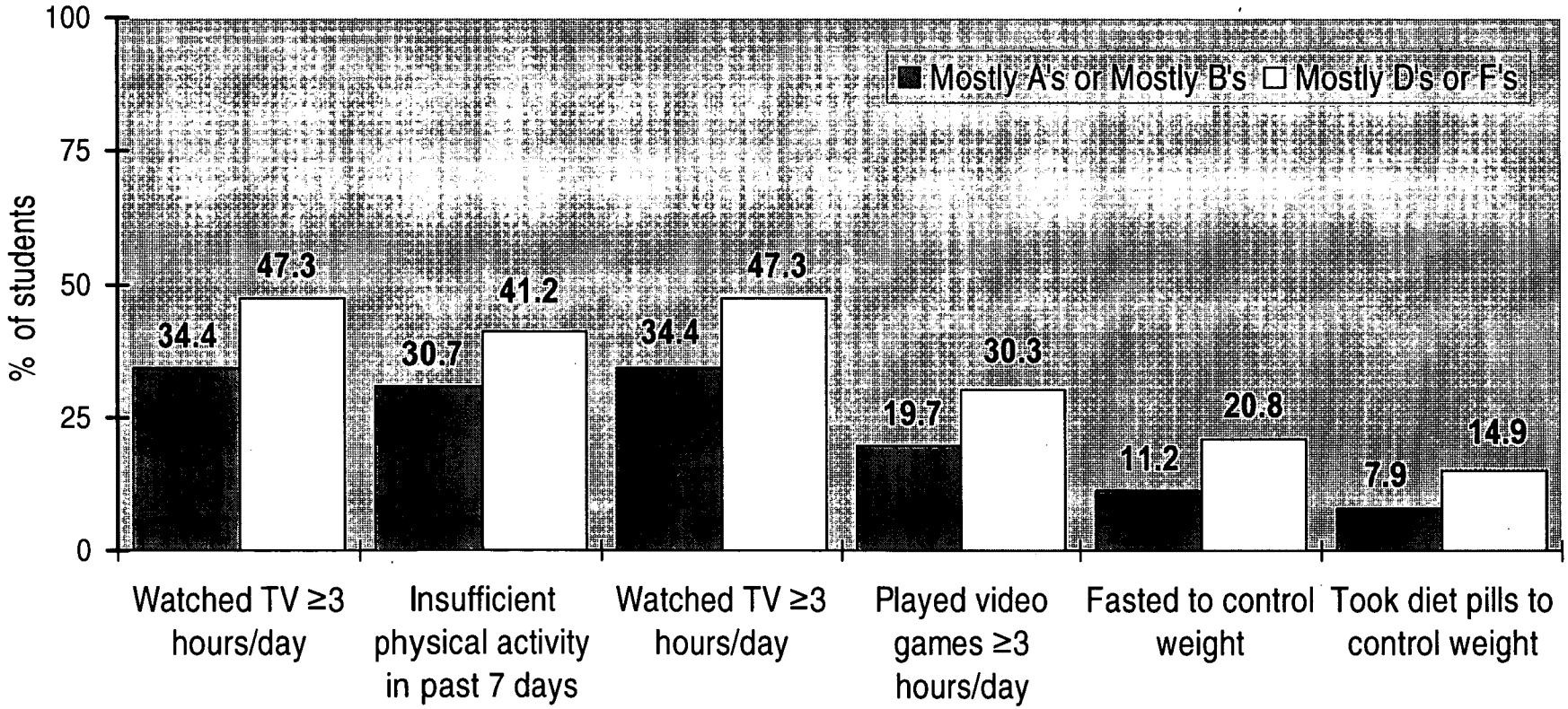


Growing body of research suggests...

- **Good nutrition is linked to improved student behavior, lower absenteeism, and reduced tardiness**
- **Eating breakfast at school is linked to greater improvements in standardized text scores and math grades.**
- Physical fitness levels predict for better math performance
- Participation in physical activity is consistently related to lower levels of anxiety and stress
- Participation in high activity physical education program may strengthen scores for elementary-age children on standardized tests.
- Physical activity can positively affect concentration, memory, and classroom behaviors.
- **Severely overweight children miss 4 times as much school as normal weight children.**



Percentage of U.S. High School Students Getting Mostly A's or B's and Mostly D's or F's* Who Engage in Selected Health Risk Behaviors



*As reported by students

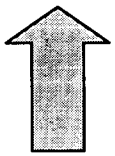
Unpublished analyses of CDC, National Youth Risk Behavior Survey, 2003

Participation in the School Breakfast Program and Academic Performance

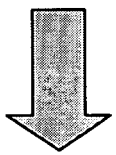
- Compared to peers who do not participate in the School Breakfast Program, low-income elementary school students who do participate have:
  - greater improvements in standardized test scores and math grades
  - reduced rates of absenteeism, tardiness, and psychosocial problems

Murphy et al. Arch Pediatr Adolesc Med 1998; Meyers et al. Am J Dis Child 1989

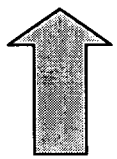
Greater Access to Low-Nutrient, Energy Dense Competitive Foods at School is Associated With:

-  intake of total calories, soft drinks, total fat, and saturated fat

  Cullen K et al. *JADA* 100(12): 1482-1486; Cullen K & Thompson D. *JADA* 105(12): 1952-1954

-  intake of fruits, vegetables, milk, and key nutrients

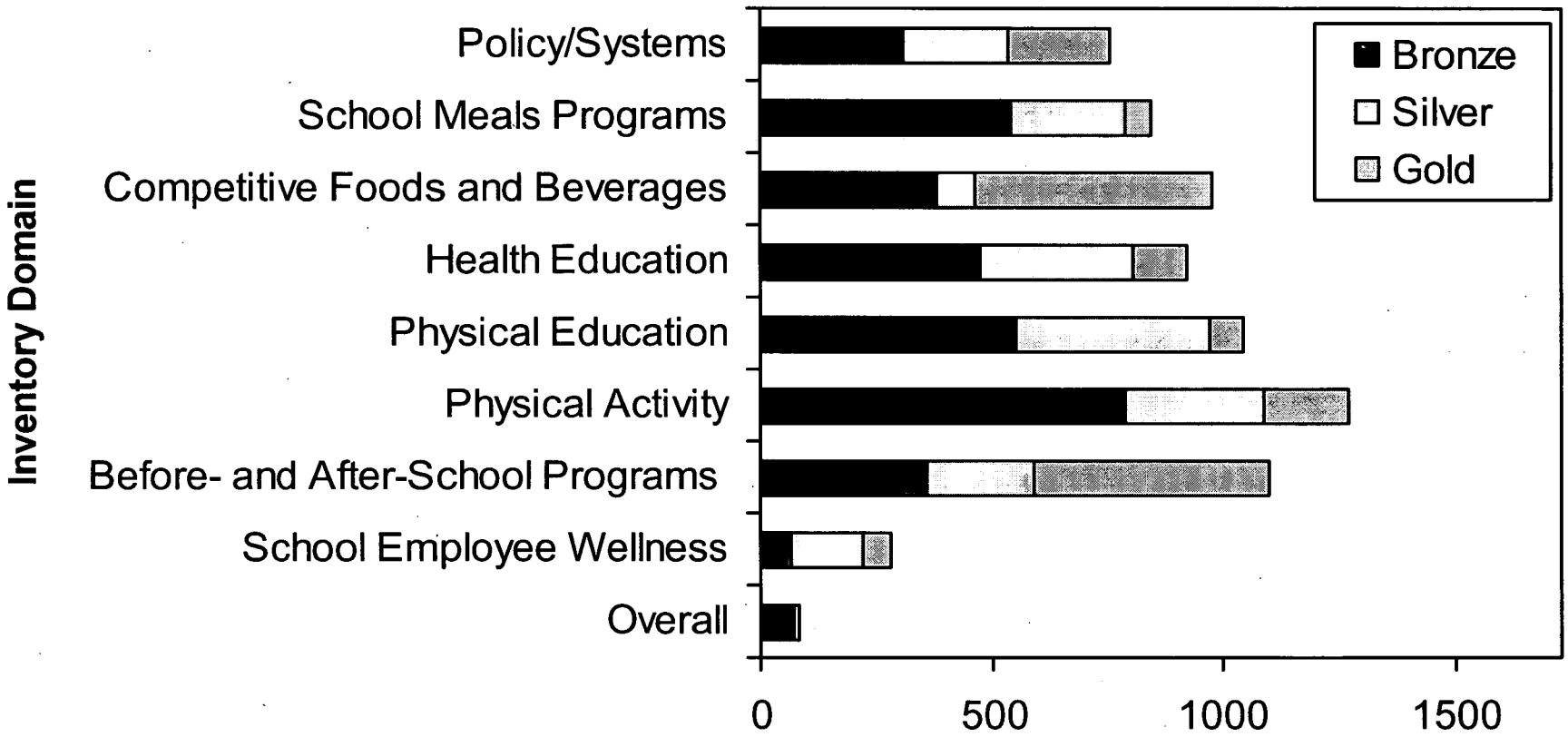
  Cullen K & Zakeri I. *AJPH* 94(3): 463-467

-  BMI among middle school students

  Fox MK et al. *JADA* 109(2):S108-S117; Kubik M et al. *AJPH* 93(7): 1168-1173;

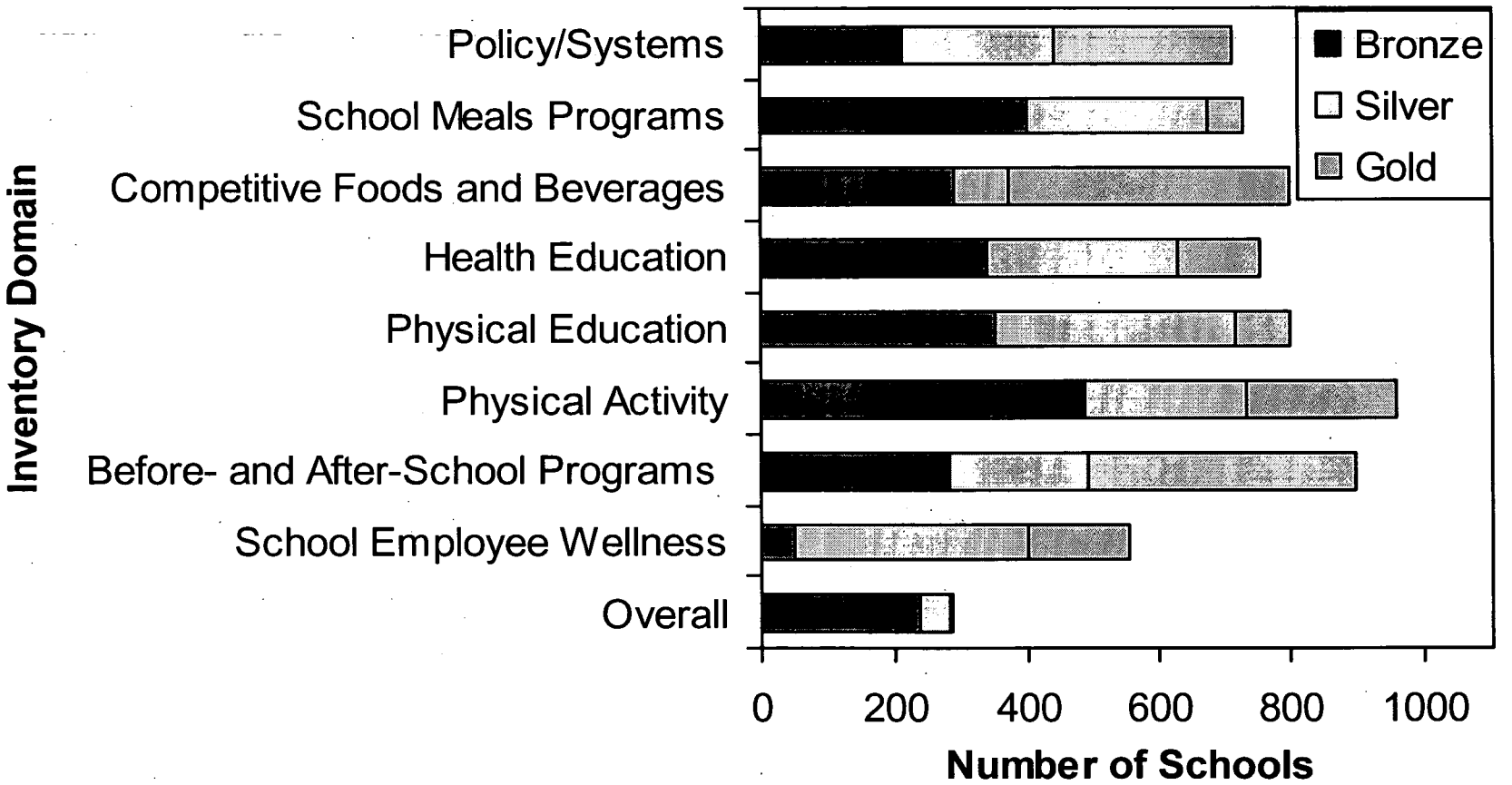
The Data

HSP Inventory Results at Baseline



Based on results from 1,726 schools

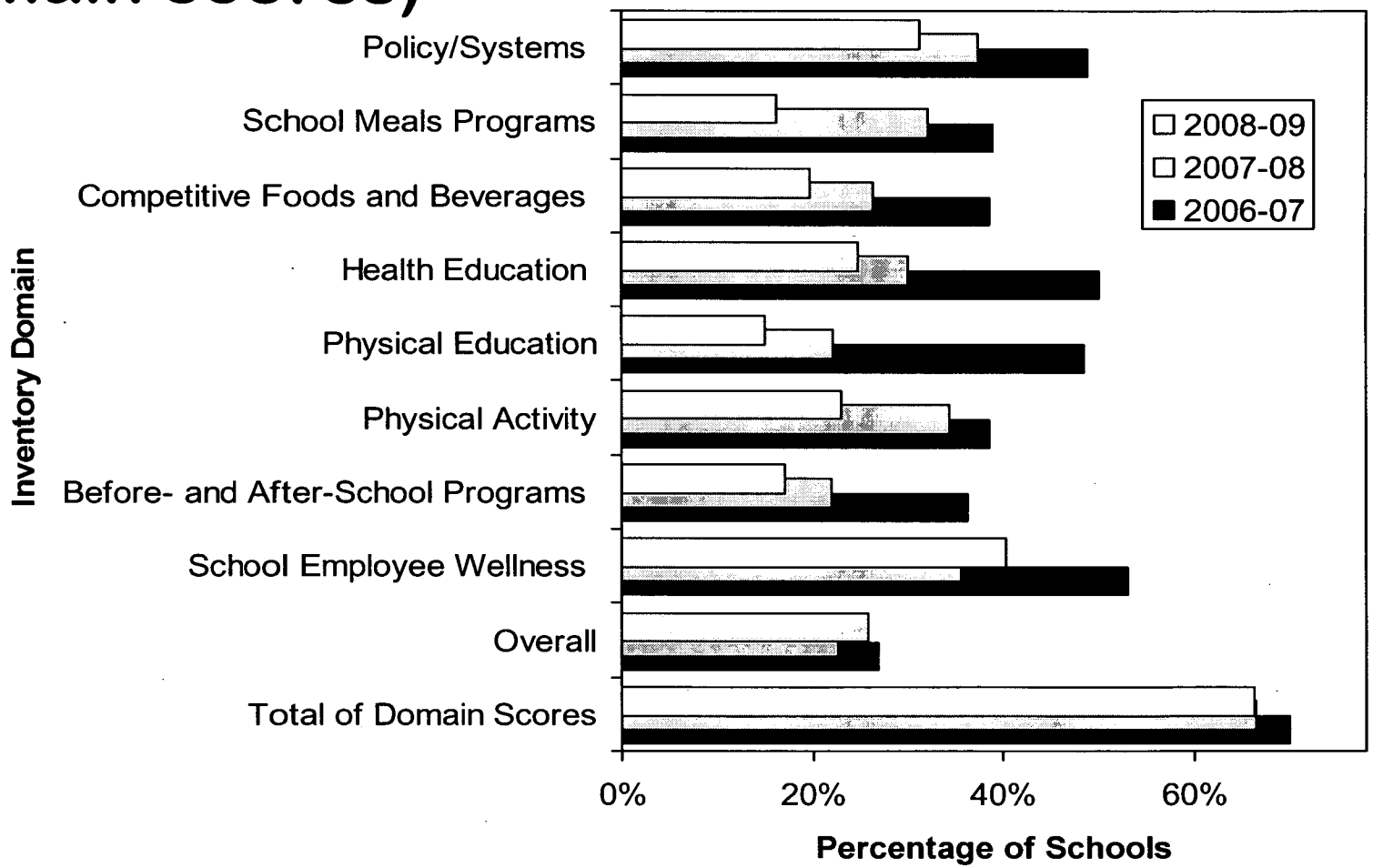
Inventory Results at Follow-Up



Based on results from 1,104 schools after 1, 2, or 3 years in program

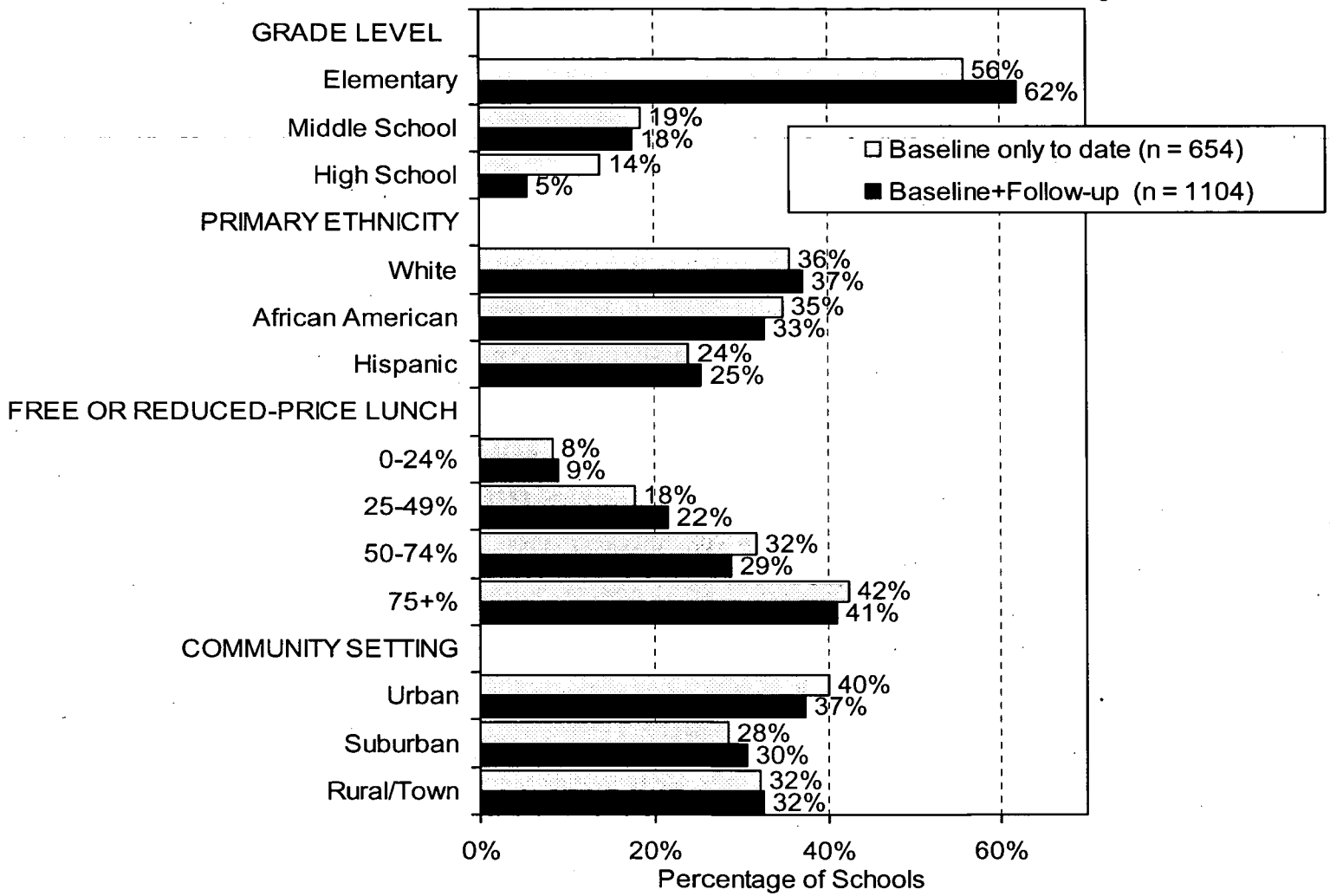
RMC RESEARCH

Schools Reporting Improvement
(Domain scores)



Results included for 132 2006-07 schools, 717 2007-08 schools, and 237 2008-09 schools.
About two thirds improved at least 1 recognition level across the domains.

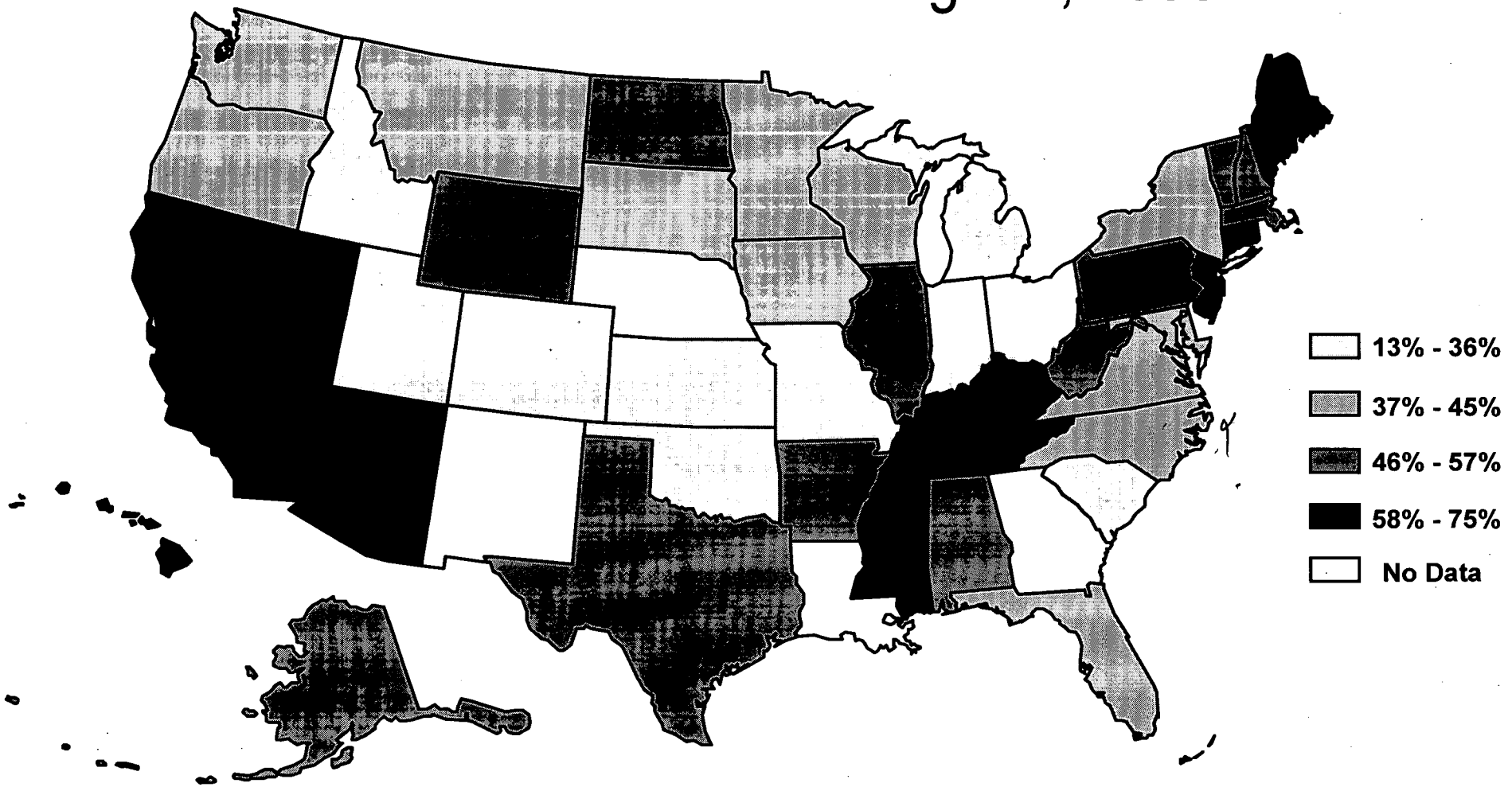
Characteristics of Two Groups



Source: National Center for Education Statistics Common Core of Data

RMC RESEARCH

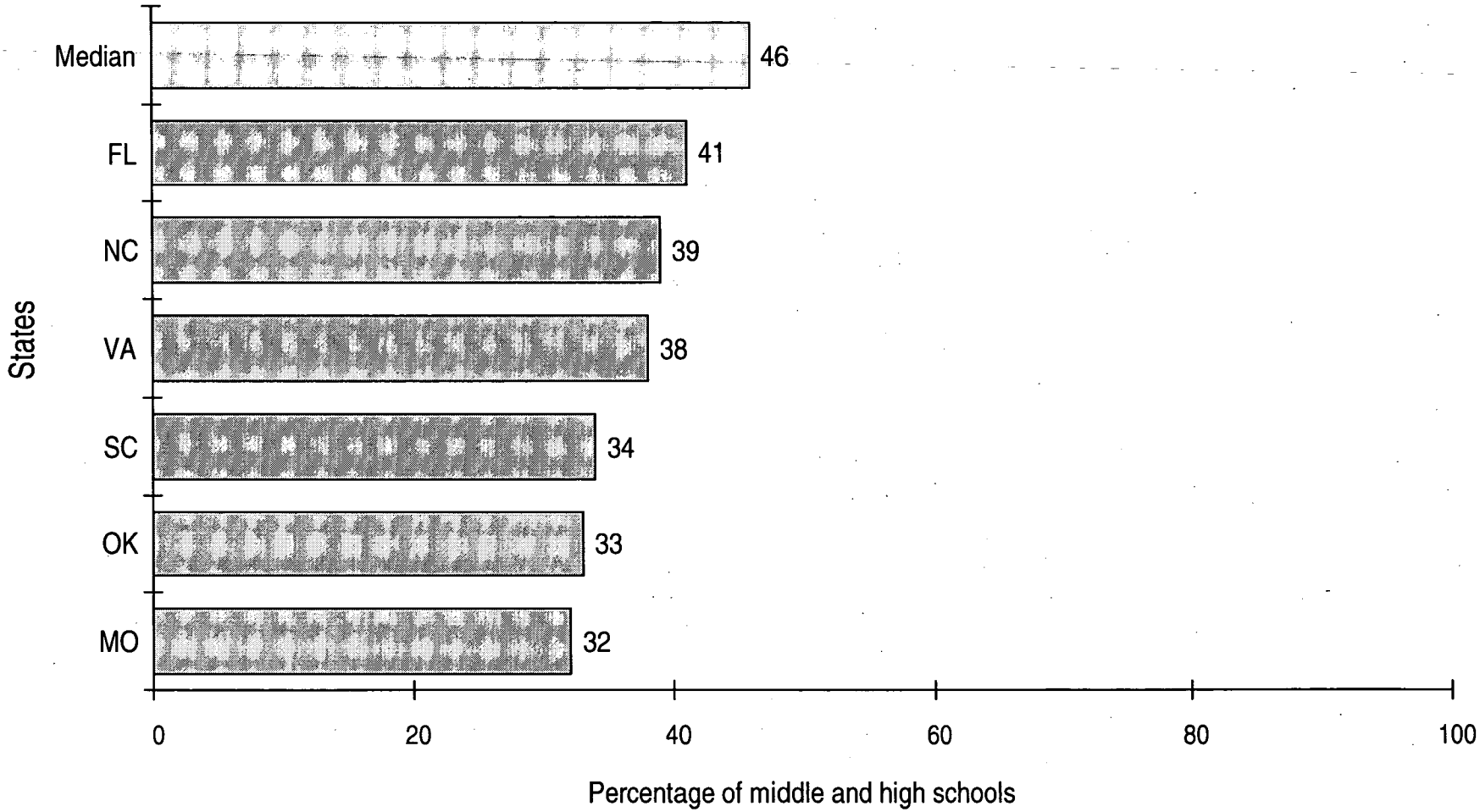
Percentage of Secondary Schools That Did Not Sell Less Nutritious Foods and Beverages* Anywhere Outside the School Food Service Program, 2008



*Baked goods not low in fat, salty snacks not low in fat, chocolate candy, other kinds of candy, and soda pop or fruit drinks that are not 100% juice

School Health Profiles, 2008

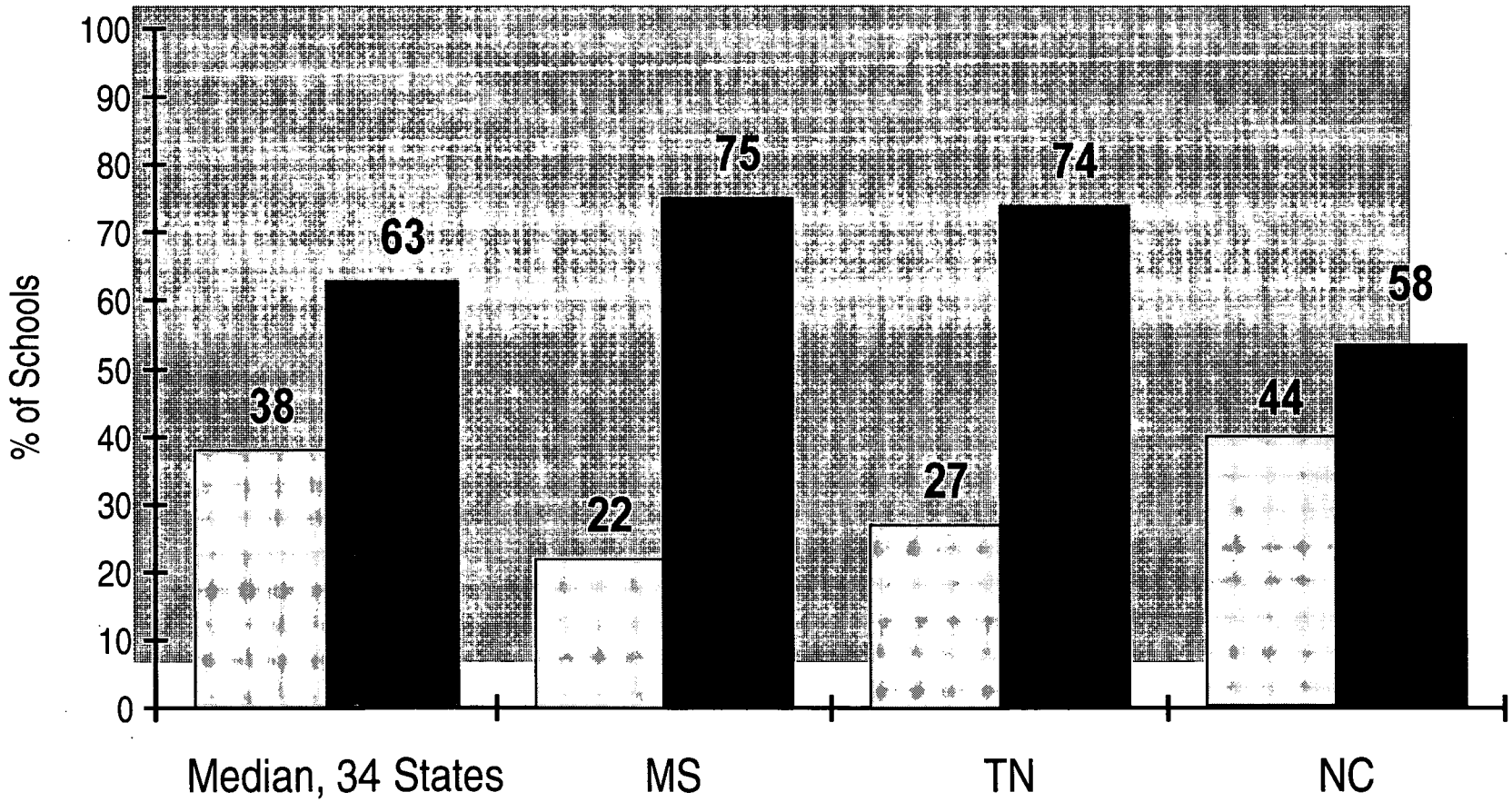
Percentage of Secondary Schools That Did Not Sell Less Nutritious Foods and Beverages* Outside the School Food Service Program—Selected Southern States and Median Among 47 States, 2008



*Baked goods and salty snacks not low in fat, chocolate and other kinds of candy, soda pop or fruit drinks that are not 100% juice

CDC, School Health Profiles

Percentage of Schools in Which Students Could Not Purchase Soda Pop or Fruit Drinks That Are Not 100% Juice—Selected States and Median Among 34 States, 2006 and 2008



CDC, School Health Profiles

North Carolina Schools are achieving change!



Congratulations to our Award Winners!!

Halifax County Schools

- **Scotland Neck Primary School: 07-08 Bronze; 08-09 Silver**
- **McIver Elementary School: 07-08 Bronze**
- **Pittman Elementary School 07-08 Bronze**
- **Hollister Elementary School: 08-09 Bronze**
- **Inborden Elementary School: 08-09 Silver**

Franklin County Schools

- **Long Mill Elementary School: 08-09 Bronze**

Warren County Schools

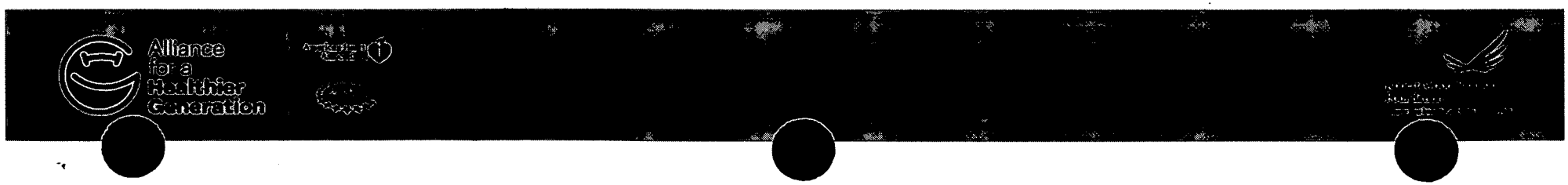
- **Vaughn Elementary School: 08-09 Bronze**

(and a HUGE thank you to all the state and local champions who have worked to help schools achieve these standards!!)

Alliance for a Healthier Generation

Robert Wood Johnson Foundation

Examples from the Field

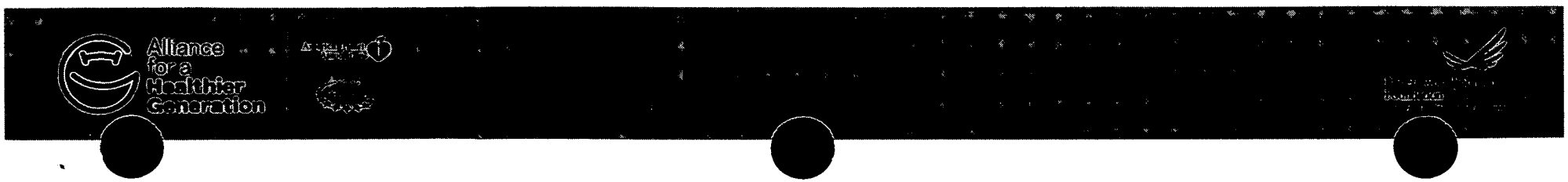


Overall Healthy Schools Program Lessons learned

- Strong state policy does facilitate healthier school environments. (CO, VT, MS, and OR modeled after HSP guidelines)
- Revenue success can be better achieved with students' participation and support- they are the customer base and target audience for healthy foods and beverages.
- Kids love to see their teachers, principal, or cafeteria staff making the same healthy changes they are and building their support is also critical. Modeling also reinforces the behavior and can convince other kids to try it out.
- Comprehensive wellness councils with representation from all stakeholder groups are important for keeping communication open and maximizing support to help overcome obstacles and institute and enforce policies.

QUESTIONS?

Jessica Donze Black RD, MPH
jessica.donzeblack@healthiergeneration.org



abc NEWS

School Nutrition Program Takes Up Obesity Fight

Kids Take Healthy Eating Habits Home From School Programs

By GITIKA AHUJA and LARA SALAHI

Feb. 11, 2010—

As an elementary school nurse, Stephanie Miklosey saw the effects of the childhood obesity epidemic right before her eyes.

At Philadelphia's John Welsh Elementary, Milkosey saw students who had a range of obesity-related conditions including diabetes, high blood pressure and asthma.

"When you start that young, they've got bigger health risks," she said. "It starts younger. It gets worse."

Click here to visit the "GMA" special section on childhood obesity.

In fact, a study published this week in the New England Journal of Medicine suggests that obese children are almost twice as likely to die before reaching age 55 than those who are a healthier weight. And with one in three children across the nation considered overweight or obese, many school nurses may also relate to what Miklosey has seen.

But what's different about this north Philadelphia school is that the community was not willing to sit back and watch its children become a part of the statistic.

The school brought in the local non-profit group, The Food Trust, to implement cost-effective but life-changing standards for the school. The group replaced soda with water, juice and milk, and replaced junk food in vending machines with snacks containing less than 200 calories.

And it didn't stop there. In math class, students solve problem sets around nutrition. The school even committed entire days to nutritional eating -- like banana day.

"They were 25 cents apiece," said Milkosey. "And we sold over 400 bananas."

Milkosey said since the school's nutrition makeover, more students are adopting healthier habits in and out of school.

Sixth grader Ivanna Esteves is convinced that healthy eating is not only important but also cool. Esteves, who said she used to snack on chips, Cheetos and soda, but now reads nutritional labels to find out if what she eats is healthy.

"When my mom goes food shopping, she buys, like, grapes and apples and oranges -- and me and my sister, we always eat the grapes in one day," she said.

Eliminating Obesity: It Takes a Village

School nutrition programs such as the one at John Welsh Elementary School may be fostering healthier children.

According to a two-year study published October 2009 in Pediatrics, simple adjustments in food options available to children cut the rate of overweight and obese children in half.

In Philadelphia, Gary Foster, director of the Center for Obesity Research and Education at Temple University, and lead author of the study, works with Food Trust to implement school and community campaigns for healthier food options. Their programs include the Corner Store Initiative, which stocks store shelves with healthy foods local children say they will actually eat.

In fact, Philadelphia has experienced an emergence of new community physical activity classes, along with the opening of a new supermarket.

Pilot programs like Philadelphia's are among many initiatives that President Obama and his newest task force are looking at as models to combat childhood obesity.

Complementing the first lady's "Let's Move" campaign launch Tuesday, President Obama announced the formation of a task force charged with solving the problem of childhood obesity "within a generation."

The president also plans to reauthorize the Child Nutrition Act, which expired September 2009. Obama is proposing a $10 billion budget increase -- $1 billion a year for 10 years -- to help provide nutritious school lunches to those who qualify.

"A part of it is rewarding schools that take nutrition and physical activity very seriously and providing additional resources for them so that there's a financial incentive attached to it," said Agriculture Secretary Tom Vilsack, a member of the task force.

Because of these programs, Milkosey sees fewer students checking in with stomach aches and other more-serious conditions she related to unhealthy eating.

"It keeps them in the classroom," she said. "And that's where they need to be."

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Katie Stanley (Rep. Yongue)

From: Butch Gunnells [butch@ncbev.org]

Sent: Tuesday, February 09, 2010 5:02 PM

To: Lt.gov@nc.gov; vandana.shah@ncmail.net; john.durvin@nc.gov; Rep. Joe Hackney (Speaker); Sen. Marc Basnight (President Pro Tempore); Lanier.Cansler@ncmail.net; lhoggard@dpi.state.nc.us; bmatthew@dpi.state.nc.us; jatkinson@dpi.state.nc.us; Sen. William Purcell; Sen. Charlie Dannelly; Sen. Don Davis; Sen. Jean Preston; Sen. Jerry W. Tillman; Sen. Michael Walters; Rep. Douglas Yongue; Rep. Larry Brown; Rep. Bob England; Rep. Robert Grady; Rep. Jennifer Weiss; Rep. Sandra Spaulding Hughes; Laura DeVivo (Speaker Hackney's Office); Amy Fulk (Pres Pro Tem's Office); Katie Hall (Pres Pro Tem's Office)

Subject: Beverage Industry Joins National Effort To Combat Childhood Obesity

Attachments: Clear on Calories News Release Final.doc; Final Clear on Calories Initiative.doc

To Key North Carolina Policy Leaders:

The non-alcoholic refreshment beverage industry today announced it is making a voluntary national commitment to further inform consumers of the calories contained in our products by putting calorie content information clearly on the front of all packages, vending machines and fountain machines. This is being done in conjunction with First Lady Michelle Obama's initiative to help families make informed choices as part of a balanced lifestyle.

The beverage industry will coordinate with the federal Food and Drug Administration to implement this new voluntary calorie initiative, which goes further than what is required by FDA's food labeling regulations.

The beverage industry made this commitment to the First Lady through its national trade association, the American Beverage Association.

Attached is a news release from ABA and also a one-page summary of the "Clear On Calories Initiative."

Sincerely,

Butch Gunnells and Amy McConkey

North Carolina Beverage Association
919.828.2737 (office)
919.880.9054 (cell)
butch@ncbev.org

NORTH CAROLINA BEVERAGE ASSOCIATION

AMERICAN BEVERAGE ASSOCIATION

CLEAR ON CALORIES INITIATIVE

America's non-alcoholic beverage companies applaud First Lady Michelle Obama's initiative to combat obesity and help families make informed choices as part of a balanced lifestyle. The beverage industry is coming together to support her initiative through a voluntary commitment to make the calories in their products even more clear and consumer-friendly by putting the information on the front of all their containers, vending machines and fountain machines. Our commitment includes ongoing innovation and reformulation of our products as well as the continued development of smaller package sizes, and dedicating marketing resources to our lower calorie products. Moreover, going forward we commit to working with FDA and the rest of the food industry to create comprehensive, uniform, easy to understand front of package labeling.

In support of the First Lady's initiative, we commit to the following Clear on Calories initiative:

1. **Product Labels:** We will display total calorie counts on the front of all containers up to and including 20 ounces; multi-serve packaging will be labeled using a 12 ounce serving (as well as number of servings per package) for all beverages. 100% juices will continue to use an 8 ounce serving size.
2. **Company-controlled Vending Machine Labels:** Total calorie counts displayed on selection buttons.
3. **Company-controlled Fountain Equipment Labels:** Calorie counts displayed prominently.

Implementation: Implementation will start in 2010 and be completed in 2012.

We are also assessing a number of different fact-based nutrition labeling approaches, including expanding the information for % Daily Values, currently found in the Nutrition Facts Panel of all packaged foods and beverages, to include other nutrients and repositioning the information to the front of pack to benefit the consumer, where relevant. Such an approach would be more in line with a GDA-like labeling approach.

Coordination with FDA: Our industry will coordinate closely with FDA to ensure that information on the front and back of the package is consistent. In addition, we request that FDA evaluate serving sizes for the entire food and beverage industry as part of their current review of labels and labeling. On the conclusion of FDA's review, we will use the standard serving size identified through research as directed by FDA.

Access to Nutritious Foods

Alice Lenihan, MPH,RD,LDN
Branch Head Nutrition Services
NC Division of Public Health

Child Obesity Task Force
February 11, 2009

North Carolina Public Health

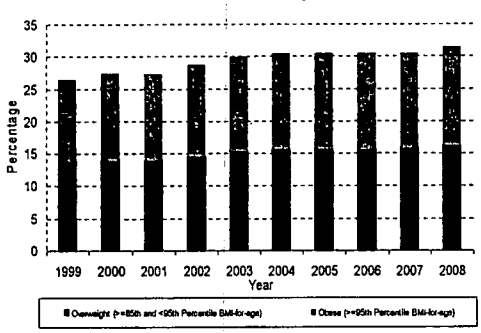
1

Discussion

- Origins and influences on childhood obesity
- Where do children eat
- Federal Nutrition Assistance Programs
- Best Practices- Opportunities for North Carolina to improve

2

Prevalence of Overweight and Obesity in North Carolina Children 2 to 5 Years of Age*, 1999-2008



*Children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics and some School Based Health Centers. Percentiles were based on the CDC/NCHS Year 2000 Body Mass Index (BMI) Reference.

3

Origins and Influences on Childhood Obesity



- Prenatal
  - Pre pregnancy weight
  - Pregnancy weight gain
- Infancy
  - Breastfed
  - Formula fed
- Preschool



4

Matilda (Scenario A)

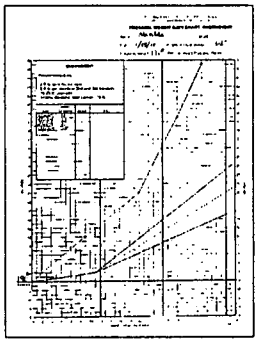
- BMI 35 prior to this pregnancy
- Eats two large meals/day; typically fast food items
- Works 40 hours/week and has no time for exercise
- Apprehensive about breastfeeding



5

Matilda's Pregravid Growth Chart

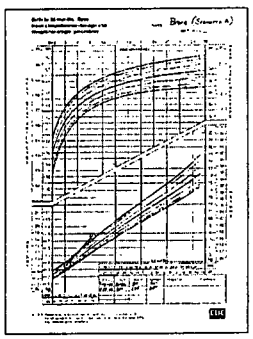
- Overweight prior to pregnancy
- Weight gain is rapid
- Total weight gain is excessive



6

Bruce's Growth

- Birth
  - Weight 8 lbs
  - Length 20 inches
  - Formula fed, early introduction of solid foods
- Six Months
  - weight – 17 lbs
  - height – 24 inches
  - Wt/ht percentile = >95th
  - Overweight



7

Matilda (Scenario B)

- BMI 35 prior to this pregnancy
- Eats two large meals/day; typically fast food items
- Works 40 hours/week and has no time for exercise
- Received breastfeeding education & wants to try it



8

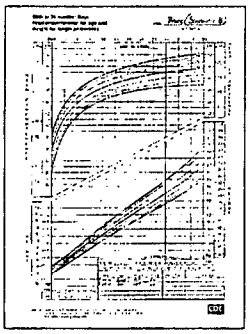
Infant Feeding Choices

- Matilda chose to breastfeed and tailored her diet based on the nutrition counseling that she received
- Infant breastfeeds on demand.
- Matilda's workplace provides nursing mothers a place to pump and break time, thus she is able to continue to provide breast milk to her infant while working.

9

Bruce's Growth

- Birth
  - Weight 8 lbs
  - Length 20 inches
  - Breastfed, delays early introduction of solids
- Six Months
  - weight – 14 lbs
  - height – 24 inches
  - wt/ht percentile = 50th-75th
  - Within normal range



10

Matilda (6 months postpartum)

- Overweight (BMI = 30)
- Busy taking care of new infant and working 40 hours/week, able to pump milk at her worksite.
- Takes advantage of her local Farmers' Market.
- Chooses lower calorie, low fat foods options at her fast food job when able.
- Walks in her neighborhood.

11

What Made the Difference ?

- Infant Feeding Choice
  - Exclusively breastfed
  - Delayed Introduction of solid foods
- Post Partum Weight Loss
  - Side benefit of breastfeeding

12

Where Do Children Eat?

- Home
- Child Care
- School
- Outside of the Home
  - Restaurant
  - Fast food
  - Friends



13

Best Practices- Opportunities for North Carolina

- Breastfeeding Promotion and Protection
- Child Care
- Schools
- Local Wellness Plans

Previous Discussions

- Farm to school, Farmers Markets
- Physical Activity
- Built Environment

14

Promoting, Protecting and Supporting Breastfeeding

A North Carolina Blueprint for Action
2006



15

Breastfeeding Promotion Opportunities

- Communities
- Workplace
- Child care facilities
- Health care facilities
- Education

16

Federal Nutrition Assistance Programs

- SNAP- Supplemental Nutrition Assistance Program (food and nutrition benefits)
- WIC- Special Supplemental Nutrition Program for Women, Infants and Children
- CACFP- Child and Adult Care Program
- SFSP- Summer Food Service Program
- NSLP- National School Lunch Program
- School Breakfast Program

17

Child Care Enhancements

NAP SACC

Color Me Healthy

preschoolers moving & eating healthy

18

CACFP Federal Meal Requirements

- Food Based not nutrient based.
- Daily Requirement
- Not required to meet Dietary Guidelines for Americans or be updated regularly

Institute of Medicine Committee convened January 2010 to study.

19

Child Care Menu Enhancements

- Whole milk
- Juice
- Meat and Meat substitutes
- Enriched Grain
- Reduced Fat Milk
- Limit processed meats- Vienna sausages, baloney, hot dogs
- No juice under 12 months of age, limit for all others
- All grain products no more than 6 grams of sugar
- Limit sweet grains and baked goods

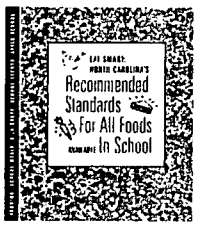
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School Opportunities

DPI ---DPH Coordination

21

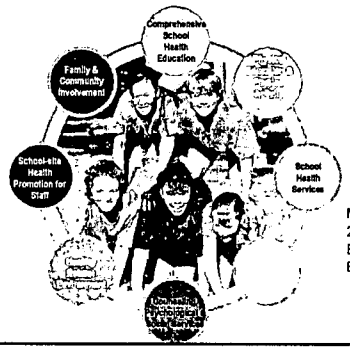
Eat Smart School Standards



Project Partners

22

8 Components of a Coordinated School Health Approach



Middle & High Schools 2002-2010.
Elementary Schools Beginning 2012.

23

NC Healthy Schools Nutrition Priority School Level Impact Measure (SLIM)

% of schools that do not sell the following foods and beverages anywhere at school outside the school food service program:

- Baked goods that are not low in fat (e.g., cookies, crackers, cakes, pastries)
- Salty snacks that are not low in fat (e.g., regular potato chips)
- Chocolate Candy &Non-chocolate candy
- Soda pop or fruit drinks not 100% juice
- Sports Drinks

'08 Baseline 32% '13Goal >36%



24

Local Wellness Policy

Requirements

- Federal Public Law 108.265 Section 204 --by June 30, 2006 all schools must develop Local Wellness Policy
- Involving parents, students, School Food Service, school board, school administrators and the public
- LEA will establish a plan for measuring implementation of the LWP

25

Key Areas

- Nutrition education
- Child Nutrition Programs in compliance
- Physical activity
- All foods/beverages available on campus
- School-based activities designed to promote student wellness
- Food safety and security
- Healthy and safe school environment

26

Local Wellness Policies- A Work in Progress

- Advocacy Toolkit
- Community Outreach
- Training and Presentations



27

Please see below and let me know if this is helpful.

- Federal OMB Circular 87 defines "Indirect Costs" as those incurred for common or joint purposes, that benefit more than one activity. This is a definition applied to all federal grants and federally funded activities.

- As applied to the Child Nutrition Program Indirect Cost covers such items as
    1. Gas
    2. Electricity
    3. Sewer
    4. Water
    5. Trash
    6. Employee Benefits

- In 2006 the School Nutrition Association conducted a 50-state survey of Child Nutrition programs and found inconsistent policies were applied across the states.

- In fact, not all states/school districts charge their Child Nutrition Program an Indirect Cost rate. Though the number that do, has been increasing.

- Furthermore, there are at least 30 different ways to calculate the amount of Indirect Cost to be charged to a Child Nutrition Program
    1. Fixed rate
    2. Provisional rate
    3. Proportion of FTEs
    4. Proportion of Square Feet
    5. etc.

Questions:

1. Of the more than 30 different ways to calculation Indirect Costs; What method is used by DPI and/or LEAs to calculate the amount of Indirect Costs for a CN program?
   a. What are the strengths and weaknesses of such an approach?

2. Once calculated, a NC 2006 study, found that CNs are charged between 0 and 100% of their indirect costs.
   a. Please Comment on this variation.
   b. Why does such a wide variation exist?

3. Why isn't there a statewide standard?

4. In 2007, a DPI Committee put forth 5 recommendations concerning Indirect Costs, they were:
   1. Conduct a 50-state study of how other states are addressing this issue.
   2. Educate School Boards on the issue
   3. Child Nutrition programs should accumulate 3-month balance in operations before a Indirect Cost is charged to a CN.
   4. Requiring more transparency through a Cost Allocation Plan defining Indirect Costs on the local level.
   5. Seek from the AG an interpretation of Chapter 115C-264.

What is the status of these recommendations?

Salud America!

The RWJF Research Network to Prevent Obesity Among Latino Children

Volume 2, Issue 3, Winter, 2009-2010

Inside This Issue

Page 2: Director's Corner, News & Funding

Page 3: Stepping Up Against Latino Childhood Obesity

Page 4: Grantee Corner

Page 5: Grantee Corner

Page 6: Research

Page 7: Policy & Built Environment Corner

Page 8: Kids' Health Corner

Find Us Online

Follow us on **Facebook**, **Twitter** and **YouTube**!

Got a News Item?

We welcome your news items, story ideas and suggestions. Please e-mail **despres@uthscsa.edu** to be featured in the E-newsletter.

Salud America! leaders unveil Web site, blog to improve Latino health



Watch the new video by *Salud America!* on Latino childhood obesity on SaludToday's YouTube page.

The leadership team behind *Salud America!* recently unveiled a new Latino health Web site and blog, SaludToday, to promote healthier lifestyles among Latinos.

The new site, found at **www.SaludToday.com**, features a **blog** with the latest news, research and real-life stories about Latino cancer, obesity and other health topics, as well as videos, resources and the capability for people to share the stories of their own successes in leading healthier lives.

Follow SaludToday on **Facebook**, **Twitter** and **YouTube**.

For example, you can go to YouTube to view the popular *Salud America!* video that dramatically frames the issue of Latino childhood obesity.

You can also check out six new public service announcements (PSAs) in English and Spanish. The culturally relevant PSAs show the benefits of preventative screening for breast, cervical and colorectal cancer among Latinos. The PSAs were produced through *Redes En Acción:* The National Latino Cancer Research Network, an NCI-funded initiative to combat cancer among Latinos. *Redes* is led by the leaders of *Salud America!*

Continued on page 8 ▷

Robert Wood Johnson Foundation

Salud America! The RWJF Research Network to Prevent Obesity Among Latino Children is a national program of the Robert Wood Johnson Foundation. The program aims to unite and increase the number of Latino scientists engaged in research on childhood obesity among Latinos to seek environmental and policy solutions to the epidemic. The network is directed by the Institute for Health Promotion Research at The UT Health Science Center at San Antonio. For more information, visit **www.salud-america.org**. The *Salud America!* E-newsletter is distributed quarterly to its national membership network.

Director's Corner

Letter to members from Dr. Amelie Ramirez


Ramirez

Since starting *Salud America!* in late 2007, we've worked to increase awareness about Latino childhood obesity among researchers, policy-makers and community leaders.

I have sounded the horn at dozens of meetings in the past two years.

Most recently, I **spoke** about Latino childhood obesity challenges and potential policy solutions at the American Public Health Association's 137th Annual Meeting in November 2009 in Philadelphia.

I also spread the word through the webinar **series** "Let's End the Childhood Obesity Epidemic," hosted by the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity. I also was a respondent at the Southern Obesity Summit in Austin, Texas, and spoke about Latino childhood obesity as the keynote speaker at a National Hispanic Heritage Month event in Rockville, Md., in October 2009.

Meanwhile, we continue to keep you updated on the latest Latino childhood obesity news and research in our E-alerts and E-newsletters.

In addition to helping more people learn about the challenges Latino children face in leading healthier lives, *Salud America!* has focused on building the field of Latino researchers to find solutions. Our 20 pilot projects are busy working in Latino communities to make positive changes. Please check out our new Grantee Corner on Pages 4 and 5 to learn more about the pilot researchers and their work.

We hope we continue to inspire you to take a closer look at Latino childhood obesity and contribute to reversing this alarming epidemic.

As always, please be sure to frequently check our **Web site** for updates on our and **others'** efforts to address Latino childhood obesity.

Amelie G. Ramirez, Dr.P.H.

Director, *Salud America!*
Director, Institute for Health Promotion Research at The University of Texas Health Science Center at San Antonio

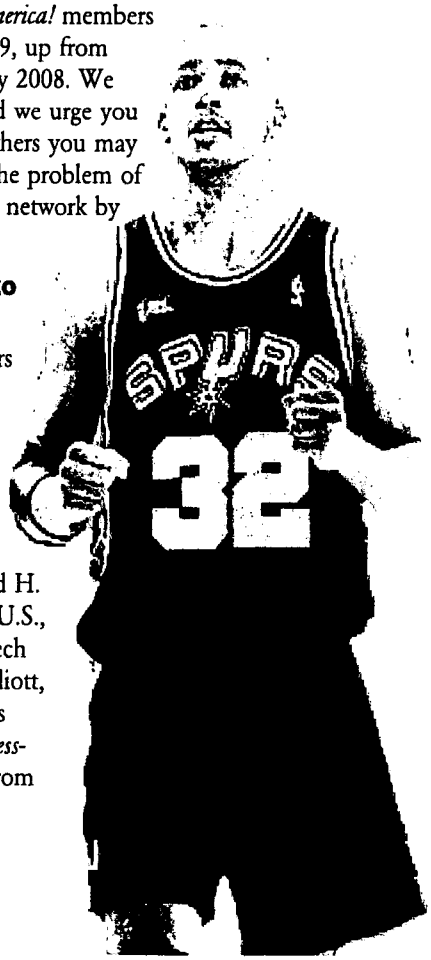
News Briefs

Salud America! membership number rises

The number of *Salud America!* members has grown to 1,525 as of December 2009, up from 1,280 in December 2008 and 785 in July 2008. We are gaining new members every day, and we urge you to invite colleagues to join, as well as others you may know who are interested in addressing the problem of obesity among Latino children. Join the network by clicking **here**.

Summit Report details efforts to reverse Latino child obesity

Have you heard what the nation's leaders and researchers said to address Latino childhood obesity at out Inaugural *Salud America!* Scientific Summit? If not, be sure to check out our Summit **Report** to find out the details from the summit, held September 9-11, 2009 in San Antonio, Texas. Dr. Richard H. Carmona, 17th Surgeon General of the U.S., was our keynote speaker. Watch his speech **here**. Other special guests were: Sean Elliott, a former San Antonio Spur (at right); his wife Claudia Zapata, a *San Antonio Express-News* health columnist; and a message from champion cyclist Lance Armstrong.



Funding Opportunities

Improving Diet and Physical Activity Assessments

Several National Institutes of Health (NIH) agencies are seeking **applications** for grants to support research to enhance the quality of measurements of dietary intake and physical activity. Applications may include development of assessment tools for culturally diverse populations and more. Letters of intent are due May 5, 2010.

NIH Grants

The National Institutes of Health (NIH) compiles a wide variety of obesity-related research funding **opportunities** that are currently seeking applications.

Stepping Up Against Latino Childhood Obesity

Latina mother strives to improve health of her kids, community

Unhappy with unhealthy menu items at restaurants near her San Diego home, Xinia Sanchez called and visited eateries to ask chefs and owners to serve healthier food.

Many slammed the door in her face.

But the mother of two teens was surprised when some listened–and added healthier food choices, like fruit cups, whole-wheat sandwiches, lean turkey and low-fat options.

"Mothers need to ask for what they need for their children," Sanchez said. "It doesn't hurt to have your voice heard. It can help everyone if you speak up."

Xinia Sanchez' **story** is just one of many mothers, including several Latinas, featured in the new *Be Well Book* from the Alliance for a Healthier Generation.

The book showcases moms working to establish life-long, healthy habits in their kids with the hope that their stories will inspire other parents. It is available free **online**.

Sanchez, who has a daughter, 19, and son, 17, believes that what goes on a child's plate should look like a rainbow. Colorful, natural foods are usually free from artificial ingredients and packed with vitamins and nutrients.



Watch the video of Xinia Sanchez' story, part of the new Be Well Book that showcases mothers who help make their families healthier.

She also found substitutes for her favorite Latino recipes–like vegetarian quesadillas with whole wheat tortillas, onions, red pepper, corn and veggies.

Sanchez also instructs her kids to exercise for at least an hour a day.

And she brings these healthy messages to the community, too, working with a university and health agency to do seminars on nutrition, exercise, and healthy living.

"I can't think of a better gift to give your children than strong bodies and minds," she said.

Salud America! NAC

Elva Arredondo
Marice Ashe
Laura Brennan
Nancy Butte
Anna Diez-Roux
Robert Garcia
Lawrence Green
▶ **Robin Hamre**
Terry Huang
Barbara Israel
Laura Kettel Khan
Judith Ottoson
Frank Penedo
Charlotte Pratt
Maya Rockeymoore
James Sallis
Schwartz
Story
Elsie Taveras
Mildred Thompson
Amy Lazarus Yaroch

Meet the National Advisory Committee

As a registered dietitian in Iowa in the 1990s, Robin Hamre was alarmed by how she was seeing chronic diseases that were once found only in adults, such as type 2 diabetes and hypertension, in more and more children.

"I decided I needed to do more than work with one person at a time. I knew we had to change the system to prevent obesity," Hamre said.

To change the system, Hamre joined the U.S. Centers for Disease Control and Prevention (CDC) as a health scientist in 1999 and is now a public health analyst who develops and cultivates partnerships across the nation to prevent obesity and other chronic diseases.

Much of her work at the CDC has had a system-level impact. For example, she led a nutrition and physical activity program that provided states with $16 million per year for training on weight management and social marketing; workshops on nutrition, activity and obesity program development; and program sustainability.



Robin Hamre

She also co-led a study on the benefits of a national practice-based research network of clinicians to prevent childhood obesity.

In her current role with the CDC's Division of Nutrition, Physical Activity and Obesity, Hamre examines the political, economic and public health environments to spur collaborative efforts to prevent obesity.

She also wants more Latino researchers, members of the media and families to work together to increase healthy environments and healthy lifestyles.

"Spanish-language media may want to partner with public health to improve the choices Latino families make," Hamre said. "I also would like to see Latino children more involved in the change they want to see for their families–access to healthy food, pricing policies for food and more safe places to play."

Grantee Corner

Meet *Salud America!* Grantee Myriam Torres



Myriam Torres

Myriam Torres, a South Carolina researcher who has a strong record of improving minority health, knows the critical situation of Latino health in her state.

South Carolina's Latino population surged 342 percent from 1990 to 2005.

Most Latinos here have spent less than eight years in the U.S. and many aren't English proficient and are uninsured.

More than 17 percent of Latino children here are obese, compared to less than 12 percent of whites, and they don't meet physical activity recommendations.

These factors make obesity prevention a top priority, Torres said.

And that's why, thanks to *Salud America!* pilot funding, Torres and her colleagues created *Juntas Podemos* (Together We Can), in which Latina mothers will photograph the neighborhoods their children live in, in order to convince civic leaders to make healthier environments in West Columbia, S.C.

"As a Latina, I cannot have peace seeing all the needs around me and doing nothing, so we thought about effective ways to help prevent the obesity epidemic among children," said Torres, a clinical assistant professor of epidemiology at the University of South Carolina. "We thought that empowering the mothers is the best way to attack any problem."

Torres is one of 20 pilot researchers funded by the Robert Wood Johnson Foundation through *Salud America!* for $75,000 over two years.

Torres' pilot project, *Juntas Podemos*, began in July 2009.

Juntas Podemos will:

- set up an advisory group of mothers, researchers and city/school officials;
- give mothers cameras to document children's play and barriers to play;
- interview school officials about children's play behaviors;
- analyze results in focus groups; and
- present the findings and recommend policies to city/school officials.



Dr. Torres' research project, *Juntas Podemos*, will use Photovoice, a strategy that combines photography with grassroots action to reduce obesity among Latino children in South Carolina.

"We believe Latina mothers will generate policy recommendations about opportunities for physical activity for children," Torres said.

Torres sees her project as a new part of her already vast experience trying to improve the health of Latinos in South Carolina.

As a PhD student at the University of South Carolina, she first got involved in Latino issues by helping on a Latino-focused research grant led by her mentor, Caroline Macera.

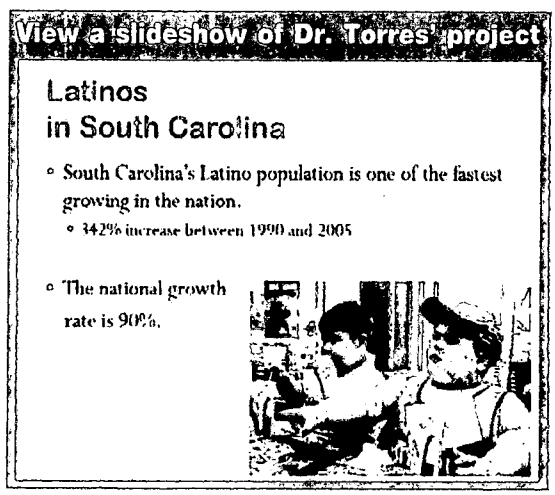
Today she directs the University of South Carolina's Consortium for Latino Immigration Studies. The consortium, created in 2004, promotes and coordinates interdisciplinary and transnational research on the experiences of Latinos in South Carolina and the Southeast.

Her research has included: a statewide Latino health needs assessment; a study on the use of preventive health services among different Latino populations; a perinatal HIV prevention program for Latinas; a study on the economic impact of Latinos on South Carolina; and a study looking at the effects of the economic recession and South Carolina's 2008 immigration law on Mexicans living in the state.

She is a member of many local, regional and state Latino community groups, and often brings her research findings to these venues. She also provides cultural competency training where needed.

And now Torres hopes *Juntas Podemos* can reduce Latino childhood obesity rates.

"We think our project will empower Latino families," she said, "and help them think about childhood obesity and develop solutions that can work for them."



Grantee Corner

Meet *Salud America!* Grantee Robert Dudley



Robert Dudley

As early as high school, Robert Dudley wanted to be a scientist–white coat, goggles, test tubes, the whole lab experience.

He even started working at a blood lab during college.

But the lab's educational director got Dudley involved in helping local high-school teachers learn about immunology and design projects for their classes.

"The experience gave me a love for education and the effect that science can have at the human level that moved me to go into medicine," said Dudley, who got his medical degree from the University of Pennsylvania and now is a pediatrician at the Community Health Center, Inc., a nonprofit that provides affordable health care in Connecticut.

Today Dudley is still using science to help people for his new *Salud America!*-supported pilot project, an evaluation of his center's Healthy Tomorrows for Teens (HTT) program and its ability to help teen girls at Connecticut's largest high school, New Britain. More than half of New Britain students are Latino.

HTT is an existing program that encourages healthy lifestyles among New Britain girls with nutrition counseling, YWCA fitness programs and community service projects.

But so far, Latinas haven't consistently participated in HTT.

So Dudley's pilot project, one of 20 funded by the Robert Wood Johnson Foundation through *Salud America!* for $75,000 over two years, aims to evaluate HTT's strengths and weaknesses to spawn new knowledge of what spurs participation by Latinas and improve the program's ability to engage Latina teens in healthy lifestyles.

"We want to understand and overcome barriers to consistent engagement by Latina teens," said Dudley.

In a recent survey of New Britain ninth-graders, Latinas were more likely to be obese and dissatisfied with their weight than their white or black counterparts. Latinas also were the least likely to be physically active.



Dr. Dudley's project will use Photovoice to research Latino children's activity and eating habits. Pictured is a group of Connecticut Latinas who made photo storyboards and presented them to officials.

More than half of Latinas at the school fail P.E. class, compared to 19 percent of whites.

"The magnitude of the obesity epidemic has really pushed us to target at-risk children and come up with innovative interventions," Dudley said.

Dudley's pilot project will conduct:

- Focus group/interviews/Photovoice with five Puerto Rican teen girls
- Five focus groups with at least 35 Latino parents
- Five focus groups with at least 35 Latina teens, three with HTT participants and two with non-HTT participants
- Exit interviews with at least four long-term HTT participants

Dudley hopes the results will improve and sustain the existing HTT program, make P.E. more acceptable to Latinas and help the school engage girls in other activities that may help address school P.E. failure and high pregnancy rates.

It will also help the Spanish Speaking Center in downtown New Britain better serve low-income Latinos, as well as help the local YWCA target its services to Latinos.

"We want these organizations to have the information needed to work together to improve services that help Latina teens live health lifestyles," Dudley said.

View a slideshow of Dr. Dudley's project

Community Health Center, Inc.

Healthy Tomorrows for Teens
A Mid-course Evaluation

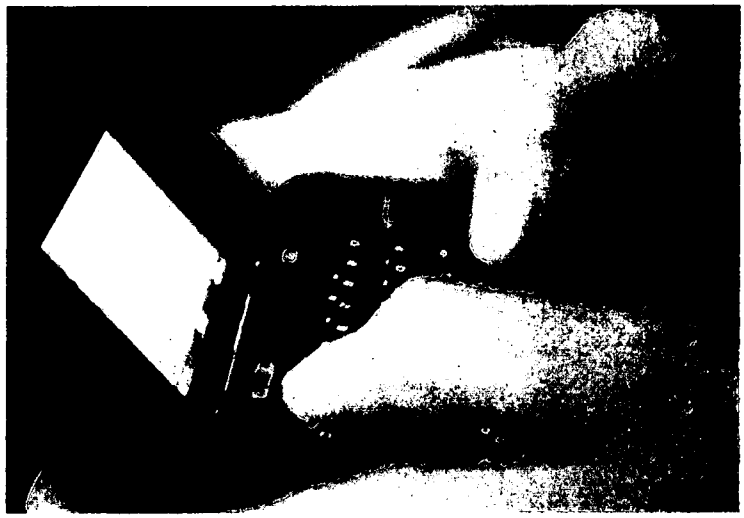
Robert Dudley MD, MEd, FAAP
Community Health Center, Inc
New Britain, CT

Research

OMG! IHPR/GrlScouts txtng 2 get Latina grls 2 xrciz

Through teen-friendly text messaging and Girl Scouts, the new "Physical Activity Partnership for Girls" aims to increase fitness among Latina girls in San Antonio, Texas.

The partnership, led by the Institute for Health Promotion Research (IHPR) teams local universities with community groups to try to boost activity and reduce sedentary behaviors among Latinas ages 11-14 through text messaging, Girl Scout troop activities and community outreach.



From the Southwestern University's Megaphone Online

"We think using 'kid-popular' technology and the partnership of academics, community leaders and Girl Scouts will help Latina girls, who have higher obesity rates than other youths, be more active," said IHPR researcher Dr. Deborah Parra-Medina, who directs the partnership, funded by the American Recovery and Reinvestment Act of 2009.

Partners include:

- The IHPR at The UT Health Science Center at San Antonio
- UTSA (Health & Kinesiology, Electrical & Computer Engineering)
- Girl Scouts of Southwest Texas
- The Edgewood Family Network in San Antonio

These agencies will work together to understand what impacts Latina girls' activity through parent focus groups, in-depth interviews and media surveys.

Girl Scouts also will create photo essays and maps of their activity environment.

Project partners then will design a culturally competent intervention to inspire Latina girls to participate in an hour of moderate-to-vigorous physical activity a day and reduce sedentary activities.

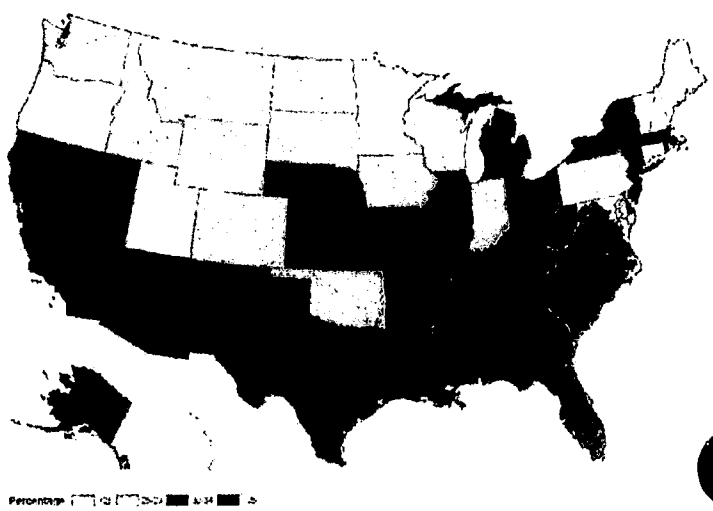
Girl Scout troops will be randomized into regular programming or the new intervention, which will deliver health messages through cell phone texts, troop leaders and outreach.

"We think this technology-savvy, collaborative project can boost activity, enjoyment of activity and cardiorespiratory fitness among local Latina girls," said Dr. Parra-Medina. "If it does, this program can be used by Girl Scouts across the nation."

Research Briefs

Report: Childhood obesity rates higher in Southern U.S.

The Robert Wood Johnson Foundation Center to Prevent Childhood Obesity has released a **fact sheet** on Southern obesity that shows disproportionately higher rates of childhood obesity here compared to the rest of the U.S. The eight states with the highest percentages of overweight or obese children are all in the South. In every Southern state except Oklahoma, at least 30 percent of children are overweight or obese. Income, race and ethnicity, and education are part of the problem. At all income levels, African-American and Latino children were in worse health than whites. White boys born in 2000 have a 27 percent risk of being diagnosed with diabetes during their lifetimes, while African-American and Latino boys have a 40 and 45 percent lifetime risk, respectively.



Percentages of Overweight or Obese Youth Aged 10–17 Years in 2007

Policy and Built Environment Corner

Lessons learned: Increasing physical activity in special populations

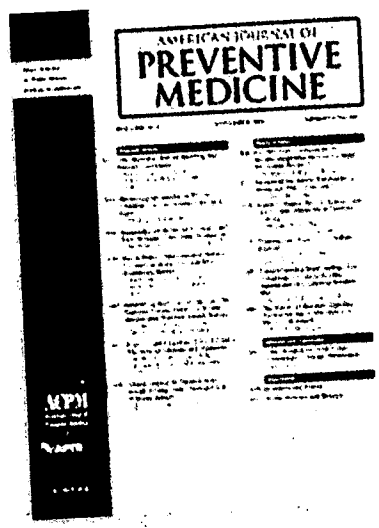
The Active Living by Design program, community action model and lessons learned from 15 grantee communities are featured in a supplement of the December 2009 edition of the *American Journal of Preventive Medicine.*

The practice-based special issue describes community partnerships representing a range of lead agencies with emphasis on increasing physical activity in special populations, including children and Latinos.

There are examples of the process of planning and implementing comprehensive approaches to increase community levels of physical activity, including how to engage partners, secure resources, increase community participation, design policy and environment interventions, increase political or community support, address challenges or minimize barriers, and keep the momentum going over time.

One of the supplement's articles features the success of the Active Living Logan Square, an urban Chicago community of 84,466 residents, mostly Latinos.

Through the Active Living by Design initiative, the Logan Square Neighborhood Association leveraged its 48 years of existence in the neighborhood to create opportunities and build partnerships.



The partnership successfully piloted Open Streets (temporary street closures) and advocated for development of the Bloomingdale Trail, an elevated rails-to-trails project. In schools, the partnership changed the culture at McAuliffe Elementary to support healthy behaviors through new policies, physical projects and programs.

Also featured are commentary on establishing best practices for changing the built environment to promote physical activity and **implications** for state and local officials.

Policy & Built Environment News Briefs

RWJF Center highlights federal policy issues

The RWJF Center to Prevent Childhood Obesity sends weekly email updates on policy and legislative issues and federal agency news. To learn more about the Center, visit its Web **site**. Click on "Stay Informed" to sign up for the email updates.

RWJF Center highlights key local strategies to address childhood obesity

The RWJF Center to Prevent Childhood Obesity has also produced a **document** that highlights the leading policies, from the Institute of Medicine, Centers for Disease Control and Prevention, and Leadership for Healthy Communities, that are most likely to change the local landscape to enable our children to achieve a healthy lifestyle and enable communities to reverse the obesity epidemic.

Healthy Kids, Healthy Communities expands to 41 communities

In an effort to spur action at the local level to reverse the childhood obesity epidemic, the RWJF is expanding a landmark national program to create communities where children and their families have access to healthy, affordable foods and safe places to play and exercise. Healthy Kids, Healthy Communities–one of the Foundation's largest and most ambitious community-action **initiatives** ever–is a cornerstone of RWJF's $500 million commitment in childhood obesity prevention. A total of 50 sites are being funded through this program to craft innovative solutions aimed at helping children and families lead healthier lives. One of the **sites** working to prevent childhood obesity is in is San Antonio, Texas.

An annotated resource book for built environment and physical activity

The annotated resource **book** for Healthy Kids, Healthy Communities includes a variety of resources for communities working on physical activity and the built environment. The guide is organized by different topic areas, some of which include: youth engagement, safety and crime, and land use and transportation. It also includes action tools and a list of organizations working to build the connection between physical activity and the built environment.

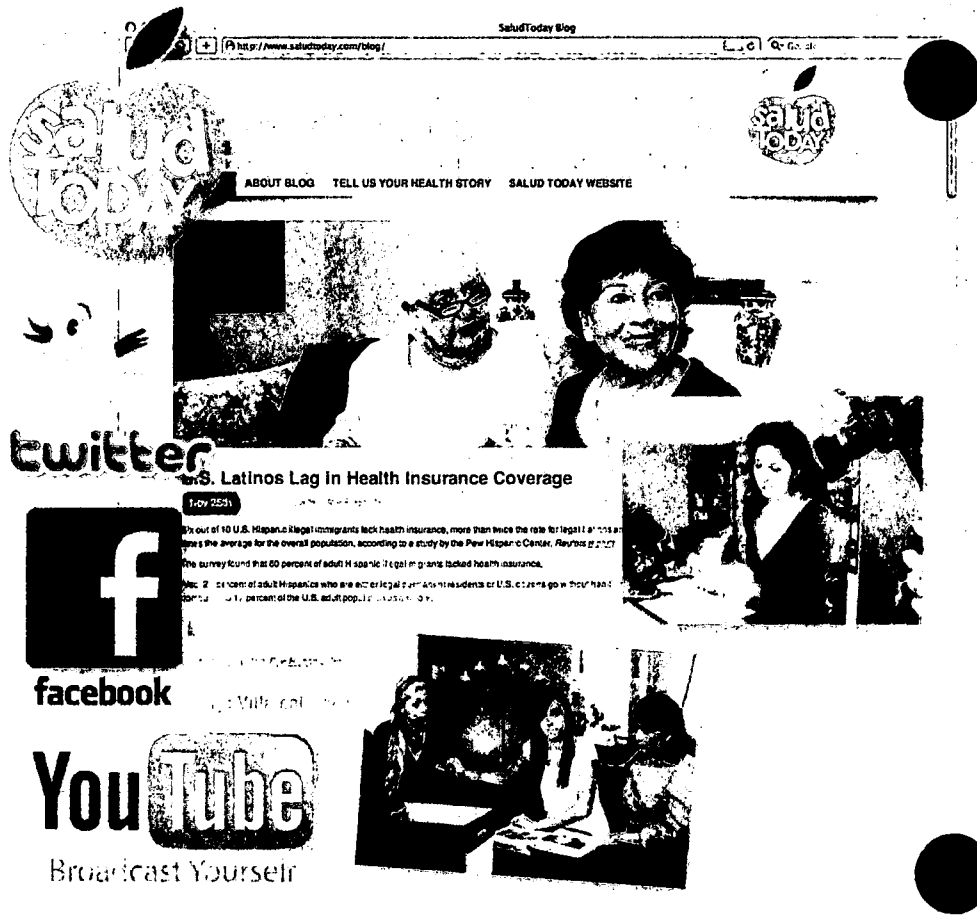
New Latino health web site, blog

▶ Continued from page 1

The new site also features the latest resources on health. For example, visitors can find out how to get local or national cancer information in Spanish, find out the best steps to take to quit using tobacco, or find a cancer clinical trial near them.

In all, the new site, blog and social network connections aim to catalyze Latino families, community leaders and health researchers to reduce and prevent health disparities.

"By bringing Latinos the latest stories, news and events regarding Latino health through a blog and social media and encouraging them to contribute their own insight and stories, we hope we can make huge leaps in improving Latino health," said Dr. Amelie G. Ramirez, director of *Salud America!* and the Institute for Health Promotion Research (IHPR) at The UT Health Science Center at San Antonio, which developed SaludToday.



About the E-newsletter

This E-newsletter is produced quarterly by *Salud America!* Please send news items or story ideas to **despres@uthscsa.edu**.

Editor: Cliff Despres

Contributor: Cliff Despres

Design: Jeffrey Heinke Design

Salud America! The RWJF Research Network to Prevent Obesity Among Latino Children

Principal Investigator, Dr. Amelie G. Ramirez

The Institute for Health Promotion Research

The University of Texas Health Science Center at San Antonio

(210) 562-6500 • **IHPR.uthscsa.edu**

Salud America! is a national program of the Robert Wood Johnson Foundation. The program aims to unite and increase the number of Latino scientists engaged in research on childhood obesity among Latinos to seek environmental and policy solutions to the epidemic. The network is directed by the Institute for Health Promotion Research at The UT Health Science Center at San Antonio. For more information, **click here**. To learn more about the Robert Wood Johnson Foundation's efforts to combat childhood obesity, **click here**.

Kids' Health Q&A

Many adults are setting New Year's resolutions to get fit. But when it comes to kids, how much physical activity do they need?

Children and adolescents should do **1 hour or more** of physical activity each day, according to the U.S. Centers for Disease Control and Prevention.

This may sound like a lot, but many children already meet the Physical Activity Guidelines for Americans. If they aren't meeting recommendations, encourage your child to participate in activities that are age-appropriate, enjoyable and offer variety.

Just make sure your child or adolescent is doing three types of physical activity:

Aerobic activity should make up most of your child's 60 or more minutes of physical activity each day. This can include either moderate-intensity or vigorous-intensity activity. Be sure to include vigorous-intensity aerobic activity on at least three days a week.

Include muscle-strengthening activities, such as gymnastics or push-ups, at least three days a week as part of your child's 60 or more minutes.

Include bone-strengthening activities, such as jumping rope or running, at least 3 days a week as part of your child's 60 or more minutes.

To find out exactly what counts as aerobic-, muscle- and bone-strengthening activities for kids, click **here**.

PREVENTING OBESITY BY DESIGN (POD)

< back to the list



Workshop with all three centers

ABOUT POD

Preventing Obesity by Design (POD) is aimed at reversing the trend toward childhood obesity by improving OUTDOOR ENVIRONMENTAL DIVERSITY of childcare centers, which research suggests can increase children's level of physical activity, increase time spent outdoors by children and teachers, and increase children's awareness of vegetables, fruit, and nuts as healthy foods. Project POD considers design of outdoor environments in early childhood as a preventive health intervention.

The project is driven by a) evidence that young children learn most effectively (good nutritional habits for example) through hands-on experience, and b) evidence that being outdoors is critical to children's physical development (outdoor environments are correlates of physical activity; green environments in particular support attention functioning). In addition, understanding food selection and preparation may support the development of lesson plans related to language, math, science, the arts, and others.

Three childcare centers were selected from 30 participating in the current NLI/NIEHS project for which baseline data had been gathered.

The project is divided into four activities:

1. TEACHER TRAINING on the use of the outdoors to promote physical activity and healthy nutrition
2. PARTICIPATORY DESIGN ASSISTANCE to preschool staff/volunteers to help them modify their outdoors to support children's daily nutritional and physical activity needs
3. START-UP INCENTIVES to buy plant materials and tools and honoraria to support lead teachers to implement projects
4. DISSEMINATION of information to ensure transfer of knowledge. The three projects will act as catalysts for change by other NC childcare providers

The LONG TERM GOAL is to generate and transfer knowledge to create a cultural re-alignment of care for young children emphasizing the importance of the outdoors as a preventive health strategy.

POD is supported by the Blue Cross Blue Shield of North Carolina Foundation.
Thank you for your support!

BlueCross BlueShield of North Carolina Foundation

Would you like to convert your Current playground into a magical wonderland of nature exploration for your students?

APPLY FOR POD

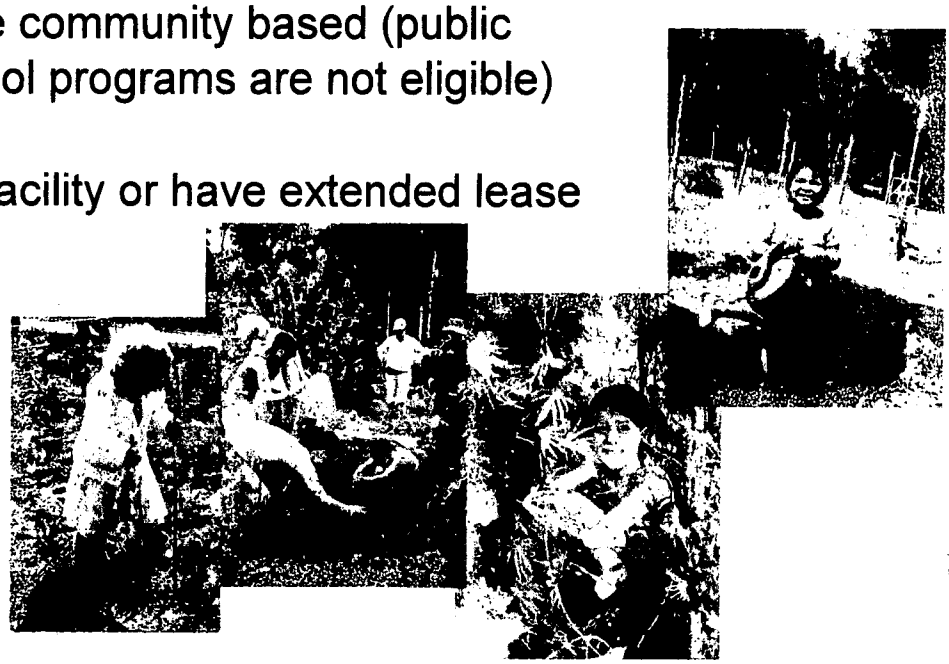
If chosen for the Preventing Obesity by Design (POD) project you will receive staff training in garden design, technical assistance from landscape architects and children's play specialists from NC State, we can help you plan a fun filled landscape for your children to learn and grow in a natural environment right outside the door of your classrooms that will meet all childcare licensing guidelines.

To Qualify Program Must:

Be participating or able to participate in a Quality Enhancement or Quality Maintenance project with CCSA TA

Be community based (public school programs are not eligible)

Own facility or have extended lease



For Questions Please Contact Maria Hitt (967-9091) or Elyse Cepull (967-3272) CCSA TA department
Deadline for Application March 5, 2010

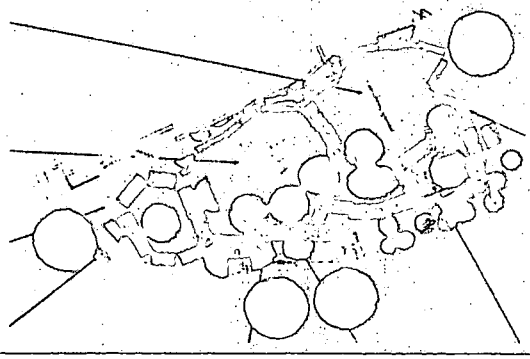
Preventing Obesity by Design (POD)

Community School for People Under Six

Sponsored by the Blue Cross Blue Shield of North Carolina Foundation

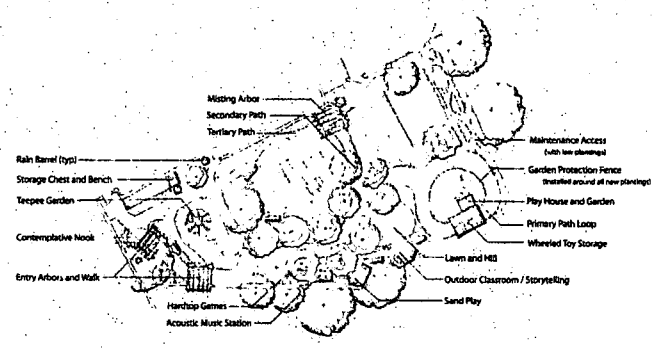
Design Workshop





Schematic Design

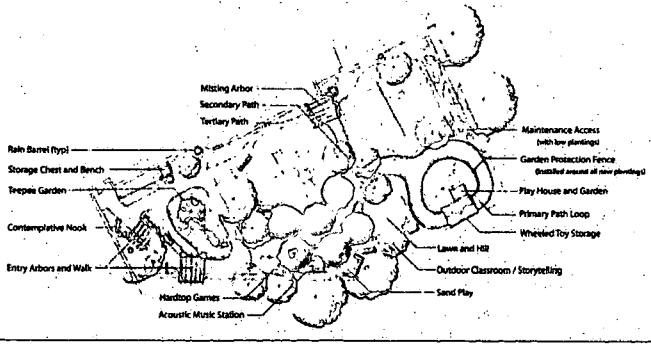
Following the design workshop with the participants, the NLI team organized an in-house design charrette to refine the conceptual designs based on the activities, character, and behavior settings defined by each center. Site circulation, relationships of elements, proposed vegetation, and shade were considered. A rendered and labeled draft schematic plan was produced for review by the centers, and with their input, the final schematic plan was produced by the NLI team.



Phase I

The final schematic design for the full site was presented to individual centers using a Power Point format. The presentation described each of the behavior settings and interrelationships between them. Since the mini-grants only supported a part of the final schematic plan, the first wave of improvements (phase one) was identified in collaboration with the center directors.

For phase one the decision was made to implement a circuitous mulched path system which was located directly outside of the safety zone of the existing climbing structure. Also, six Crape Myrtle trees and groundcovers were planted along the path for shade and definition. A teepee structure with vines was added and a garden was planted around it. Finally a small tree was planted near the existing climbing structure for shade.



Installation

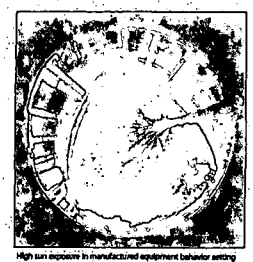




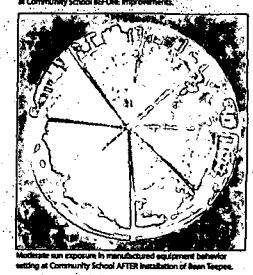


POEMS Evaluation & Skyview Factor

Item #		Common Sq. Footage
1.1	Entry and Path Design-Appropriate	1
1.2	Welcoming Impression	1
1.3	Place for Social Interaction	1
1.4	Learning Areas are Balanced	1
1.5	Outdoor Area is Fenced	1
1.6	Classrooms Have Outdoors Receive Adequate Sun and Exterior Shade	1
1.7	Windows- At the Children's Eye Level	0
1.8	Windows- Opened to Allow Fresh Air	1
1.9	Open Directly Outdoors into Usable Transition Spaces	1
1.1	Shaded and Dry Entrance- Adequate	1
1.11	Overall Impression of the Outdoors is of a Natural Area	1
1.12	Outdoor Space is Easily Accessible by Children	1
1.13	Shade is Provided	1
	TOTAL	11
Item #	INDOOR TECH: Play and Learning Settings	
2.1	Learning Settings with Constructed or Manufactured Elements	1
2.2	Artistic Elements	1
2.3	Multipurpose, Open, Gallery Area	1
2.4	Horizontal, Elevated Work Surfaces	1
2.5	Circulation Areas are Ample	1
2.6	Play Materials and Equipment - Appropriate	1
2.7	Enough Outdoor Toys can be Reached	1
2.8	Play Materials and Toys can be Reached	1
2.9	Wheeled Toys - Are Available	1
2.1	Privacy is Adequate	0
2.11	Manufactured Loose Parts are Available	1
2.12	Natural Loose Parts are Available	1
2.13	Decorative, Colorful, and Stimulating Elements	0
	TOTAL	10

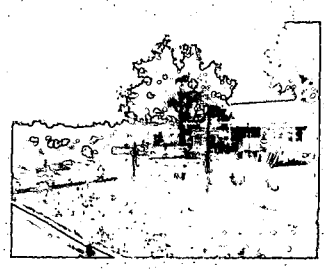


High sun exposure in manufactured equipment behavior setting at Community School BEFORE improvements.



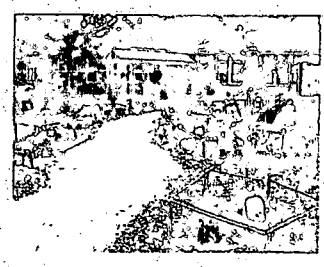
Moderate sun exposure in manufactured equipment behavior setting at Community School AFTER installation of Bean Teepee.

Before





After





SMART START PILOT GRANTS

Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC)

Final 2009 Evaluation Report

Iheoma Iruka, FPG Child Development Institute, UNC-Chapel Hill

Kelly Maxwell, FPG Child Development Institute, UNC-Chapel Hill

Joy Sotolongo, The North Carolina Partnership for Children, Inc.

Smart START

The North Carolina Partnership for Children, Inc.



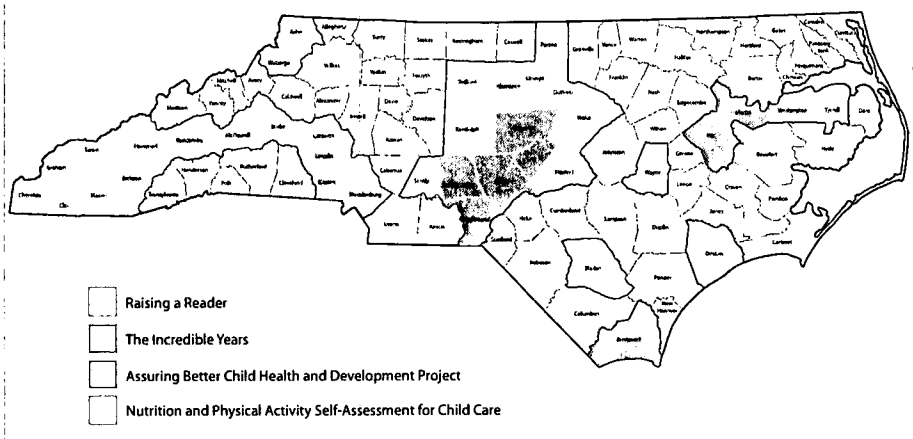
Overview of Smart Start Pilot Grant Program

The Smart Start Pilot Grant Program targets critical issues facing young children and their families. With limited resources, Smart Start adopted a strategic, high-impact approach by piloting evidence-based programs in a diverse range of communities across the state. To be selected, programs needed to: (1) be innovative, (2) produce clearly defined child or family outcomes, and (3) have the potential to become a statewide model.

Table 1. Critical Issues and Pilot Programs

Critical Early Childhood Issue	Smart Start Pilot Grant Program
Childhood obesity	Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC)
Identification of children with developmental delays or concerns	Assuring Better Child Health and Development (ABCD)
Pre-reading skills	Raising a Reader (RAR)
Parenting skills that address children's challenging behaviors	The Incredible Years BASIC Parent Training Program—Early Childhood (IY)

Figure 1. Counties Receiving 2007–2009 Grants



As of June 2009, 26 pilot grant programs finished implementation of these evidence-based programs in 38 counties (Figure 1).

Scope

This report focuses on the Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC) Pilot Grant Program and provides information about the program and its participants, findings, conclusions, and recommendations.

Table 2. Location and Distribution of Participating Centers

County	Number of Centers
Burke	11
Catawba	21
Guilford	33
McDowell	4
Mecklenburg	14
Orange	9
Person	7
Stanly	9
Wake	10
Wayne	10
TOTAL	**128**

Table 3. Star Ratings of Participating Centers

Star Rated License Level	Number of Centers
★	1
★★	0
★★★	65
★★★★	51
★★★★★	11

The Obesity Epidemic and the Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC) Program

Obesity in kids is now an epidemic in the United States according to the National Institutes of Health.[1] In North Carolina, the percentage of children ages 2 to 4 who are overweight or at risk for becoming overweight has increased from 22% in 1995 to almost 32% in 2008.[2] Early childhood programs can play an important role in combating the obesity epidemic. Approximately 37% of North Carolina's children between the ages of 2 and 5 are enrolled in licensed child care centers,[3] and they may consume between 50% and 100% of their Recommended Dietary Allowances while at the center.[4]

The NAP SACC program partners with state-trained child care health consultants who work with early childhood programs to improve nutrition and physical activity practices and policies. Smart Start introduced NAP SACC in November 2007 with the intention that participating centers would demonstrate improvement in nutritional and physical activity practices as measured by NAP SACC data gathered before and after the program.

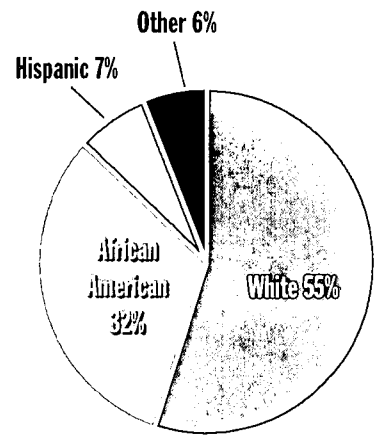
Participants

Between November 2007 and June 2009, the NAP SACC Pilot Grant Program reached 6,047 children between the ages of 2 and 5 years from 128 centers in 10 counties. Almost all of the participating centers had at least a 3-star rated license.

1. http://www.nih.gov/news/WordonHealth/jun2002/childhoodobesity.htm
2. North Carolina Nutrition and Physical Activity Surveillance System (2008) Retrieved on September 17, 2009 from http://eatsmartmovemorenc.com
3. North Carolina Office of State Planning and the North Carolina Division of Child Development
4. http://www.napsacc.org

Childhood obesity rates are especially high in ethnic minority children and children from low-income families.[5] Data show that the program reached children most likely in need of this intervention. Specifically, 46% of children birth through 5 years in the participating centers received child care subsidies and 45% were non-White (Figure 2).

Figure 2.
Ethnicity of Children in Pilot NAP SACC Centers[6]



NAP SACC Assessment

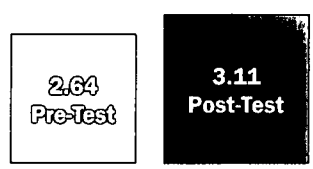
Child care programs implemented the NAP SACC program from November 2007 through June 2009. The *Nutrition and Physical Activity Self-Assessment for Child Care* (NAP SACC) survey[7] was used to determine changes in the quality of nutritional and physical activity practices and policies at each child care center. This survey includes 52 items measuring specific areas in nutrition, such as how often healthy food is offered, and specific areas in physical activity, such as providing time for active play. Participating center directors completed the NAP SACC assessment before they received technical assistance to improve nutritional and physical activity practices and policies and again after the program ended. Each center selected 2–3 key areas to improve; some focused more on nutrition, while others focused more on physical activity.

Findings

Nutrition

- Programs made significant gains in their overall nutrition practices. About half (52%) of the programs demonstrated significant improvement in their overall nutrition practices (Figure 3).
- The average nutrition practices rating before the program began was 2.6. At the end of the program, the average nutrition practices rating was 3.1.
- Significant changes were made in the following areas:
  - Meats, Fats, and Grains (e.g., lean meats instead of fried meats)
  - Beverages (e.g., water and milk instead of sugary drinks)
  - Menus and Variety (e.g., offering new foods)
  - Foods Offered Outside of Regular Meals and Snacks (e.g., offering healthy food during holidays)
  - Supporting Healthy Eating (e.g., staff and children eat together)
- Compared to 4- and 5-star rated child care programs, directors of 3-star rated programs reported greater reduction in children's consumption of fatty foods and sugary drinks as well as support for healthy eating.

Figure 3.
Nutrition Practices Scores



Scores range from 1 to 4 with higher scores reflecting best practices for nutrition.

5. Kumanyika, S., & Grier, S. (Spring 2006). Targeting interventions for ethnic minority and low-income populations. The Future of Children, 16(1), 187-207.
6. Percentages are based on children 2 to 5 years of age
7. Ammerman, A. S., Benjamin, S. E., Sommers, J. K., & Ward, D. S. (2004). *The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) environmental self-assessment instrument.* Division of Public Health, NC DHHS, Raleigh, NC, and the Center for Health Promotion and Disease Prevention, The University of North Carolina at Chapel Hill. Revised May 2007.

Figure 4.
Physical Activity Practices Scores



Scores range from 1 to 4 with higher scores reflecting best practices for physical activity.

Success Story

A child care center in Guilford County reported the following: Because of this program there have been many positive changes in our center. We improved our menu planning. We learned that it was okay to serve the children water instead of juice twice a week. We also began to serve different kinds of vegetables and beans instead of always using the standards such as green beans, corn and potatoes. The children really have enjoyed our menu changes and welcome trying different food items.

Another improvement in our center is that we now have a very nice room where the children can play and exercise during inclement weather. NAP SACC helped us get new equipment and toys for this room. Our teachers have learned how to interact in physical activities with the children. This makes exercise more fun for the children. We are very excited about how this wonderful program has improved our center.

Physical Activity

- Programs made significant gains in their overall physical activity practices. About half (53%) of the programs demonstrated significant improvement in their overall physical activity practices (Figure 4).
- Significant changes were made in the following areas:
  - Active Play and Inactive Time (e.g., frequent times for active play outside)
  - Play Environment (e.g., variety of safe play equipment)

Conclusion and Recommendations

The results from this evaluation suggest that child care directors who participated in the NAP SACC intervention reported statistically significant changes in their program's overall nutrition and physical activity practices.

According to center directors' reports, children's consumption of fatty foods and sugary drinks as well as support for healthy eating improved significantly after participating in NAP SACC.

NAP SACC is a promising intervention, thus future evaluations should include independent observations of nutrition and physical activity practices rather than relying solely on self-reported data from participating child care center directors. It may also be beneficial to determine the effectiveness of NAP SACC in lower quality programs (i.e., 1- and 2-star), particularly since this evaluation was primarily limited to 3-, 4-, and 5-star centers and directors of 3-star programs reported greater gains than directors of 4- and 5-star programs.

Smart Start thanks the Apple Gold Group and the BlueCross BlueShield North Carolina Foundation for investing in the NAP SACC program.

For more information about the Smart Start Pilot Grant Program, contact Tracy Zimmerman (919) 821-7999 | tzimmerman@ncsmartstart.org

UNC FPG CHILD DEVELOPMENT INSTITUTE

Smart START
The North Carolina Partnership for Children, Inc.

Nutrition and Physical Activity Self-Assessment for Child-Care
NAP SACC

University of North Carolina at Chapel Hill, Center for Health Promotion and Disease Prevention
Division of Public Health, North Carolina Department of Health and Human Services

INTENT OF THE INTERVENTION

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) program is a practice-based intervention designed to enhance policies, practices, and environments in child care by improving the:

- nutritional quality of food served,
- amount and quality of physical activity
- staff-child interactions
- facility nutrition and physical activity policies and practices and related environmental characteristics

The NAP SACC intervention primarily addresses the inter-personal and organizational levels of the socioecologic model.

OVERVIEW

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) program targets child care policy, practice and environmental influences on nutrition and physical activity behaviors in young children. Extensive formative work with stakeholder groups (child care providers, parents, and experts in the field) informed the development of the intervention. NAP SACC uses an organizational assessment of 14 areas of nutrition and physical activity policy, practices and environments to identify the strengths and limitations of the child care facility. Following the self-assessment, a health consultant (i.e., child care health consultant, nurse, health educator or other trained professional) works with the child care facility staff to set goals for change and develop plans for follow-up actions to improve practice. Collaborative goal-setting is followed by staff training and targeted technical assistance to promote organizational change.

Intended Population: Child care centers and young children (ages 2 – 5 years)

Setting: Child care centers (The intervention can be adapted for family child care homes.)

Length of time in the field: Since January 2003

CORE ELEMENTS

This section outlines the aspects of an intervention that are central to its theory and logic and that are thought to be responsible for the intervention's effectiveness. Core elements are critical features of the intervention's intent and design and should be kept intact when the intervention is implemented or adapted.

1. **Organizational Self-assessment:** Child care directors or other lead staff assess the strengths and weaknesses of healthy eating practices and regular physical activity in the child care facility using a structured tool.

2. **Goal Setting and Action Planning**: Each participating facility sets goals for organizational change and develops a plan for improving areas in greatest need and/or in areas where staff are most ready and willing to make such changes.
3. **Continuing Education for Child Care Providers:** A series of five workshops aimed at increasing child care providers' knowledge of the relationship between nutrition, physical activity and the development of healthy weight in children, and guidelines and strategies for overcoming barriers to organizational change.
4. **Skill Building Activities:** The intervention imbeds skill-building activities in each continuing education workshop to allow staff to increase their confidence (self-efficacy) to make both personal lifestyle changes and organizational changes.
5. **Technical Assistance and Consultation:** NAP SACC Consultants promote problem solving, link child care facilities to community resources, assist staff as needed, and support organizational change.
6. **Follow-up and Reinforcement:** Consultants follow-up with child care facilities by phone, email, or in-person to assess progress and document/reinforce positive changes and develop plans for continuous quality improvement.

RESOURCES REQUIRED

Staff: At the community level, a health professional (can be drawn from fields such as health education, nutrition, and nursing) familiar with child care serves as a NAP SACC Consultant. Based on the NC experience, approximately .0375 FTE of healthcare professional time over a 6-month period (1.5 hours/week) is required to address (or accommodate) each participating child care facility.

Training: The health professional who is to serve as the NAP SACC Consultant should receive training prior to enrolling child care facilities into the intervention. Training on implementation of NAP SACC is available in a web-based format free of charge. It takes approximately four hours to complete training.

Materials: The cost of materials depends on the number of consultants and facilities that participate in the intervention:

- One tool kit is needed for every consultant implementing the intervention. In NC, tool kits were packaged in 3-inch lightweight plastic boxes ($3.00 each). The technical assistance manual that is part of the tool kit can be inserted in a one-inch soft-covered binder ($ 5.00).
- Copy costs for duplication of tool kit contents (described in the materials section of this template) are estimated at approximately $30 per toolkit.
- Cost of printing handouts for continuing education workshops.
- Cost of printing brochures and materials for parents.

Other Costs:

- Laptop computer and LCD projector (optional) for workshop presentations; could use overheads and overhead projector to decrease one-time costs
- Incentives for child care facilities such as gift cards for classroom supplies, books for classrooms, balls, hula hoops or other low-cost items that promote activity (optional, but recommended)
- Mileage reimbursement for travel to child care facilities

IMPLEMENTATION

Note: This section of the template provides a succinct outline of the basic steps to implement the intervention. A more detailed implementation guide is available in Intervention Materials, providing a thorough description of the implementation process.

NAP SACC relies on trained consultants, familiar with child care facilities, to implement the intervention. Consultants who will be working with child care facilities should complete four-hours of web-based training on implementation of the intervention, nutrition, physical activity and healthy weight in young children. Training is highly recommended to increase the confidence of the consultants and to promote implementation of the core elements of the intervention. Consultants can recruit child care facilities to participate in the intervention by letter, phone, or in-person. The intervention can be fully implemented in about six months; however, child care facilities may continue to use NAP SACC as part of quality improvement.

How It Works:

1. **Self-Assessment:** Prior to a site visit, the consultant mails a NAP SACC self-assessment instrument to the child care facility director, who completes the instrument with help from key staff, such as the cook, teacher or program planner. This tool assesses the facility on 14 key areas in nutrition and physical activity with response options ranging from minimal standard to best practice. This should be completed without Consultant help. *[Note:The instrument is recommended for use as a self-assessment but not as a research tool to assess outcomes.]*
2. **Goal Setting and Action Planning:** During a scheduled site visit, the Consultant reviews the entire self-assessment instrument with the child care facility director and talks about each key area. Based on self-assessment answers, facilities chose to improve at least 1 nutrition, 1 physical activity, and 1 other key area. The Consultant assists in the development of a facility-specific plan with action steps to implement the specific policy, practice and environmental changes they intend to address. Facility directors should be challenged to make positive and sustainable improvements.
3. **Workshop Delivery:** The NAP SACC Consultant delivers 5 ready-to-use workshops to the facility staff. These workshops include: 1) Childhood Obesity, 2) Nutrition for Young Children, 3) Physical Activity for Young Children, 4) Personal Health and Wellness for Staff, and, 5) Working with Families to Promote Healthy Weight Behaviors. Each workshop takes approximately 30-60 minutes to complete. Delivery of the workshops can be tailored to meet the needs of the Consultant and facilities and to maximize staff participation. For example, they may be delivered on site as a series during "nap time," or on a Saturday as a single event. North Carolina child care providers receive continuing education credits for attending the workshops.
4. **Targeted technical assistance:** The NAP SACC Consultant maintains regular contact (recommend monthly, but more often if needed); contact can be through in-person meetings, telephone, or email) with the facility to provide support and guidance in making their improvements. NAP SACC provides technical assistance materials to Consultants which include: 1) the Consultant Technical Assistance Manual which provides tips for meeting Best Practice Guidelines, potential strategies for overcoming barriers to change, guidance on the rationale for each "best practice" recommendation, and associated references and resources; 2) handouts for the child care facility; and 3) handouts for parents.

5. **Evaluate, Revise, and Repeat:** The NAP SACC self-assessment instrument is completed a second time (after 6 months or earlier if necessary) to see where improvement have or haven't been made. At this time Action Plans are revised to include new goals and objectives and technical assistance continues.

Keys to Success:

- Consistency with state licensing requirements: It is essential to tailor the NAP SACC assessment to ensure that responses on the tool are consistent with state licensing requirements for child care facilities. In addition, collaboration with the state agency that oversees implementation of the Child and Adult Care Food Program is helpful.
- Continuing education credits: Often, child care providers are required by the state licensing agency, to complete continuing education each year. Offering CEUs through the child care licensing agency is an incentive for staff to participate in training.
- Setting achievable goals: Some facilities are overly anxious to "fix" everything at one time. It is helpful to set smaller achievable goals and then add new goals as the facility succeeds at making change.
- Incentives for child care facilities: Incentives in the form of small items that support organizational change (gift cards for classroom supplies, balls or hula hoops, activity or nutrition books for children) can be provided periodically.
- Community resources: It is beneficial to link the child care centers to community resources in order to enhance their ability to implement change.
- Tailoring technical assistance: Some child care facilities may need lots of support and encouragement, while others may be able to accomplish change on their own so tailoring technical assistance to the needs of the facility is suggested.
- Commitment: Gaining organizational commitment from child care facilities prior to implementation is essential.
- Consultant attributes: Communication skills and experience of the Consultants working with child care centers is important to making the implementation work.

Barriers to Implementation:

- Scheduling: Initial meeting between the facility director and Consultant was often difficult to schedule.
- *Staff turnover:* The child care industry has more frequent staff turnover that is seen in many other sectors. This presents a challenge to implementation of any intervention that requires staff participation.
- **Control over food selection**: Many facilities have food catered and feel as if they have little control over changes to the foods served at the center. These facilities may need more support to succeed.
- Consultant time commitment: Consultants with many competing responsibilities had difficulty finding the time to provide adequate technical assistance and follow-up.
- Child care Director commitment: Directors who were not committed and motivated to make changes were not as willing to find the time to work on implementing changes. In

some cases, another interested staff person at the facility can take a lead with support from the Director.

- Consultant knowledge: Consultants who are not confident in their knowledge of nutrition and physical activity and feeding young children are less comfortable providing technical assistance to facilities. Consultants may need training beyond that provided by NAP SACC to acquire what is needed to make the program work at their childcare facilities.
- Addressing physical activity areas: Many times child care directors did not think that the center needed assistance with enhancing physical activity because they generally view the children as active ("hyperactive") and because the children go outside to play. Helping providers understand ACTIVE (climbing, running) vs. PASSIVE (sitting in the sand box) play may be helpful.
- Food Access: Child care facilities often buy food at large discount clubs and through whole sellers. This may limit access to whole grain products and fresh fruits and vegetables, while increasing access to inexpensive, commercially-prepared snacks and breakfast items.

EVIDENCE REVIEW SUMMARY

Underlying Theory: The NAP SACC intervention uses constructs of the Social Cognitive Theory including: expectancies, observational learning, self-efficacy, behavioral capability, environment, situation, reinforcement, and reciprocal determinism.

Strategy(ies) Used: The NAP SACC intervention includes strategies for both healthy eating and physical activity that have been adapted to child care settings, including:

- Social Support for both healthy eating and physical activity using child care providers as teachers and role models
- Increased availability of healthy foods through menu changes
- Increased time for physical activity through active play while in child care
- Increased access to places for physical activity through changes in indoor and/or outdoor play space.

Research Findings and Evaluation Outcomes:

The NAP SACC intervention was developed and evaluated first in the field as a practice-based intervention and subsequently studied in a larger randomized controlled trial involving 30 consultants assigned to 84 centers. Child care centers were randomly assigned to receive the intervention or serve as controls. Among the 82 centers remaining in the study, 56 were randomly assigned to receive the intervention. Forty-one intervention centers (73%) completed most (>75%) or all of the intervention components. The program outcomes listed below are based on this subset of intervention sites compared to controls.

Intervention Effect (overall environment and policy assessment)*: Child care centers completing most or all of the intervention components improved their nutrition and physical activity policies and practices more than control facilities. Changes (16% increase) in the total child care nutrition environment scores were statistically significant ($p<.01$). Changes in physical activity were not, but showed positive improvement.

**When all centers are included in the analysis of the intervention effect, the 11% improvement in nutrition environment and policies, was only marginally statistically significant (p=.06). Physical activity changes were modest and non-significant when compared to controls.*

Individual Item Scores in Nutrition and Physical Activity: Because the NAP SACC intervention allows some flexibility in the areas targeted for change by centers and because the observation instrument is scored using averages of sub-areas to obtain the Nutrition and Physical Activity scores, an additional assessment of an intervention effect was measured using all of the individual 75-items from the observation instrument. Nutrition effects are assessed with 51 items and physical activity with 24 items. The mean change in nutrition scores was a 4.3 point improvement in the intervention centers compared to -0.5 change in the controls; for physical activity, scores increased by 3.6 in the intervention centers compared to a -0.2 change in the controls. Both nutrition and physical activity improvements were statistically significant.

POTENTIAL PUBLIC HEALTH IMPACT

The NAP SACC intervention has a high potential for public health impact.

Reach: With approximately three quarters of US children spending time in out-of-home child care, this intervention has potential for efficiently reaching a large number of children.

Effectiveness: Data available at the time of the review suggest that, compared to a control group, intervention centers are more likely to make significant changes in nutrition policies, environments and practices and some positive (but statistically non-significant) changes in physical activity policies, environments and practices.

Adoption: There was good adoption of the intervention, with an adoption rate of 73% (41/56) for the statewide evaluation study. At the time of review, NAP SACC had been adopted/adapted in several other states.

Implementation: This intervention was designed for dissemination – training, intervention materials, implementation guidance and technical support for implementation are available. The intervention is relatively easy to implement at a relatively low cost. The intervention has been replicated in other states. It seems reasonable to expect that the intervention could be implemented as intended (with fidelity) in similar settings with similar infrastructure.

Maintenance: It was not possible to assess long-term maintenance of the intervention at the time of this review. Given the use of existing infrastructure (child care health consultants in NC), the nature of some of the changes in infrastructure, and the relatively low cost of implementation, it is reasonable to expect that the intervention could be sustained over time.

INTERVENTION MATERIALS

(Last revision: Summer 2007)

The **tool kit** includes:

- Technical Assistance Materials
  - An Intervention Implementation Guide
  - A Consultant Technical Assistance Manual that provides the rationale for best practice recommendations and suggestions for reducing barriers to change.

- Handouts for child care providers and parents (in both English and Spanish)
- A sample nutrition and physical activity policy

➢ Intervention Materials
- The self-assessment instrument with instruction sheet and a completed sample.
- The Action Planning Document with completed sample
- Five continuing education workshops including PowerPoint presentations, talking points, and activities. The 5 **workshops** offered to child care providers include: Childhood Obesity, Nutrition for Young Children; Physical Activity for Young Children; Personal Health and Wellness for Staff; Working With Families to Promote Healthy Weight Behaviors.

➢ Informational Materials
- NAP SACC informational brochure for parents
- NAP SACC recruitment letter for providers
- NAP SACC Certificate of Completion
- NAP SACC Best Practice Recommendations

➢ Evaluation Materials
- Monitoring Guide
- Workshop Evaluation
- Environment and Policy Assessment and Observation (EPAO) instrument

TRAINING AND TECHNICAL ASSISTANCE

On its website, the Center TRT provides access to online training for the implementation of the NAP SACC intervention. This training will prepare health professionals to become NAP SACC Consultants. Go to www.centertrt.org and click on the Training link then look for NAP SACC in the left navigation bar.

ADDITIONAL INFORMATION

Web links: www.napsacc.org

Program Contact(s):

Christina McWilliams
UNC Center for Health Promotion and Disease Prevention
Phone: 919-966-8648
Email: cjmcwill@email.unc.edu

Related Resources:

ChildCare Welcome Page http://nti.unc.edu/
Welcome to the CACFP http://www.cacfp.org/
National Resource Center for Health and Safety in Child Care and Early Education, State's Child Care Licensure Regulations http://nrc.uchsc.edu/STATES/states.htm

Publications:

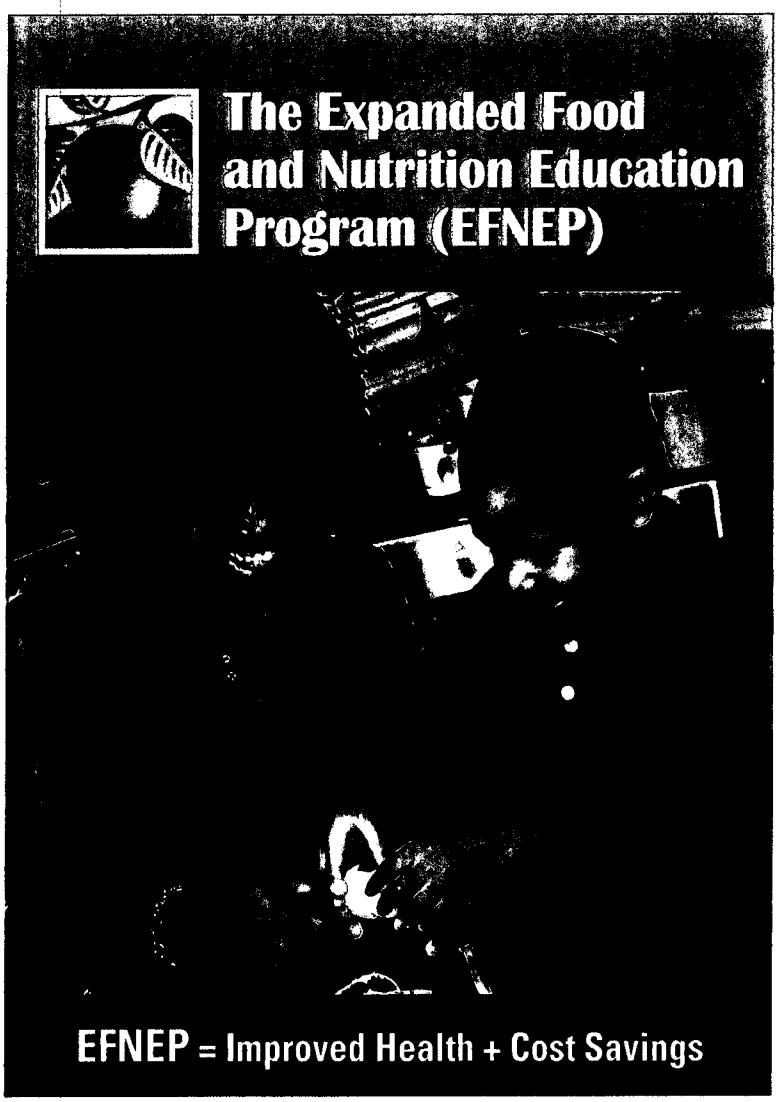
Benjamin SE, Ammerman A, Sommers J, Dodds J, Neelon B, Ward DS. Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC): Results from a Pilot Program. *J Nutr Edu Behav* 2007;39:142-149.

Ammerman A, Ward DS, Benjamin SE, Ball SC, Sommers J, Malloy M, Dodds J. An Intervention to Promote Healthy Weight: Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) Theory and Design. *Prev Chron Dis (serial online)* 2007 July. Available from: http://www.cdc.gov/pcd/issues/2007/jul/toc.htm.

Benjamin SE, Tate DF, Bangdiwala SI, Neelon BH, Ammerman AS, Dodds JM, Ward DS. Preparing Child Care Health Consultants to Address Childhood Overweight: A Randomized Controlled Trial Comparing Web to In-Person Training. Matern Child Health J. 2007 Aug 23[Epub ahead of print].

Ward DS. Benjamin SE, Ammerman AS, Ball SC, Neelon BH, Bangdiwala SI. Nutrition and physical activity in child care: Results from an environment intervention. Am J Prev Med 2008;35(4):352-356.

For more information on this intervention, visit www.Center-TRT.org.



Obesity, poor health, and limited physical activity are major health concerns. EFNEP improves the health and well-being of limited resource families and youth. Additionally, EFNEP leads to public savings. Research shows that better health is associated with reduced health care costs, less absenteeism from work, and less dependence on emergency food assistance.

USDA CSREES

United States Department of Agriculture
Cooperative State Research, Education, and Extension Service
Families, 4-H, and Nutrition

EFNEP operates through the 1862 and 1890 Land-Grant Institutions in every state and in the six U.S. territories. Using a research-based, interactive approach, peer educators from the communities they support reach over ½ million limited-resource families and youth each year. More than 80 percent of EFNEP families report living at or below 100 percent of poverty, and nearly 70 percent indicate being of minority status. This is important because poor health disproportionately affects minority and limited-resource audiences.



EFNEP
consistently demonstrates strong results.
Annual data confirms graduates:

Improve their diets

92 percent report more closely following MyPyramid recommendations, including an increase of about 1.4 servings of fruits and vegetables

Improve their nutrition practices

88 percent improve nutrition practices, such as making healthier food choices and reading nutrition labels

Stretch their food dollars farther

83 percent improve food resource management practices, such as planning meals and shopping with a grocery list

Handle food more safely

66 percent improve food safety practices, such as storing and thawing food properly

Increase their physical activity rates

40 percent more often do at least 30 minutes of moderate physical activity each day

For more information visit:
www.csrees.usda.gov/efnep

USDA is an equal opportunity employer and provider.

August 2008

December 2009

State of the COUNTY HEALTH Report

Orange County, NC

Orange County, NC: Partnering for the Public's Health | Leading Causes of Death | Health Disparities | Access to Care | Latino and Refugee Health | Hot Topics | Health Promotion | Adolescent Health | Mental Health and Substance Abuse | Transportation | How to Get Involved

HEALTHY CAROLINIANS OF ORANGE COUNTY

Orange County Health Department NCPH North Carolina Public Health

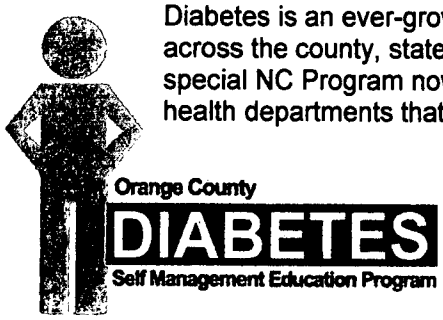
Orange County North Carolina

volunteers and 176 CERT volunteers. The volunteer program is constantly being expanded by offering more training opportunities for volunteers and outreach to community members.

Various outreach efforts are underway. This year's theme was emergency preparedness and first aid. CERT training was provided to various Cub Scout troops and Sports Endeavors. This was the first Business CERT in Orange County. PHRC nurses and volunteers assisted the various vaccine clinics; and the Corps participated in the Safety Saturday event in September to distribute emergency preparedness information to families and community members.

Diabetes Self Management Education

Contributors: Candice Watkins-Robinson and Renee Kemske, *Orange County Health Department*



Diabetes is an ever-growing problem across the county, state, and nation. A special NC Program now allows local health departments that meet certain qualifications to bill Medicaid and private insurance companies for diabetes education services.

As a new policy initiative, and because diabetes is on the rise, the Orange County Health Department has included a diabetes self- management education program (DSME) in its strategic plan. In Spring 2009, the Department received a grant from the Kate B. Reynolds Foundation to defray costs for initiating this program.

The DSME program's goal is to achieve better management of diabetes, increase access to care through an active treatment and referral network, improve health outcomes, and reduce healthcare costs. The program consists of four elements:

- Diabetes self-management education
- Medical provider education
- Improved DSME Marketing and Referral Plan
- Medical Nutrition Therapy and follow-up services.

Besides suffering from the burden of diabetes, many residents are not receiving or accessing adequate preventive care for their illness. The 2006 Orange County Behavioral Risk Factor Surveillance Survey (BRFSS) estimated that only 55% of those diagnosed with diabetes had taken a course on diabetes management. Thus, about 2,300 county residents who had already been diagnosed had yet to be educated on how to manage their disease.

2. Health Promotion

Contributors: Jamy Albo McGee, *UNC Wellness Center*; Sarah Blacklin, *Carrboro Farmers Market*; and Patrick McIntyre, *Orange County Partnership for Young Children*

Health Promotion Committee

In Orange County, 29% of children aged 2-18 years are overweight or obese. Among the 2-4 year olds, 15.8% are overweight[17]; among the 5-11 year olds, 35.7% are overweight or obese.[18] ; and among the youth (aged 12-18 years), 31% are obese.[19]

Given these alarming statistics, reducing childhood obesity has become the primary focus for the Health Promotion Committee of Healthy Carolinians of Orange County. The committee has adopted a comprehensive approach to addressing the obesity problem, and is coordinating its activities with a number of sectors and agencies.

This year, the Health Promotion (HP) Committee created a Physical Activity and Nutrition Resource Guide. This is a compilation of information from all the organizations within Orange County, public and private, that offer services addressing physical activity and nutrition of children of all ages. This Resource Guide was distributed to Healthy Carolinians partners, health provider offices, and to the public.

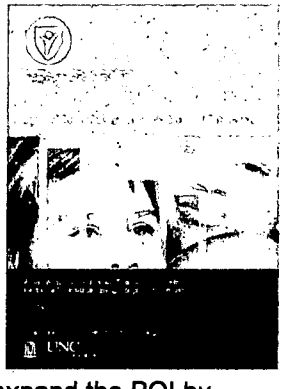
After completing the Guide, the HP Committee partnered with twelve Orange County organizations (e.g. local government, businesses, churches, both school districts, and the UNC Health Care System) to launch the *"Eat Smart Move More" Consistent Messaging Campaign.* The campaign ran during the summer months (May-August) and consisted of four key messages around physical activity and healthy eating. Partners were trained and encouraged to adopt or integrate the messages into their existing programs and communication channels.

Eat Smart Move More Orange County

Besides promotional efforts by each community organization, ten advertisements and articles written by members of the HP Committee were published in four local newspapers. The estimated number of people reached through partners alone (i.e. not including newspaper readership) was about 19,500 people. The Committee plans to conduct a smaller Phase II campaign in 2010 to promote two additional Eat Smart Move More messages.

In November 2009, Ms. Candice Watkins-Robinson, Communications Specialist at the Orange County Health Department, received a first-place *Excellence in Communications Award* for the ESMM Campaign Tool kit from the NC Association of Government Information Officers.

The HP Committee also started a Pediatric Obesity Initiative (POI) in July 2009. In collaboration with the UNC School of Nursing students, Pediatric Obesity Toolkits were created for four Orange County clinics. Also, physicians, nurse practitioners and physician assistants, clinical staff, and office manager/front desk staff attended training on Universal Assessment guidelines, Staged Treatment strategies, and the development of Motivational Interviewing skills for reinforcing positive behaviors and counseling against negative behaviors or risk factors. The Health Promotion group will now expand the POI by partnering with school nurses from both districts.



Many local agencies also continued to offer services to improve health promotion among young children and their families. These agencies include the Chapel Hill-Carrboro YMCA, the Health Department, Cooperative Extension, the Orange Partnership for Young Children, our three Recreation and Parks Departments, the Triangle SportsPlex, and many more.

In addition to Healthy Carolinians projects, some other Orange County programs that are addressing Childhood Obesity include the following:

Eating Smart

1) Local farmers markets. For example the Farmer's Market and NC Farm Fresh in Hillsborough and the Carrboro Farmers Markets have increased in popularity and are working to make local foods and fresh fruits and vegetables more available to the community.

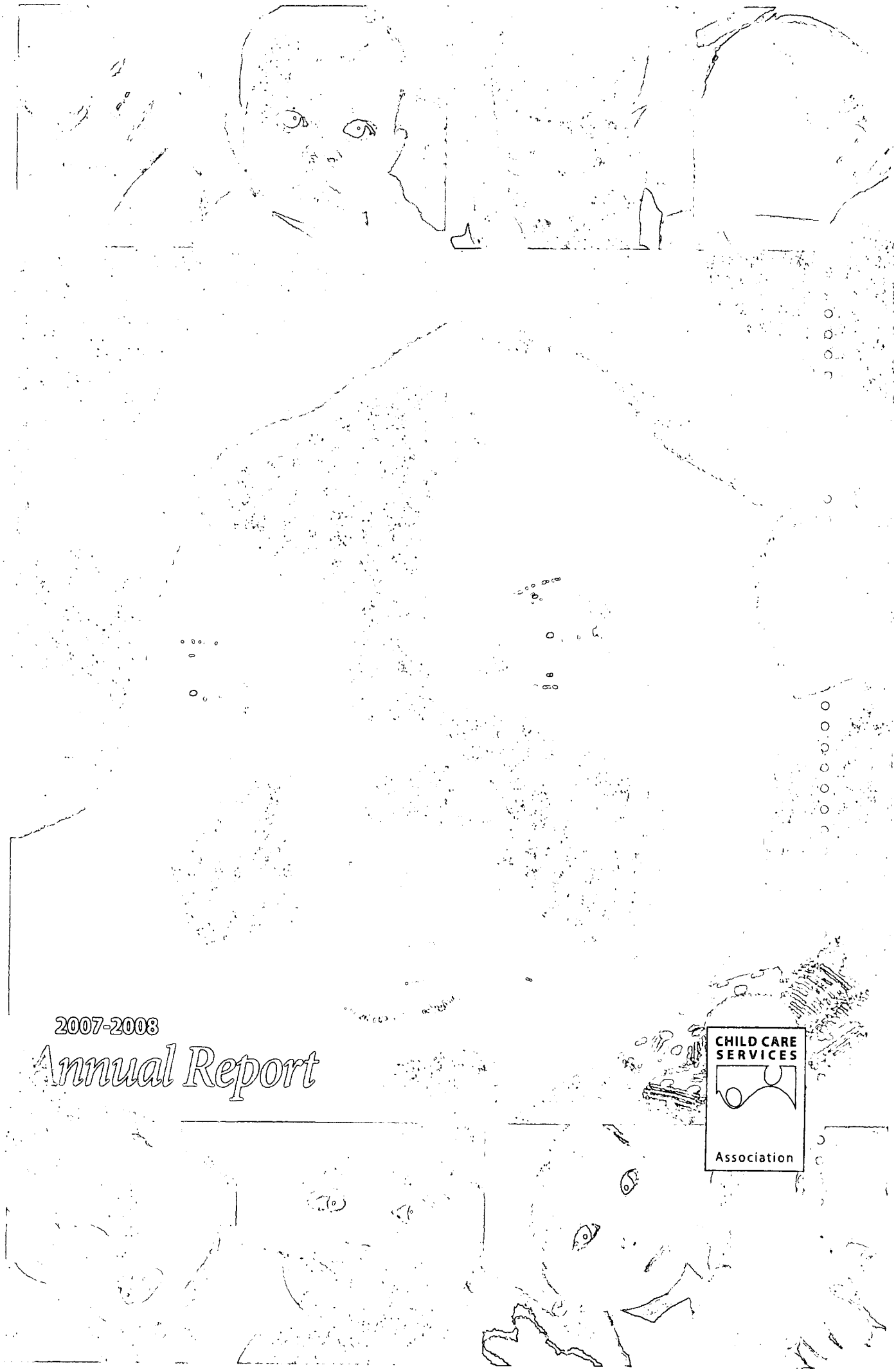
The Carrboro Farmers' Market has made great strides in increasing access to local food with the creation of the Farmer FoodShare program this year. The Farmer FoodShare program is a volunteer and farmer-led program that collects fresh market fruits and vegetables from farmers and shoppers and distributes it to a network of social service and hunger relief agencies in local under-served communities. In just 5 months, the Farmer FoodShare has collected over 12,000 pounds of produce and distributed it to hunger relief centers throughout Orange, Wake, and Durham counties.

2) The Growing Healthy Kids (Community Gardens) Program. This progam has helped over 75 children and families learn the advantages of growing their own fruits and vegetables. In Spring 2009, a third garden was created in Carrboro with support from Duke Energy, the Town of Carrboro, the Orange County Cooperative Extension Growing Healthy Kids, and the Health and Wellness Trust Fund of North Carolina. Recent evaluation data shows that after completing the program, parents reported an 88% increase in the number of fruits available in their home, and a 126% increase in the number of vegetables.

Moving More

3) Chapel Hill-Carrboro City Schools received a Physical Education Program (PEP) Grant and is currently in year two of a three year program. Funds are being used to increase physical activity across all grades.

4) The Move It! program provides scholarships for families to take part in local physical activity programs organized by the Parks and Recreation departments in Carrboro, Chapel Hill, and Orange County, the Chapel Hill-Carrboro YMCA, and the Triangle SportsPlex. The program granted access to 50 families who might otherwise not have had the opportunity to participate. Of the children who received a Move It! Scholarship, 76% had not previously participated in a local physical activity program.



2007-2008

Annual Report

CHILD CARE SERVICES Association

Creating healthy beginnings for children

Early Nutrition Matters

While the early care and education children receive will lay the foundation for their future success in school and life, the nutrition habits they form early in life can impact their life-long health. To help children establish healthy eating habits, CCSA operates a meal service program that provides two nutritious meals and one snack five days a week to children in participating child care centers. This program ensures that children are receiving fresh fruits, vegetables and whole grains on a daily basis and that their salt, sugar and fat intake is limited.



In FY 2007-08

- CCSA served 327,455 nutritiously balanced meals to 596 children in 17 child care centers.

In FY 2007-08

- 104,786 healthy meals were served to children under 3 years old.



FAMILY SERVICES

PROVIDER SERVICES

T.E.A.C.H.® EARLY CHILDHOOD PROJECT

CHILD CARE WAGES® PROJECT

TRAINING

NUTRITION SERVICES

IMPROVING QUALITY

SEARCHABLE DIRECTORY OF NC COMMUNITY COLLEGES



Nutrition Services



Child Care Services Association (CCSA) offers two nutrition services for child care programs in Durham and Orange counties:

- Meal Service Program
- Child Care Food Program

Meal Service Program

CCSA's Meal Service Program provides two nutritious meals plus one nutritious snack per day to children enrolled in participating child care centers. Following U.S. Department of Agriculture (USDA) guidelines, the catered meals provide ample portion sizes that meet or exceed Child and Adult Care Food Program standards. By purchasing food in bulk, the Meal Service Program allows child care centers to purchase nutritional meals and snacks at cost, without having to maintain expensive kitchens. It also allows directors to focus more of their attention on quality care instead of on shopping, menu planning, and cooking. To participate in the Meal Service Program, centers must maintain at least a three star license or be working toward a three star license through one of CCSA's local quality improvement projects. This program is primarily available to child care programs in Orange County.

For more information about the Meal Service Program, contact CCSA at:

Child Care Services Association
P.O. Box 901
Chapel Hill, North Carolina 27514
[P] 919.967.3272
[F] 919.967.7683
Contact Us Now
Open Monday through Friday, 8:00 a.m. - 5:00 p.m.

Child Care Food Program

CCSA also sponsors the USDA's Child and Adult Care Food Program for family child care homes in Durham and surrounding counties. Funded under the National School Lunch Act, the Child Care Food Program (CCFP) is designed to improve the nutritional status of young children in child care by providing financial assistance to child care programs. Family child care providers must have a sponsoring agency, such as CCSA, to participate. When participating providers serve nutritious meals to the children in their care and keep daily records such as meals served and attendance, they receive per meal reimbursements for food expenses. Participants also receive nutritional workshops, recipes, tips and on-site nutrition consultations.

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For more information about the Child Care Food Program, contact CCSA at:

Child Care Services Association
1201 South Briggs Avenue
Suite 200
Durham, North Carolina 27703
[P] 919.403.6950
[F] 919.403.6959
Contact Us Now
Open Monday through Friday, 8:00 a.m. - 5:00 p.m.

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Orange County Partnership for Young Children

The Healthy Kids Campaign



Joint Legislative Task Force on Childhood Obesity
February 11, 2010

Preventing Obesity in Orange County

Margaret Samuels, LCSW
Executive Director
Orange County Partnership for Young Children



Orange County Partnership for Young Children

The Healthy Kids Campaign

Orange County Partnership for Young Children is a nonprofit dedicated to ensuring that all children in Orange County arrive at school healthy and ready to succeed. birth to age five is the most critical time in a child's development.

Through **Smart Start, More At Four** and **foundation grants and fundraising** our programs focus on early childhood education, child health care, early intervention, parenting education and family support.

Creating Community Solutions

- Surveys, Focus Groups, Meetings
- Identifying Model Programs
- Recruiting Community Partners

Orange County, NC
A Snap Shot

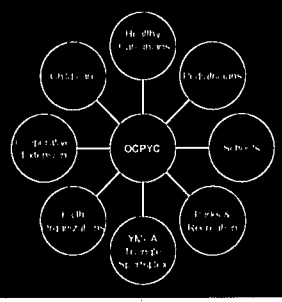
29% of children aged 2-18 years are overweight or obese.

Among the 2-4 year olds, 15.8% are overweight

5-11 year olds-35.7% are overweight or obese

12-18 years- 31% are obese

Creating a Community Solution: Community Partners ***Where Children Live, Learn, Play and Pray***



Campaign to Fight Obesity

•Reach thousands of young children and their families wherever they live, learn, play or pray.

- Neighborhoods
- •Child Care Centers
- •Parks and Recreation
- •Doctor's offices
- •Places of Worship



•Innovative and research-based programs designed to increase healthy eating and physical activity among young children and families in Orange County.

Campaign Goal and Process

The Partnership led community planning process and fundraising campaign

Raised approximately $300,000 in a 2 year period

Involved individuals, state grants corporations, foundations



Healthy Kids Campaign Cabinet

Carmen Hooker Odom, Secretary of Health & Human Services

Howard Lee, Chairman, State Board of Education

Rep. Verla Insko

Dr. Alan Stiles, UNC Children's Hospital

Tony Waldrop, Research & Econ. Development, UNC

Dr. Steve Zeisel, School of Public Health, UNC

Roger Perry, East West Partners

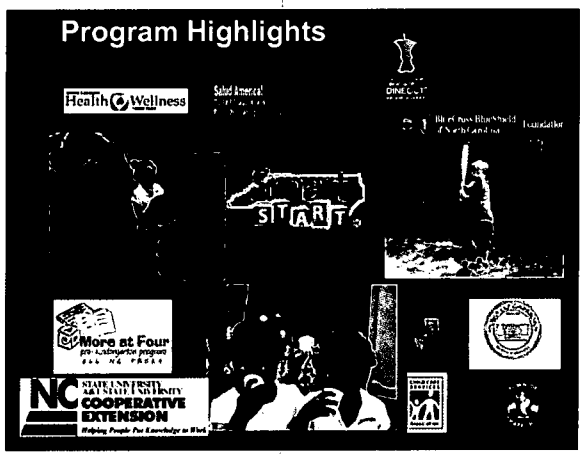
John Russell, Quintiles Transnational Corp.

Why The Partnership?

- Capacity to lead community fundraising campaign
- Track record of creating effective programs for young children & families
- Expertise of Board Members
- Focus on Community Collaboration
- Results Oriented
- Fiscal Accountability
- Program Evaluation



Program Highlights



Community Gardens



Growing Healthy Kids

- 3rd Year
- Garden Advisory Committee and Gardener's Advisory Board
- School Site; Community Site & Private Land Site.
- The Carrboro Elementary garden has now begun to include learning opportunities in the More at Four classrooms at the school.
- Families participate in the EFNEP program- a collaboration with OC Cooperative Extension



Growing Healthy Kids Pilot Data

-Pre Data:

At-Risk of Overweight/Overweight (8)

-Post Data

3 of these children had BMI classifications of Normal and 1 reduced his BMI classification from Overweight to At-Risk of Overweight.

After completing the program parents reported:

-An overall increase in the number of fruits and vegetables in their home.

-a 126% increase in the number of vegetables available in the home.

-88% increase in the number of fruits available in the home

Funding for the Growing Healthy Kids Program

Initial funding for the program was a two-year grant from the North Carolina Health and Wellness Trust Fund in the amount of $53,000.

A Two-Year Salud America! Robert Wood Johnson Foundation grant in the amount of $75,000. This is grant will used for research on the effects of increased access to better nutrition for Latino children. It is in collaboration with UNC Chapel Hill.



MOVE IT!



- Program provided scholarships for families to participate in local physical activity programs –
- The program served 62 children from across the county.
- 81% of families participating in the program earned less than $25,000 per year.
- 76% of participating children had not previously participated in a physical activity program
- Move It! was a collaboration between the Carrboro Recreation and Parks Dept., Chapel Hill Parks and Rec. Dept, Orange County Recreation and Parks Dept., Chapel Hill/Carrboro YMCA, and the Triangle SportsPlex.

ABCs of Good Health/ Nutrition and Physical Activity Self-Assessment for Child-Care

- Targets physical activity and nutrition practices in child care centers. Provides directors and staff with knowledge and support to aid children in developing healthy behaviors.
- Approximately 200 children served to date
- Collaboration with Orange County Health Department; North Carolina Partnership for Children and Blue Cross Blue Shield Foundation





09-10 OC NAPSACC

Current BMI Data on 85 Children

Almost 30% are At Risk or Overweight according to BMI calculations (ages 2-5)

	Nutrition Mean Pre-Test	Nutrition Mean Post-Test	Physical Activity Mean Pre-Test	Physical Activity Mean Post-Test
State wide Results	2.64	3.11	2.72	3.38

Smart Start Performance Based Incentive System

Orange County	Min	HP	08-09	07-08	06-07	05-06	04-05
Body Mass Index	<=12.27%	<=10%	14.70 %	16.80 %	16.40 %	18.70 %	21.70 %





Play More Move More

Pedometers for Childcare teachers

35 Child Care Center workers are participating

Age range 18-63 (Avg. age 36)

23 females and 2 males

19 AA; 5 Latino; 1 Caucasian



Preventing Obesity By Design

- Improves Outdoor Environment of childcare centers
- Increase children's level of physical activity; time spent outdoors by children and teachers; Increases children's awareness of vegetables, fruit, and nuts as healthy foods
- NC State Outdoor Learning Environment; North Carolina Partnership for Children and Blue Cross Blue Shield Foundation




Additional Orange County Community Efforts

- Chapel Hill Carrboro City Schools & Orange County Schools
- Town of Carrboro
- Child Care Services Association
- Be Active North Carolina
- North Carolina Botanical Garden



Questions

Margaret Samuels

919-967-9091



Orange County Partnership *for* Young Children



The Healthy Kids Campaign

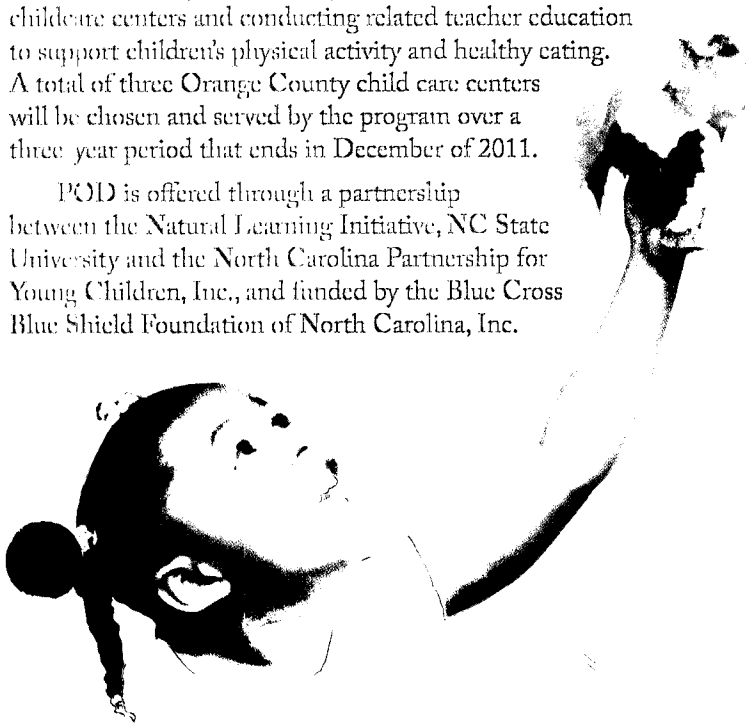
In 2007 the Orange County Partnership for Young Children (OCPYC) embarked on our first ever campaign to address the critical issue of childhood obesity in Orange County. The Healthy Kids Campaign is a broad-based collaborative effort that targets the health concerns of young children that are not being met by any other organization in the county.

The Healthy Kids Campaign funds three innovative and research based programs that all focus on preventing child obesity by increasing opportunities for children to eat smart and move more. The Healthy Kids Campaign programs reach out to over 300 children and families in a variety of settings -wherever they live, learn, play or pray.

The success of the Healthy Kids programs have been leveraged to find new sources of funding for the initiative. In the past year the Partnership has worked diligently so that all of the Healthy Kids programs remain funded and will continue to have a positive change on the children of this community. In doing so we have received two national grants and have secured additional funding from local governments and foundations. The new funding allows us to expand existing programs, which in turn creates a stronger network for families and children to stay active.

OCPYC was chosen to participate in an exciting new children's obesity prevention program called Preventing Obesity by Design (POD). The long-term goal of POD is to reverse the trend toward childhood obesity through improving outdoor environments in childcare centers and conducting related teacher education to support children's physical activity and healthy eating. A total of three Orange County child care centers will be chosen and served by the program over a three year period that ends in December of 2011.

POD is offered through a partnership between the Natural Learning Initiative, NC State University and the North Carolina Partnership for Young Children, Inc., and funded by the Blue Cross Blue Shield Foundation of North Carolina, Inc.



One of only twenty accepted applicants nationally, the Partnership is extremely proud to have been able to receive an award of this kind. Working with the Frank Porter Graham Child Development Institute, the grant will fund new research on Latino families and the effect of better access to nutrition and physical activity. The study will take part in cooperation with the established Carrboro Growing Healthy Kids project, which is a community garden initiative that is currently serving more than 50 families.

OCPYC has received a grant for $3,500 from the Blue Cross and Blue Shield of North Carolina(BCBSNC) Foundation. The funding will provide local child care center teachers with pedometers to better track their physical activity throughout the day.

In cooperation with the Smart Start Child Care Health Consultant, a position out of the Orange County Health Department, 150 pedometers will be handed out with 15-20 different child care centers participating. This project will be run concurrently with the ABCs of Good Health which has implemented a nutrition and physical activity based curriculum in the centers.

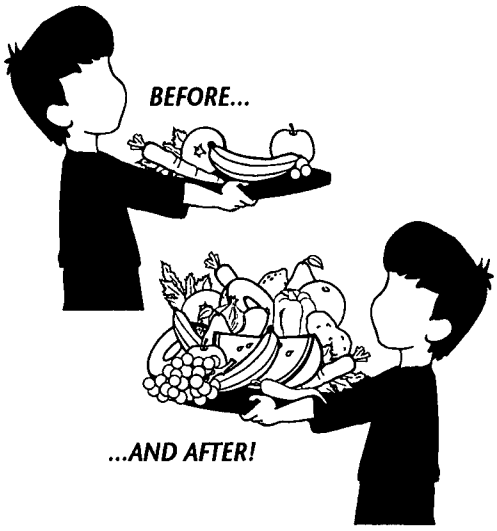
ABCs of Good Health (Child Care Centers)

The ABCs of Good Health has been implemented into 9 childcare centers and has reached 132 children since its inception. The program uses a curriculum based approach to work with child care teachers to provide added information and training on how to implement better nutrition and physical activity in the child's daily routine. This program is supported by a grant from Blue Cross and Blue Shield of North Carolina Foundation. It is implemented through a position at the Orange County Health Department.





132 children age 2-5 years participated in the ABCs of Good Health program!



After completing the program, parents reported an 88% increase in the number of fruits available in their home, and a 126% increase in the number of vegetables!



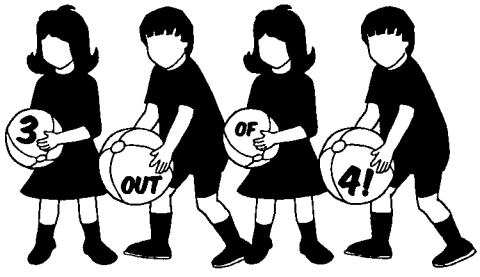
Growing Healthy Kids (Community Gardens)

Since 2007 the Growing Healthy Kids Program has helped over 75 children and families learn the advantages of growing their own fruits and vegetables. The results of the interactions have been very positive. Originally the project was maintaining 2 gardens in Carrboro, but as of this spring, a third garden was created on James St. in Carrboro and was made possible by a collab[illegible] with Duke Energy. Growing H[illegible] Kids was started by a grant from the Health and Wellness Trust Fund of North Carolina and is also supported by the Orange County Cooperative Extension and the Town of Carrboro.

Move It! (Scholarships)

The Move It! program established or funded scholarships for families to take part in local physical activity programs. Taking part in the project were the Carrboro Recreations and Parks Department, Chapel Hill Recreations and Parks Department, the Orange County Recreations and Parks Department, Chapel Hill-Carrboro YMCA and the Triangle SportsPlex. The program allowed access to 50 families who might otherwise not have had the opportunity to participate.





76% of children who received a Move It! Scholarship had not previously participated in a local physical activity program!





Orange County Partnership for Young Children

1829 E. Franklin Street
Chapel Hill, NC 27514
(919) 967-9091
www.orangesmartstart.org

Smart START®

The North Carolina Partnership for Children, Inc.



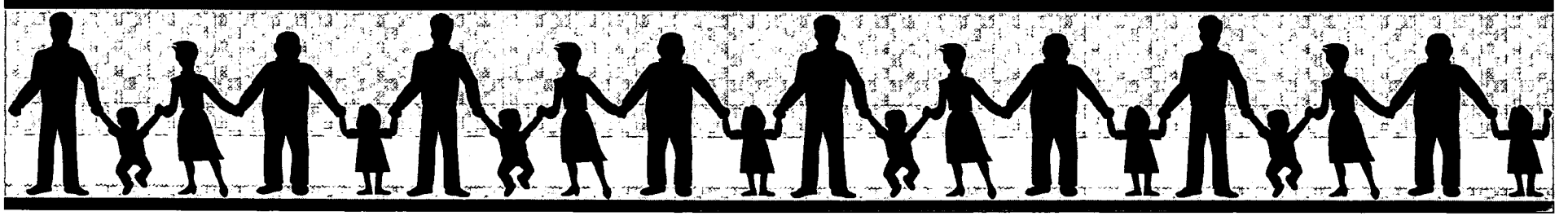
Obesity Prevention Strategies in the Child Care Setting:

Advantages & Disadvantages

Jani Kozlowski, MA, The North Carolina Partnership for Children, Inc.

Why focus on the child care setting for obesity prevention?

- Nationally, 60% of mothers with preschoolers are employed; NC has one of the highest rates of working mothers
- Currently there are 271,589 children in child care in NC
- Over 80% of children under age 5 spend some time in non-parental care (US Census Bureau; 2005)
- Link between type of child care and kindergarten obesity rates (Maher et al; *Pediatrics* 2008)
- Link between child care quality and levels of sedentary behavior in children (Story et al; www.futureofchildren.org)

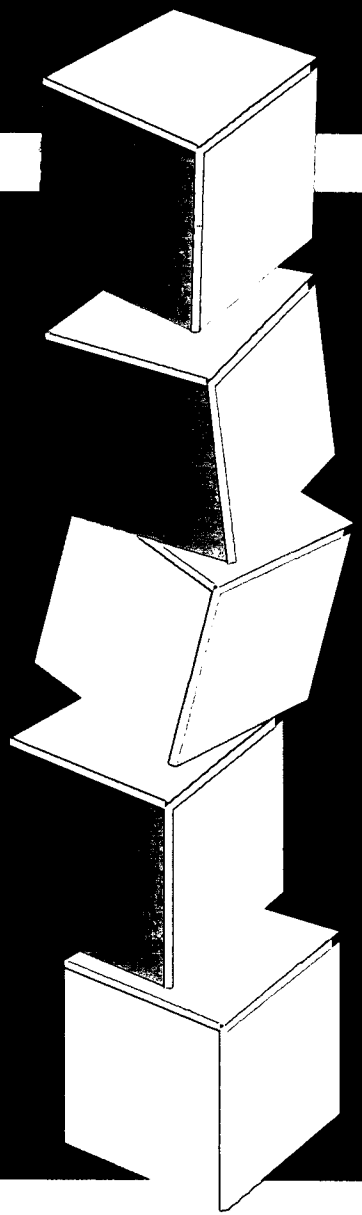


A "captive" audience

- Creating a culture of healthy practices in child care:
  - A compelling outdoor environment
  - Opportunities for outdoor play
  - Adults who role model healthy behaviors
  - Fruits & vegetables offered
  - Limits on junk food & sweetened beverages
  - Limits on screen time
  - Parent education opportunities



The child care advantage: Regulation & Funding Sources



Regulation Systems

- Environmental health regulations
- Playground safety standards
- Child care licensing regulations
  - Minimum outdoor space requirements
  - Outdoor play every day
  - Mealtimes
  - Quality rating system in NC

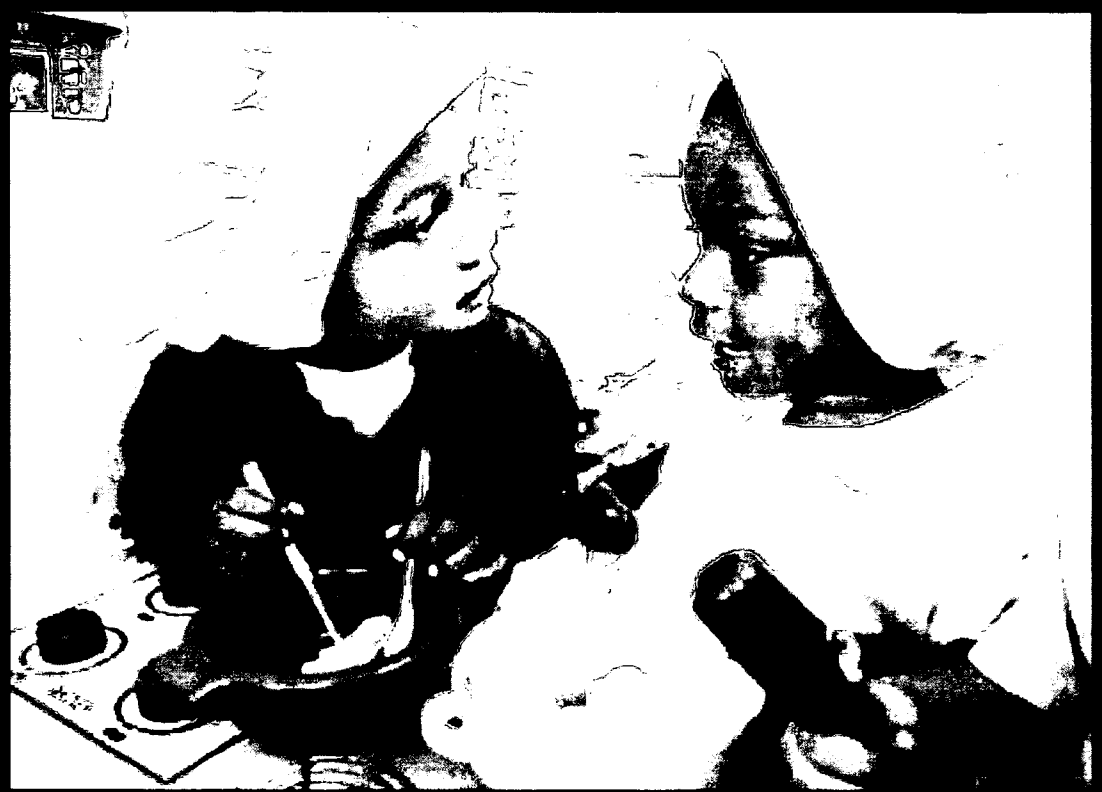
Funding Sources

- Child and Adult Care Food Program
- Child Care & Development Fund
  - Child care subsidy
  - Child care quality
- Smart Start
- Head Start & More at Four



The child care advantage: Healthy Eating

- Meals/snacks typically provided
- Teacher as role model
- Learning environment to practice healthy habits
- Potential to introduce healthy nutrition concepts into the curriculum



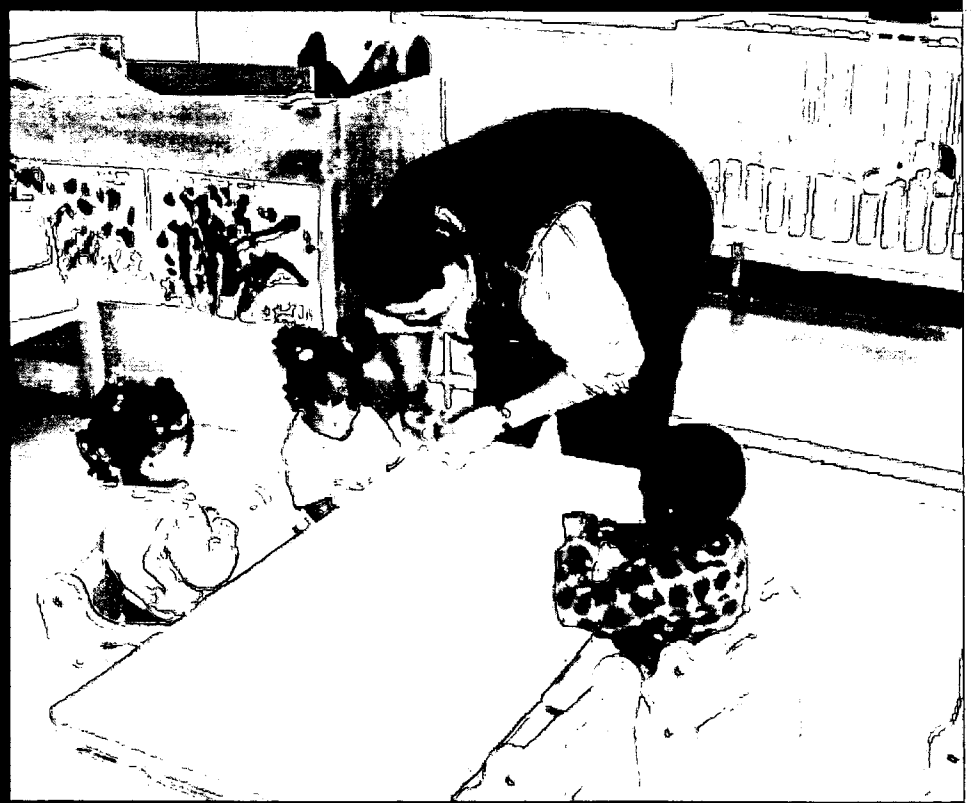
The child care advantage: Physical Activity



- Outdoor learning environment available for active play
- Potential to introduce active play opportunities into the curriculum
- Untapped potential: 2009 study found that preschoolers were sedentary 90% of the day (Brown, et al; *Child Development*. 2009)

Special Considerations for the Child Care Setting

- Family involvement opportunities & challenges
- Issues related to the teacher as role model
- Teacher concerns about adding "one more thing..."
- The culture of food & celebrations
- Reaching the children who are not served in a child care setting



Obesity Prevention Strategies Implemented in NC Child Care Settings

- Preventing Obesity by Design
- NAP SACC
- Eat Smart, Move More
- Obesity Prevention Curricula:
  - I Am Moving, I Am Learning
  - Be Active Kids
  - Color Me Healthy



Contact Information

Jani Kozlowski, MA
The North Carolina Partnership for Children, Inc.
Email: jkozlowski@ncsmartstart.org
Phone: (919) 821-9581



Smart START®

The North Carolina Partnership for Children, Inc.



Evidence-Based Obesity Prevention Strategies in Other States

Jani Kozlowski, MA, The North Carolina Partnership for Children, Inc.

Key Considerations for Obesity Prevention Strategies

- 2009 report from Elliot Segal at the HSC Foundation recommends that strategies are:
  - Comprehensive
  - Evidence-Based
  - Focus on Children Birth-5



Key Considerations for Obesity Prevention Strategies

- 5 key elements identified:
  - Nutrition
  - Physical activity
  - Public health prevention and health services
  - Built environment
  - Promoting human capital

Sample of Models Identified

- **Head Start Body Start**
  - Federal-local model (federal funding)
  - Grants to improve outdoor play spaces
  - Provide resources, training and technical assistance
  - Work with the Office of Head Start to set national priorities and develop policy



Sample of Models Identified

- **Nemours Health and Prevention Services (Delaware)**
  - Private foundation funding with state agency collaboration
  - Sesame Street developed toolkit: Healthy Habits for Life
  - Child care licensing policy change
  - Technical assistance to child care facilities with a focus on:
    - Increasing provider knowledge about obesity
    - Making food selection changes
    - Increasing physical activity through more outdoor free play time



Sample of Models Identified

- **Child Care Policy Change**
  - Gold Sneaker Initiative (TN)
    - Branding campaign
    - Child care programs that implement high quality nutrition & physical activity policies earn a Gold Sneaker designation
    - Child care provider training
  - Fit Kentucky Coalition
    - Lead by the early childhood committee of the Coalition
    - Pursuit of nutrition & physical activity standards for licensed child care



Sample of Models Identified

- Early Sprouts (New Hampshire)
  - Gardening & nutrition program
  - "Seed to table" curriculum
  - Creation of a school garden
  - Introduce six target vegetables through:
    - Sensory exploration
    - Tasting sessions
    - Cooking activities
    - Family recipe kits



Sample of Models Identified

- **SPARK Early Childhood Physical Activity and Wellness (Memphis & NYC)**
  - High activity, academically integrated, enjoyable movement opportunities
  - Curriculum
  - Training
  - Equipment
  - Follow-up support



Additional Collaborative Models

- **Collaborative planning**
  - **Healthy Kids – Las Cruces (New Mexico)**
- **Data systems**
  - **KIDSNET (Rhode Island)**
- Policy efforts
  - Nutrition (Michigan, W. Virginia, Alabama, Georgia, Louisiana, Mississippi)
  - Physical activity (Alaska, Massachusetts, Mississippi)
  - Screen time (Maine, New Mexico, Vermont, New York)



Now Where Do We Go From Here?



Contact Information

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The North Carolina Partnership for Children, Inc.
Email: jkozlowski@ncsmartstart.org
Phone: (919) 821-9581



STATE OF NORTH CAROLINA
NORTH CAROLINA
GENERAL ASSEMBLY
STATE LEGISLATIVE
BUILDING
RALEIGH, NORTH CAROLINA
27601

December 28, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R Purcell
Chairman, Representative Douglas Y Yongue

SUBJECT: **Meeting Notice for Tuesday, February 15, 2010**

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY: **Tuesday** **TIME:** **9:30 am – 3:00 pm**

DATE: **February 15, 2010**

LOCATION: **Room 544, Legislative Office Building**

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend.

Posted:

cc: Committee X
Record
Interested Parties X

Minutes
Task Force on Childhood Obesity
9:30 am Monday, February 15, 2010

The Legislative Task Force on Childhood Obesity met Monday, February 15, 2010 at 9:30 am in Room 544 of the Legislative Office Building. Senator Bill Purcell presided over the meeting. The theme of the meeting is "Children's Physical Activity, Body Mass Index (BMI), and Fitness". The following House members were in attendance: Representative Douglas Yongue (Co-Chair), and Representatives Brown, Grady, Hughes, Weiss, and Senators Dannelly, Davis, Tillman, and Walters. Please see the attached agenda, attendance, and visitor registration (Attachments 1, 2, 3). Chairman Purcell welcomed legislators, Sgt.-at-Arms, staff, and the public. He then invited the first of seven presenters to speak.

Arkansas Policy & Robert Wood Johnson Foundation Efforts
Ms. Paula Card-Higginson, Deputy Director, Center to Prevent Childhood Obesity, Robert Wood Johnson Foundation and Associate Director, Arkansas Center for Health Improvement, gave an overview of the efforts by the state of Arkansas and the Robert Wood Johnson Foundation. The Arkansas General Assembly passed Act 1220 in 2003 to change the environment in public schools, to gauge the community, and to increase awareness among parents and leaders. Act 1220 propagated the following changes: (1) required professional development for cafeteria workers, (2) established the Arkansas Child Health Advisory Committee, (3) changed content of vending machines in schools, (4) required confidential BMI assessment of students, (5) implemented new physical education/activity requirements, (6) required public disclosure of pouring contracts, and (7) established local parent advisory committees in each school. The University of Arkansas for Medical Sciences College of Public Health has monitored progress and evaluated implementation of the legislation. Positive findings included increased parental and student awareness, innovation in the form of taste tests, as well as continued policy improvement. The data collection allowed the state to find that 38% of students are overweight or obese – a rate that has plateued since. A total of 99% of schools participated. Continuing medical education for physicians has been developed since 2004 in order to address parents' concerns once they receive their child's confidential health report card. The Arkansas State Board of Education has taken action in recent years by restricting the sell of competitive foods, restricting vending machine use during school hours, and implementing nutrition and health curriculum changes, and more.

Chairman Yongue asked about the composition of the Child Health Advisory Committee. Ms. Card-Higginson noted that of about 20 members across health and education sectors, there are representatives of the Arkansas Center for Health Improvement, Arkansas Department of Health, Arkansas Department of Education, gubernatorial appointments, legislative appointments, and more. The committee has grown since Act 1220 was passed from 15 to 20 members. For a complete list, see the attached copy of Act 1220. She indicated that the Advisory Committee continually acts independently of the legislature. Senator Tillman asked if the Advisory

Committee was created by the legislation, and if the Committee was key to making changes. Ms. Card-Higginson said the Advisory Committee was a creation of Act 1220 and was not key to passage of the bill, but was instrumental to implementation. Representative Brown suggested that the committee take a serious look at the progress made in Arkansas as a result of Act 1220. Chairman Purcell recognized Mr. David Gardner, Department of Public Instruction, for a question. Mr. Gardner asked for more detail about the change in 2007 regarding physical education requirements and the BMI assessment in schools. Ms. Card-Higginson noted that as legislators were informed by educators of the need for more instructional classroom time, the physical education requirements were relaxed in 2007. Ms. Susan Harrison asked if the state contributes to cafeteria meals. Ms. Card-Higginson answered saying that schools only receive federal USDA funds for meals, with no state funds, and have been encouraged to apply for American Reinvestment and Recovery Act funds for equipment needs. Ms. Paula Collins, Senior Policy Advisor, Healthy Responsible Students, State Board of Education, asked for the cost of the BMI assessment. This figure was unknown, although she noted that equipment was a major cost.

Ms. Card-Higginson, who also serves as Deputy Director of the Robert Wood Johnson Foundation's Center to Prevent Childhood Obesity, continued by reviewing the following goals of the center:

(1) Reduce the prevalence of overweight and obesity among children in the U.S.
(2) Decrease racial, socio-economic disparities in childhood obesity
(3) Create systemic, sustainable change

This growing national epidemic is a result of food addiction, possible brain development changes, prenatal imprinting, and energy imbalance according to Ms. Card-Higginson. She suggested that energy imbalance is a major causal factor as we consume more calories that we expend through any physical activity. The Center to Prevent Childhood Obesity suggests that all levels of government participate in policy changes to increase awareness and shift the energy imbalance by targeting the food environment of children, built environment (parks, sidewalks, playgrounds, and facilities), schools, and health care. She briefly mentioned the federal impact on access to healthy foods and community environments, noting new efforts to change trends thorough the Healthy Food Financing Initiative. She encouraged the task force review the recommendations of the Institute of Medicine, Centers for Disease Control and Prevention, and Leadership for Healthy Communities in developing policy recommendations in the future. State policy changes could include joint use agreements in order to maximize the use of parks, gyms, etc. She suggested that the state could use grant dollars to market healthy foods and active living. Ms. Card-Higginson noted that these issues must be tackled from every angle with a supportive public. Please see the Center's website at: www.reversechildhoodobesity.org . See the attached handout and a copy of Act 1220 (Attachment 4 & 5). Chairman Yongue asked for her suggestions in passing the necessary policies. Ms. Card-Higginson noted that the work must be completed by all levels of government – local, state, and federal. She suggested that the state has more power through the legislature and the State Board of Education. Although, she says that locals can certainly act on their own without state mandates. Representative Weiss asked what advice was given in Arkansas once Child Health Reports were sent to parents. Ms. Card-Higginson says that parents were advised with information from recommendations of the American Academy of Pediatrics, but some gap still exists between reporting and medical

intervention due to access. Senator Tillman expressed his excitement about the possibility of moving forward to curb childhood obesity. Senator Dannelly expressed his concern over adding more state mandates for schools to follow. Ms. Card-Higginson noted that while schools are only one part of the puzzle, they certainly have the power to enhance nutrition and physical education. She mentioned that research indicates that children learn more as their focus is increased once they become more active. Representative Hughes asked how a farmer may collaborate more with schools in planning to create a healthier, fresh menu. Ms. Card-Higginson noted the success of the Farm-to-School program in bridging this gap – helping farmers to plan long term.

Built Environment

Chairman Purcell called upon Mr. Phillip Bors, Project Officer, Active Living by Design, to present to the committee. Mr. Bors spoke about the growing consensus regarding community built environments and strategies to implement policies in NC. Mr. Bors also works with Healthy Kids, Healthy Communities, NC Institute for Public Health, using grant funds from the Robert Wood Johnson Foundation. This work is targeted towards cities and communities, and does not involve schools. Please see Mr. Bors presentation in its entirety (Attachment 6). The concept of the 'built environment' considers the access in communities for activity, the character of the community, how we move, and where the activity happens. According to a survey taken by Health Departments across the state, 60% of North Carolinas in 2007 reported they would in fact become more physically active given the opportunity through safe and accessible sidewalks and trails. Mr. Bors identified the following six goals and recommendations to the Task Force:

(1) More walkable destinations
(2) Safer routes to and from school
(3) Safer routes in communities
(4) Creation and maintenance of parks and open space
(5) Creation and maintenance of trails and greenways
(6) Shared use of schools after hours.

Mr. Bors discussed funding options for recommendations 1-3, as well as, similar efforts by other states to implement policies. Many of these policy recommendations, Mr. Bors suggested, could have benefits for all members of a community beyond children and weight status.

Dr. Kelly Evenson, Research Associate Professor, University of North Carolina, discussed recommendations 4-6 in her remarks to the Task Force. Dr. Evenson presented the 2008 NC Pedestrian and Bicycle Plan, as accomplished by public participation, and includes an analysis of current conditions. The development of the published Plan involves local planning advocates, health advocates, transportation officials, local representatives, etc. Dr. Evenson and her associates surveyed municipalities last year to ask questions about the inclusion of plans, funding sources, and barriers. The number one barrier listed was funding, followed closely by liability issues. There were three main funding sources: (73%) Municipal earmarked funds, (57%) Powell Bill funds, (48%) Capital Improvement Programs. Please see the attached handout and document highlighting the various pedestrian and bicycle plans from around the state (Attachment 6 & 7). Among the 544 municipalities in the state – there were 28 with a pedestrian plan, 23 with a bicycle plan, and 5 with a combined plan. The combined plans were funded with

only local resources. Once completing her review and explanation of recommendations 4, 5 and 6, Dr. Evenson and Mr. Bors took questions from members. Senator Dannelly asked how to encourage citizens to use bicycle lanes, as they are not used as widely in Charlotte as they may be in other large metropolitan areas. Mr. Bors said that building awareness is instrumental for planners once these projects are complete. Senator Walters asked about how to encourage citizens who live in rural areas of the state. Mr. Bors suggested that joint or shared use facilities – such as school, churches, etc. – are important for rural areas. He also mentioned that walkable destinations are possible in city centers – even in rural areas. Representative Hughes asked who conducted the evaluation in the Healthy Active Children Policy. Dr. Evenson said that LEAs were asked to submit a progress report. Mr. Dave Gardner, Section Chief, Healthy Schools, NC Department of Public Instruction, suggested that the contact for the School Health Advisory Council was responsible for collecting the information. Representative Brown suggested that the state should encourage more local governments to develop plans. Senator Davis commented on the struggles small communities have in meeting a state match when a locale may have a budget of less than $100,000. Representative Weiss commented on the successes of the Healthy Carolinians group. Dr. Evenson suggested that many local communities have Local Fitness Councils who may have collective access to grant funds. Mr. Bors noted that while much of the funding starts with the NC Department of Transportation, there are other resources. There were no other questions for the presenters.

Role of Primary Care Physicians

Dr. Elizabeth Tilson, Medical Director, Community Care of Wake and Johnston Counties, provided the perspective and role of Primary Care Physicians and the role of BMI screening in identifying overweight and obese children. She began her remarks by highlighting the organization and goals of Community Care of North Carolina – a program of the NC Department of Health and Human Services. Community Care of North Carolina or CCNC coordinates Medicaid contracts through 14 networks to provide local clinical care for Medicaid enrollees. The primary goals of CCNC are: (1) to improve the care of Medicaid enrollees while controlling costs, (2) to develop Community Networks and local systems capable of and responsible for managing recipient care, and (3) to fully develop and support the Primary Care Medical Home. In February 2010, there were 3500 primary care physicians responsible for more than 985,000 Medicaid enrollees. Community Care of Wake and Johnston Counties has focused its efforts in three areas: BMI assessment, blood pressure, and survey. Complications of childhood obesity as perceived by primary care physicians include sleep apnea, fatty liver disease, depression, asthma, type II diabetes, heart disease, and more. Dr. Tilson listed the barriers physicians face in treating these children. Barriers include limited time, tools, and training, limited access to nutritionists, and differing payer policies. As a result of grant funds from the Kate B. Reynolds Foundation, CCNC is working to combat childhood obesity in 4 of the 14 networks over a 2 year span. Community Care of Wake and Johnston Counties is one of the four participating networks. A total of 15 counties are included in these four networks. The grant funds allow Community Care of Wake and Johnston Counties to identify best practices to share with all other providers, develop clinical tools and train for future statewide utilization, identify and link to community resources, provide care management through nurses and social workers, and pilot co-location models with nutritionists. By the end of year one and two, all annual goals were met if not exceeded. Dr. Tilson has worked to customize the program elements in Wake and Johnston Counties by fostering advocacy in the communities. She presented a chart provided to family

doctors to gage BMI appropriately according to age. This was a critical tool provided to physicians to educate them on the sensitivity of the Body Mass Index calculation. Other clinical tools included blood pressure assessment charts by gender and age, a survey for parents on their child's eating habits, a list of strategies for parents and children to develop better eating habits and be more fit, a local park and greenway guide, sugar and fat displays, portion size and healthy meal planning tools, and motivational interviews. Partnering with Advocates for Health in Action (AHA), the network in Wake and Johnston Counties has worked more closely with physicians to become advocates in their communities to increase awareness. This partnership has succeeded in developing a 'Healthy Snack Guide' and establishing a workplace wellness program. Dr. Tilson emphasized that everyone must be a player. She also suggested that this is a family issue- with particular pressure on mothers. As mothers typically control the diet of their children through grocery shopping, cooking, and preparing meals, mothers must be educated and aware. Dr. Tilson suggested that if the state allowed nutritionists to bill independently of primary care providers, children would perhaps have more access to balanced care. Chairman Purcell opened the floor to questions. Representative Weiss asked if it is too soon to see results. Dr. Tilson noted that since the grant was awarded in January 2008 and runs through January 2010, there is no evidence yet of marked improvement on the patient level. She then asked about the cost of expanding this program statewide. Dr. Tilson noted that CCWJC received about $40,000 to complete the work. The statewide cost of implementation was unknown. For more information, you may visit the website at www.ccwjc.com. Please see Dr. Tilson's handout for more detail (Attachment 8).

The committee recessed for lunch at 12:15 pm and reconvened at 1:15 pm.

Department of Public Instruction

Dr. David Gardner, Section Chief, Healthy Schools, NC Department of Public Instruction, thanked the Task Force for the opportunity to share their efforts to impact childhood obesity in NC. The Healthy Schools Section at NCDPI receives grant funding from the Centers for Disease Control, Division of Adolescents School Health. This funding bridges the gap between the Department of Public Instruction and the NC Division of Public Health. The North Carolina Standard Course of Study for Healthful Living gives guidance, with scope and sequence, to teachers and LEAs and sets out objectives to be met by all LEAs. The content taught and time dedicated varies across LEAs. This Healthful Living Standard Course of Study focuses on physical education and health education from Kindergarten through high school, is predicated on national standards, and promotes the use of evidence-based tools and instruction. The last revision occurred in 2006. The next revision is under way. The content, by grade, is detailed in the attached handout (Attachment 9).

Grades K-5 focus, in Physical Education, is on movement, motor skills, sports literacy, heath related fitness, and personal responsibility. Beginning in middle school, Grades 6-8, health education is combined with physical education to create 'Healthful Living' education to be taught by a licensed physical education teacher. There is a focus on personal fitness, lifetime activities, and activities that enhance decision making skills and offer a challenge. In high school, Grades 9-12, there is a one-hour healthful living education requirement, to be taught by a licensed physical education teacher and a licensed health education teacher – typically over a two

semester span. The focus is on healthy weight management, personal wellness, and the benefits of daily physical education.

Elementary grades K-5, in Health Education, focus on servings and portion control, healthy weight management, nutrition labels, with no time requirement or designated health class. Middle school students learn Health Education with a focus on dietary guidelines, the role of nutrition on weight management, eating disorders, media literacy, and balancing caloric intake with energy expenditure. High schools students, taught by a licensed teacher, focus on personal weight management, analysis of popular weight loss plans, personal and consumer health, and the use of technology as a tool.

The Healthy Active Children Policy, as adopted by the State Board of Education, GCS-S-000, seeks to accomplish the following:

(1) Requires establishment of School Health Advisory Councils (SHACs) at the local level,
(2) Mandates 30 minutes of physical activity daily,
(3) Recommends 150 minutes of Physical Education per week in Grades K-5
(4) Recommends 225 minutes of Healthful Living Education in Grades 6-8
(5) Protects recess and other physical activity
(6) Promotes Coordinated School health approach
(7) Requires an annual report from LEAs to the State Board of Education

The Healthy Active Children Policy has achieved a 95% response rate in 2009, with 106 of 112 LEAs reporting. Mr. Gardner shared that 61% of School Health Advisory Councils reported to their Local Boards of Education in 2009. Mr. Gardner highlighted a sampling of data collection efforts across the state, such as the Youth Risk Behavior survey, School Health Profile survey, School Level Impact Measures, In-School Prevention of Disease.

Challenges for the Department of Public Instruction, superintendents, principles, and teachers include time, inadequate facilities and equipment, other school priorities, and confusion over the difference between physical education and physical activity, disproportionate emphasis on athletics, local control limitations, and school size. Concerning the difference between physical activity and physical education, schools interpret these two requirements in various ways. With limited space and time, many schools confuse the two.

Mr. Gardner finally offered opportunities for the Task Force to consider. He suggested sharing and managing date in more effective ways, enacting policies to encourage and enhance joint use agreements, enact policies that enable LEAs to build schools that are nutrition friendly, develop and implement a K-12 evidence-based assessment and accountability plan for Healthful Living Education.

Chairman Purcell opened the floor to questions. Senator Tillman expressed his concern over the lack of control by only encouraging physical activity. Representative Weiss encouraged the task force to consider ways to encourage more intramural sports – in order to give more students the opportunity to be physically active. Chairman Yongue spoke about his experience in visits to other countries and their schools. He noted that we need a major shift in attitudes and behaviors

by putting our health first. Representative Brown noted that many opportunities exist in community recreation sports teams. Senator Davis asked, regarding the 30 minute requirement of physical activity, if schools are allowed to be creative in their use of recess. Mr. Gardner noted the difficulty in enforcing physical activity during recess. With no further questions, Chairman Purcell invited the next presenter.

MATCH Program

Mr. Tim Hardison, Program Director, MATCH – Moving Adolescents with Technology to Choose Health, spoke to the task force about his program's energy, success, and cost-effectiveness. The MATCH program, awarded grant funds by the 2008-2009 NC Task Force on Preventing Childhood Obesity's Pilot Program Think Tank, is aligned with the NC Standard Course of Study. The NC Task Force on Preventing Childhood Obesity was a directive of the 2008 state budget, and was lead by Co-Chairs – Dr. Leah Devlin, State Health Director, NC Division of Public Health, and Chairman Howard Lee, State Board of Education. The MATCH Program uses existing policy and programs. Mr. Hardison, a teacher, focused on the need to educate students by changing their attitudes and behaviors about nutrition and physical activity. MATCH is a 14-week middle school, cross-curricular program taught in 7th grade. The Program, incorporating the work of Eat Smart Move More, has been successful with excellent data to prove results. The program does not mention weight, but focuses instead on health and choices. MATCH provides incentive based rewards when students meet goals. The program incorporates 30 minutes of physical activity per day and involves all classroom subjects. The program has seen marked results in academic progress and BMI. The NC State Board of Education voted to expand in 2009 across five counties, with funding from Blue Cross and Blue Shield of NC. Please see the attached handouts outlining the program's success (Attachment 10, 11, 12).

Dr. Suzanne Lazorick, MD, Brody School of Medicine, East Carolina University, presented the potential cost savings of the MATCH program. She first noted that the program is unique in teaching behavior change using cognitive theory. She argued that the program is developmentally appropriate. Dr. Lazorick said as BMI is the main outcome, the goal is to increase BMI over the years with growth on a gradual basis. Movement of the BMI should be toward the mean, as the Z-score decreases. Dr. Lazorick presented the one year follow up results at the middle school in Williamston, NC. Thus far, there is no guarantee that the success can be replicated in much more broad context. Dr. Lazorick will be researching the program's success with this in mind. As teachers have been surveyed, they have overwhelmingly approved of the techniques, admitting an increased awareness of childhood obesity. Dr. Lazorick reviewed the various policy implications, initially suggesting that enforcement of the 30 minutes of daily activity was necessary. She recommended improving the nutritional offering in schools, and enhancing the use of shared and joint use. Chairman Purcell opened the floor to questions. Senator Tillman praised Dr. Hardison and the practical work and progress of the program. Senator Davis praised the program for its innovation and creative techniques. Representative Yongue, Senator Walters, Senator Dannelly, and Representative Hughes praised the program for its success.

U.S. Army

The final presenter, Col. Kevin Schwedo, Deputy Commanding Officer, United State Army, Basic Combat Training Center, spoke to the task force about the unique challenges faced by the

Army when training soldiers. Colonel Schwedo spoke about eh increasing rates of obesity as overweight adults become more and more unhealthy, caring more health risks. Since 2003, the number of soldiers medically diagnosed as overweight has doubled in the Army. During the same time period, the rate of back and joint injuries have significantly increased as well. As there are more and more unhealthy men and women attempting to enlist, many have been turned away. In an effort to curb this problem, and recruit 150,000 per year, the US Army has created a program called ARMS – the Assessment of Recruit Motivation and Strength. ARMS is a performance-based tool to screen those applicants who were otherwise disqualified for service. Col. Schwedo highlighted the success of a weight loss program for decreasing BMI and decreasing other health risks. For more detail, please see the attached handout (Attachment 13). Following his presentation, Representative Weiss asked if the Army is changing diets on base – for soldiers and their families. Col. Schwedo indicated that the dining facilities are improving their menus.

With no further presentations and discussion, Chairman Purcell adjourned the meeting at 4:15 pm.

Douglas Y. Yongue

Representative Douglas Yongue, Co-Chairman

Katie Stanley

Katie Stanley, Committee Assistant

Task Force on Childhood Obesity

AGENDA

Monday, February 15, 2010
9:30 am
Legislative Office Building
Room 544

Children's Physical Activity, BMI, and Fitness

I Introduction
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

II Paula Card-Higginson, Deputy Director, Center on Childhood Obesity, Robert Wood Johnson Foundation

III Philip Bors, MPH, Project Officer, Active Living By Design & Health Kids, Healthy Communities, NC Institute for Public Health

IV Dr. Kelly Evenson, PhD, Research Associate Professor, Gillings School of Global Public Health, University of North Carolina

Dr. Elizabeth Tilson, MD, MPH, Medical Director, Community Care of Wake and Johnston Counties

Lunch Break

VI David Gardner, Section Chief, Healthy Schools, NC Department of Public Instruction

VII Tim Hardison, Program Director, Moving Adolescents with Technology to Choose Health (MATCH)
Dr. Suzanne Lazorick, MD, Brody School of Medicine, East Carolina University

VIII Col. Kevin Shwedo, Deputy Commanding Officer, United States Army, Basic Combat Training Center, Center of Excellence

IX Discussion

Future Meeting Dates:

Tuesday, February 23, (10:00 am – 3:00 pm) Food Industry – Room 643 LOB

Reversing Childhood Obesity: A National Movement

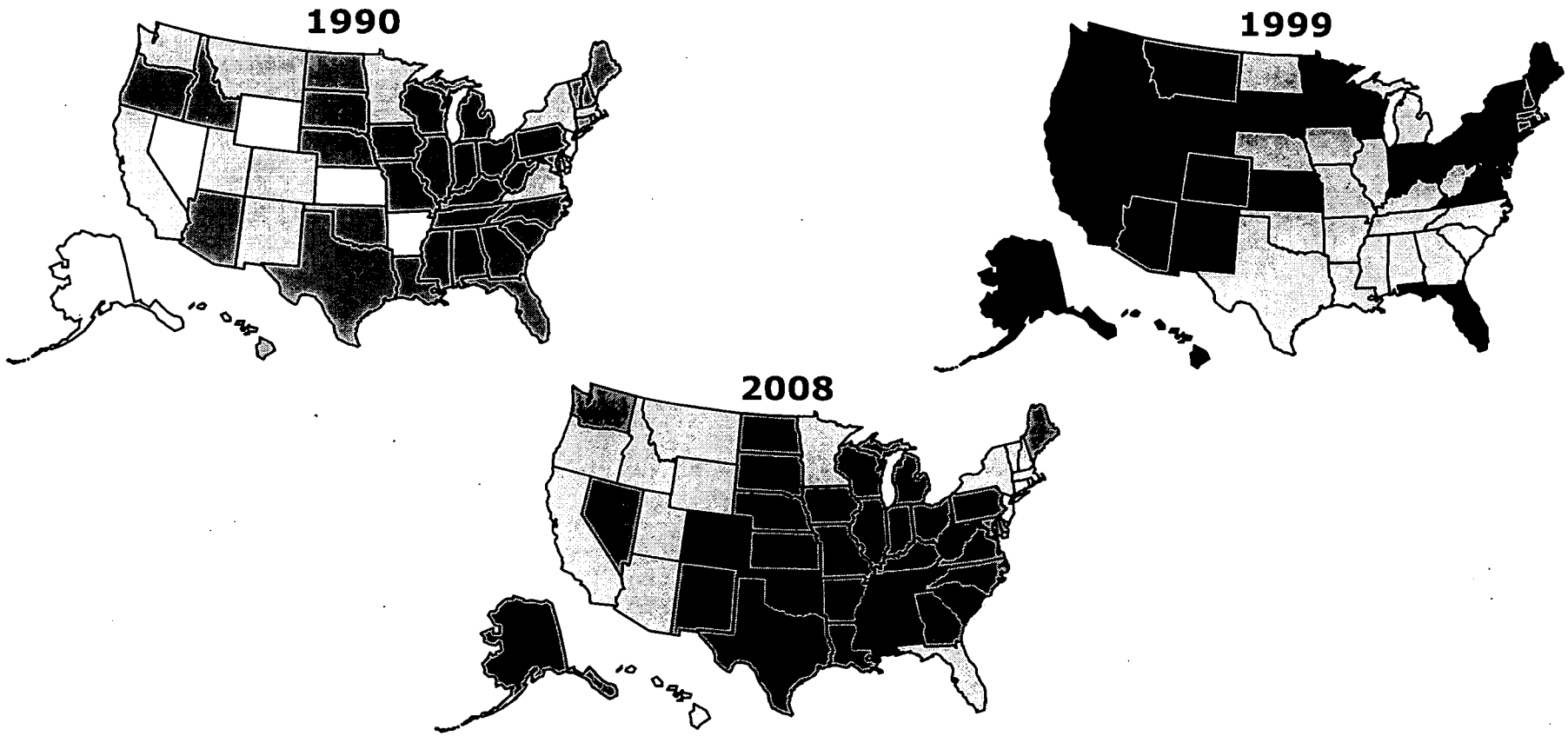
Paula Card-Higginson

Deputy Director,
Robert Wood Johnson Foundation
Center to Prevent Childhood Obesity

February 15, 2010

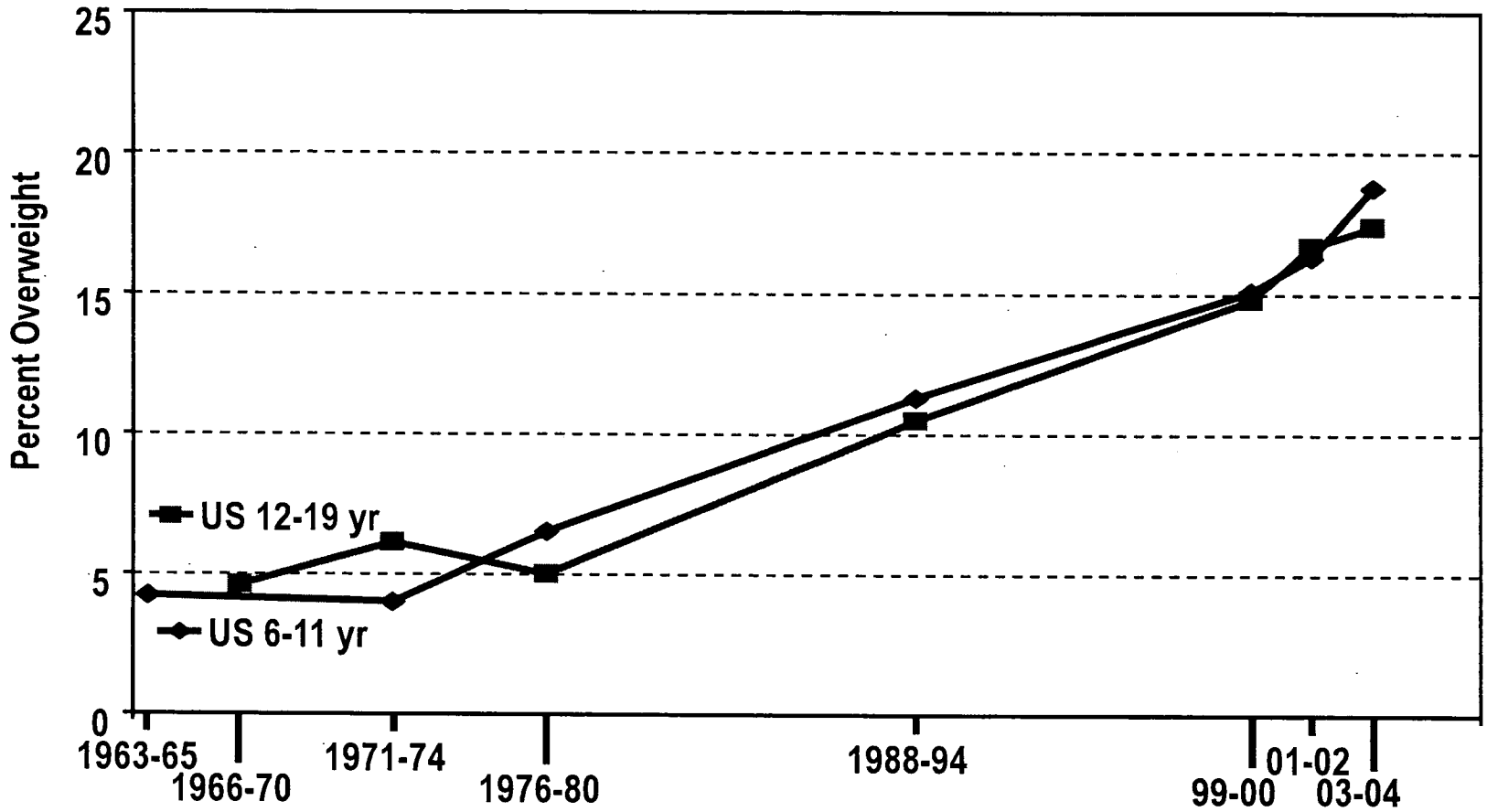
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 1999, 2008

(*BMI ≥30, or about 30 lbs. overweight for 5'4" person)



Source: CDC Behavioral Risk Factor Surveillance System.

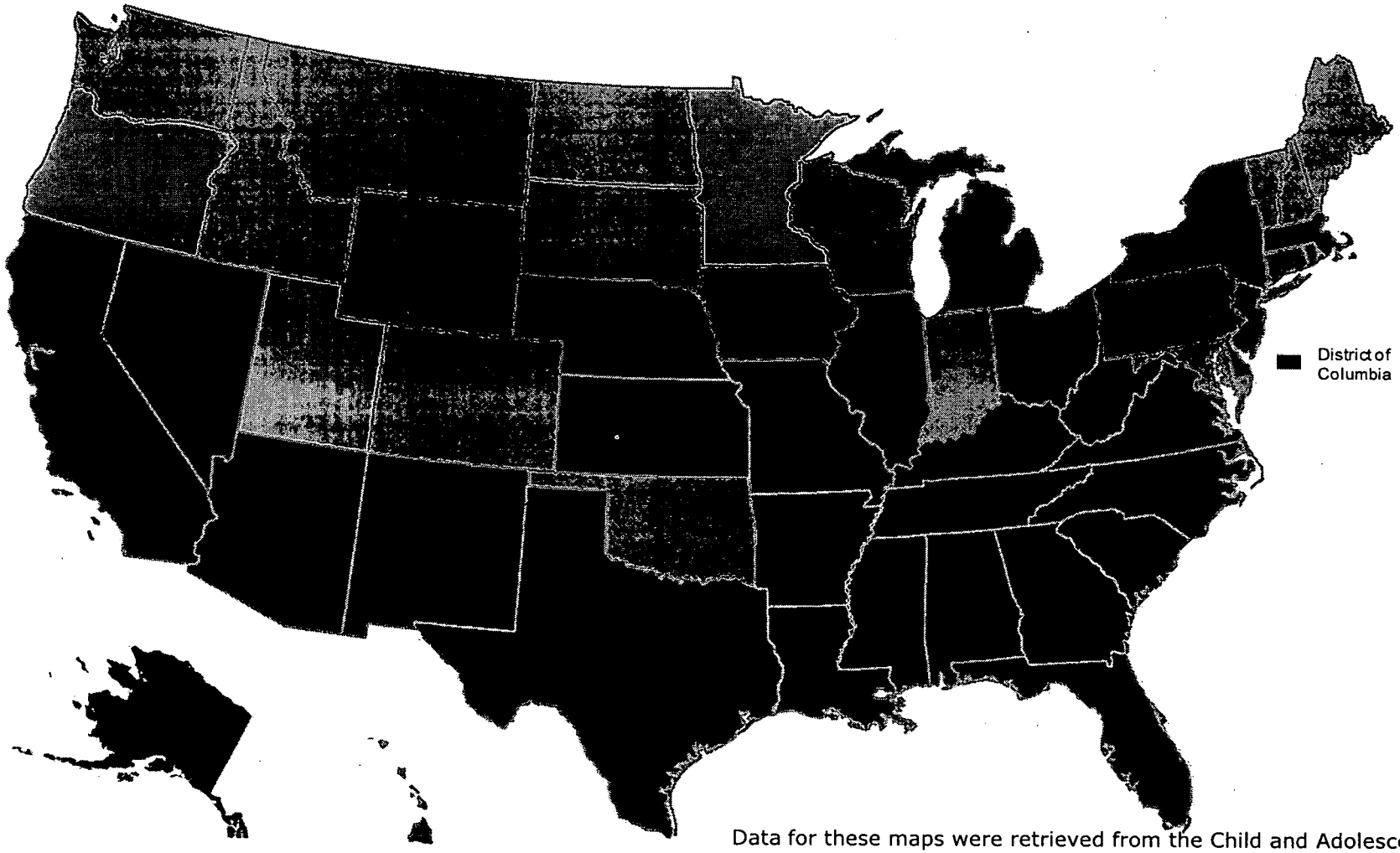
National Childhood Obesity Trends



NHANES data sources: Ogden et al. *Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000.* JAMA 2002;288(14):1728-1732. Ogden et al. *Prevalence of Overweight and Obesity in the United States, 1999-2004.* JAMA 2006;295(13):1549-1555.

ACHI

Percentage of Children who are Obese Aged 10–17 Years by State (2007)



Percentage <10 10-14 15-19 ≥20

Data for these maps were retrieved from the Child and Adolescent Health Measurement Initiative, 2003 and 2007 National Surveys of Children's Health, Data Resource Center for Child and Adolescent Health website (accessed 10/03/08 and 5/26/09, www.nschdata.org).

ACHI

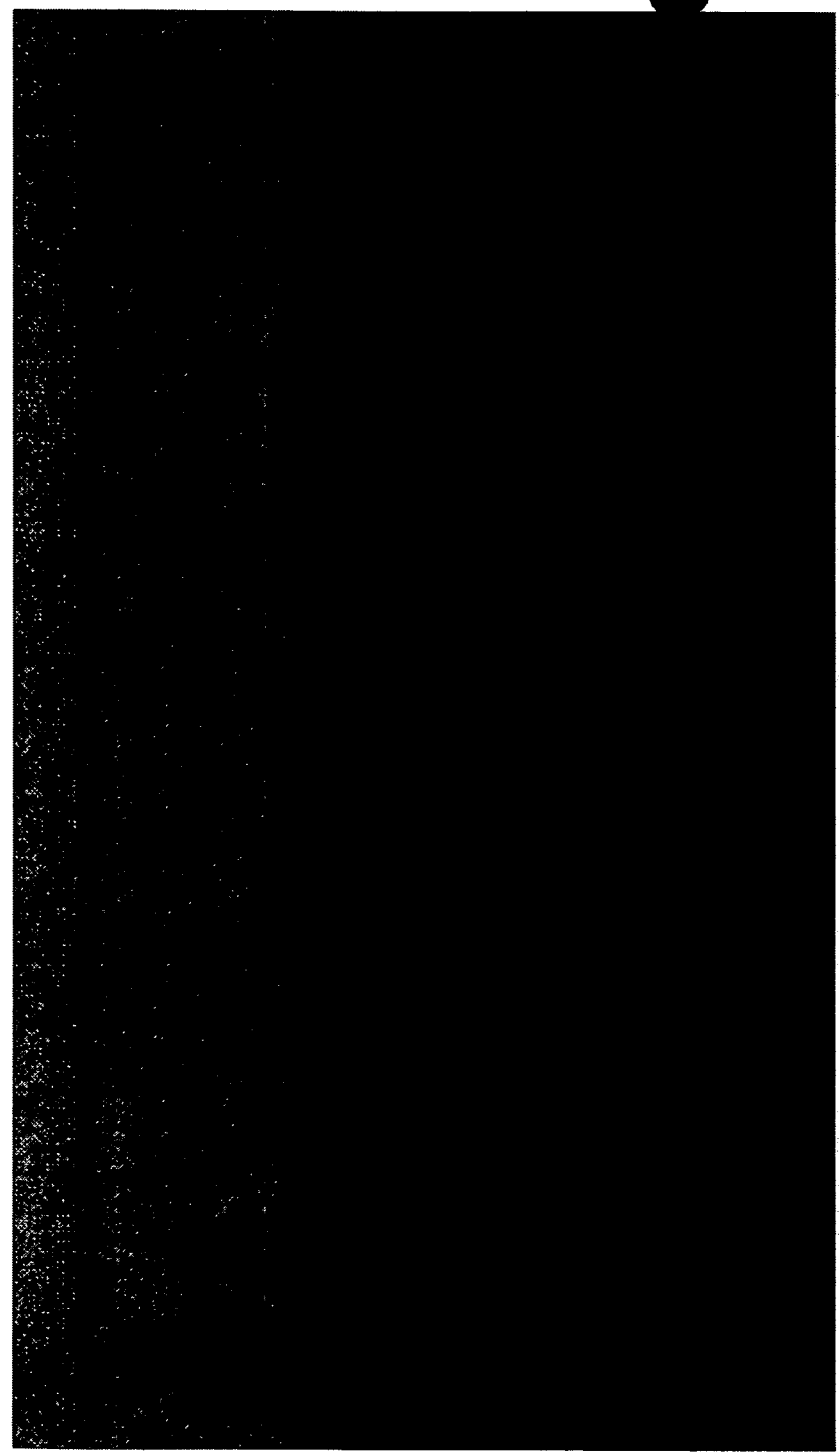
Act 1220 of 2003: Arkansas Child and Adolescent Obesity Initiative

Paula Card-Higginson

Associate Director,
Arkansas Center
for Health Improvement

ACHI

ARKANSAS CENTER FOR HEALTH IMPROVEMENT



84th General Assembly Act 1220 of 2003

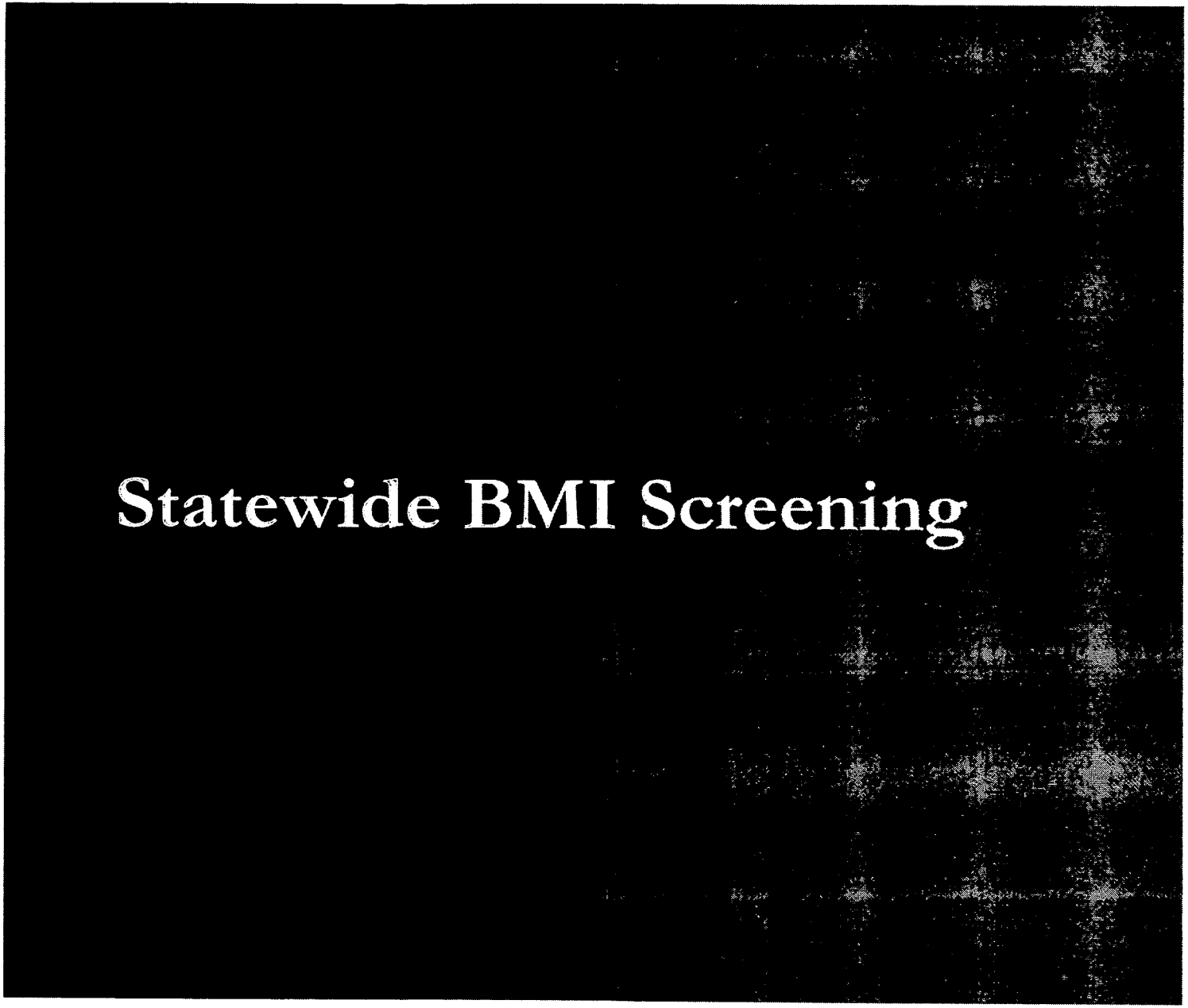
An act to create a Child Health Advisory Committee; to ***coordinate statewide efforts to combat childhood obesity and related illnesses; to improve the health of the next generation of Arkansans****; and for other purposes.*

Goals:

- Change the environment within which children go to school and learn health habits every day
- Engage the community to support parents and build a system that encourages health
- Enhance awareness of child and adolescent obesity to mobilize resources and establish support structures

Act 1220 Requirements

1. Establishment of an Arkansas Child Health Advisory Committee
2. Vending machine content and access changes
3. Physical activity / education requirements
4. Requirement of professional education for all cafeteria workers
5. Public disclosure of "pouring contracts"
6. Establishment of local parent advisory committees for all schools
7. Confidential child health report delivered annually to parents with body mass index (BMI) assessment



ACHI

Guiding Principles for BMI Reporting in Children & Adolescents

- **BMI assessment is a health screening tool like vision, hearing or scoliosis screenings routinely performed in public schools**
- **All students should be assessed – no one singled out**
- **Confidentiality should be maintained in measuring and reporting**
- **Confidential Child Health Reports are a health advisory tool for parents – not a grade or report card**

Child Health Report (2004)

BRYANT SCHOOL DISTRICT
BRYANT ELEMENTARY SCHOOL
200 NW 4TH
BRYANT, AR 72022

T60PC3P4

Dear Parent or Gu

This Child Health
because of her we

Why is this repor
If a child is overwe
are overweight arc
disease. Children

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problem for Samar

What is a BMI?
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it is a screening te
problems early. Th
problems from dev
changes as childre
boys. So, it is impo
if your child is grow

What should you
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visit your doctor, pl
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- Offer healthy snacks, like fruits, vegetables, and other foods low in sugar and salt.
- Drink fewer sodas and drink more water, low-fat milk, or low-calorie drinks.
- Limit television, video games, and computer time to no more than 2 hours a day.
- Take family walks, bicycle, run, or exercise with your child.

Healthy habits start early. Please be aware that diet, physical activity, and other health habits will affect your child's health and life. Thank you.

On behalf of your child's school

Joe Thompson

Joseph W. Thompson, MD, MPH
Director, Arkansas Center for Health Improvement

Please go to www.achi.net for more information.
A free CME project for doctors is available at www.achi.net.

A generous gift from the American Diabetes Association made distribution of this letter possible.

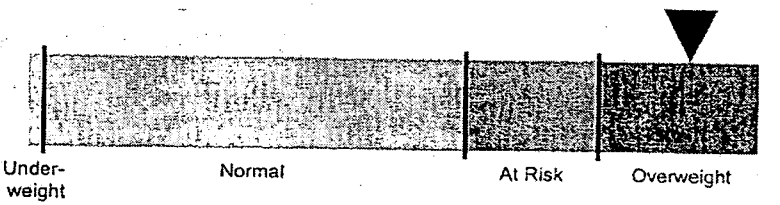
Is your child's weight a health problem?

Your child was weighed and measured at Bryant Elementary School on November 17, 2003. [redacted] was 60.5 inches tall and weighed 137.4 pounds. Based on her height and weight, [redacted] has a Body Mass Index (BMI) of 26.4. A BMI of 26.4 for a 10-year-old girl suggests that your child may be OVERWEIGHT (see chart). This may be a major health problem for [redacted].

What is a BMI?

A BMI tells if a person may be overweight or underweight. It is a screening test. Doctors use screening tests to find problems early. This may help prevent more serious problems from developing later. A healthy BMI number changes as children age and is different between girls and boys. So, it is important to measure BMI each year to see if your child is growing and developing in a healthy way.

Your Child's BMI



The arrow shows how your child's BMI compares with other Arkansas school children.

What should you do?

Source: Arkansas Center for Health Improvement, Little Rock, AR, 2004.

Spanish Child Health Report (2005)

EXAMPLE SCHOOL DISTRICT
EXAMPLE SCHOOL NAME
Address
City, AR, #####

May 16, 2005

Parent Name
«MailingAddress1»
«MailingCity», «MailingState» «Zip»

Estimados Padres:

Esta carta importante se refiere a la salud de Example Student. Por favor léala toda.

Muchos ni
estatura y
el percent
está al rie

Si un niña
exceso de
que están
sobrepesc
otros prob

Rarament
muscular.
IMC está
doctor de

¿Por qué
Las leyes
reporte so
con la vist
que se tor
que, es im

¿Es el pe
El pasado
la escuela
y pesó 13
sugiere qu

¿Qué debe hacer usted?
Dado que el IMC de EXAMPLE sugiere que ella está **sobrepeso**, sería bueno que hablara con el doctor de su niña. Por favor enséñele esta carta al doctor (EXAMPLE's BMI was **30.8** or **97.4** percentile). Su doctor verificara el IMC de su niña y se asegurara que las medidas que se tomaron en la escuela son las correctas. Además, su doctor puede informarle acerca de una alimentación saludable y actividades físicas para su niña. Por ejemplo, la Academia Americana de Pediatría es un grupo de médicos que atienden a niños y sugieren que su familia debe de:

- Ofrecer bocadillos saludables tales como frutas, verduras y otras comidas bajas en azúcar y sal.
- Beber menos sodas y tomar más agua, leche desgrasada o bebidas bajas en calorías.
- Limitar a dos horas diarias el tiempo viendo televisión o jugando videos.
- Hacer ejercicios con sus niños tales como corriendo, caminando o usando la bicicleta.

Los hábitos saludables empiezan a una edad temprana. Por favor, esté conciente que la alimentación y la actividad física afectarán la salud y vida de su niña.

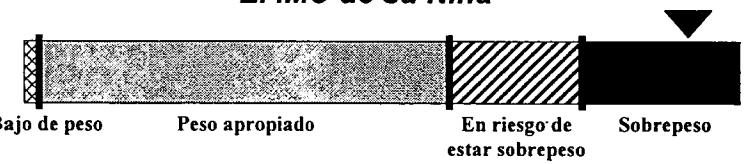
Gracias,
EXAMPLE SCHOOL NAME

Para mayor información, visite www.achi.net.

¿Por qué se midió el IMC en la escuela?
Las leyes del estado de Arkansas requieren que la escuela de su niña mida el IMC cada año y que se le envíe a usted un reporte sobre los resultados. En las escuelas de Arkansas también se practican pruebas iniciales para buscar problemas con la vista y la audición de los niños. Medir el IMC de su niña es otra manera de ayudarle a cuidar su salud. Acciones que se tomen ahora pueden ayudar a disminuir el riesgo de desarrollar enfermedades serias cuando crezca su niña. Así que, es importante medir el IMC cada año para ver si su niña está creciendo y desarrollando de una manera saludable.

¿Es el peso de su niña un problema de salud?
El pasado 3/1/05, su niña fue medida y pesada en la escuela. EXAMPLE midió 4 pies con 8 pulgadas y pesó 137.4 libras, lo que le da un IMC que sugiere que ella pueda estar **sobrepeso**.

El IMC de su Niña



La línea demuestra como el IMC de su niña se compara con el de otros niños en las escuelas de Arkansas.

¿Qué debe hacer usted?

Source: Arkansas Center for Health Improvement; Little Rock, AR, 2005.

ACHI

Participation in Arkansas BMI Assessments (Grades K, 2, 4, 6, 8 and 10)

Category	Year 1 ('03–'04)		Year 2 ('04–'05)		Year 3 ('05–'06)		Year 4 ('06–'07)		Year 5 ('07–'08)		Year 6 ('08–'09)	
	Percent	Total	Percent	Total	Percent	Total	Percent	Total	Percent	Total	Percent	Total
Participation*												
Public schools	**94.5%**	1,056 of 1,118	**98.8%**	1,110 of 1,124	**98.7%**	1,082 of 1,106	**99.2%**	1,062 of 1,071	**99.2%**	1,069 of 1,078	**98.7%**	1,072 of 1,086
Students (K, 2, 4, 6, 8 and 10)	**92.8%**	201,669 of 217,206	**96.1%**	209,563 of 217,460	**92.7%**	205,526 of 221,758	**97.1%**	223,214 of 229,815	**98.5%**	217,601 of 220,946	**97.9%**	216,871 of 221,583
Student data		**201,669**		**209,563**		**205,526**		**223,214**		**217,601**		**216,871**

Results include all data available for years 1, 2, 3, 4 and 5 for grades K, 2, 4, 6, 8 and 10, and year 6 data for the same grades received by June 11, 2009. The most common reason students were not assessed for BMI was absence from school. Fluctuation in the total number of public schools each year is due to school closings, new school openings and mergers. Only schools with students in even-number grades were included in this report. Source: *Assessment of Childhood and Adolescent Obesity in Arkansas* (Year 6, Fall 2008 – Spring 2009). Little Rock, AR: ACHI; September 2009.

ACHI

Percentage of Arkansas Students by Weight Classification

Category	Year 1 ('03 – '04)	Year 2 ('04 – '05)	Year 3 ('05 – '06)	Year 4 ('06 – '07)	Year 5 ('07 – '08)	Year 6 ('08 – '09)
Obese	20.8%	20.7%	20.4%	20.4%	20.5%	20.4%
Overweight	17.3%	17.3%	17.2%	17.3%	17.4%	17.2%
Healthy weight	60.2%	60.1%	60.6%	60.5%	60.2%	60.4%
Underweight	1.7%	1.9%	1.8%	1.8%	1.9%	1.9%
Total students assessed*	201,669	201,669	201,669	201,669	201,669	201,669

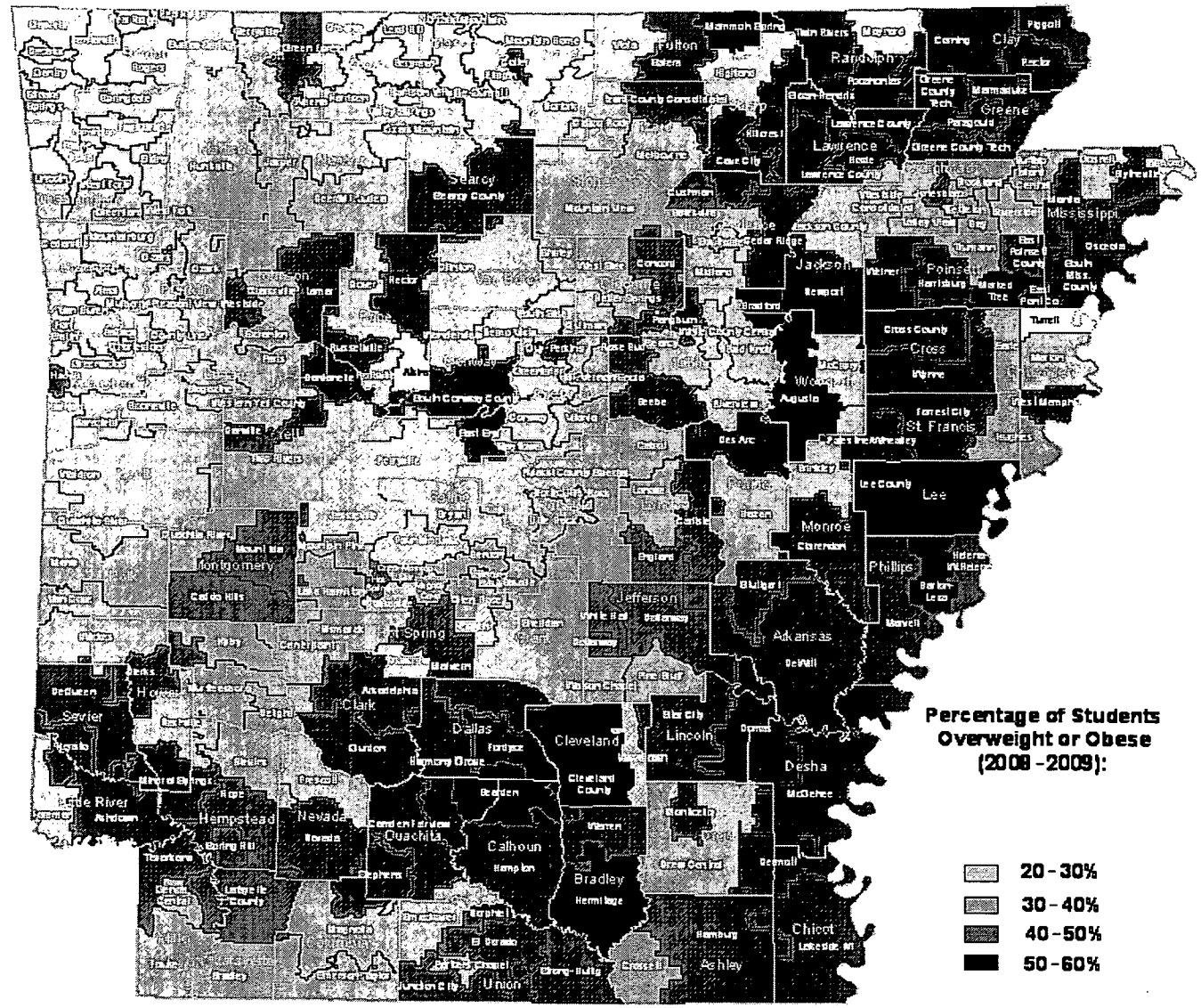
Results include all data available for years 1, 2, 3, 4 and 5 for grades K, 2, 4, 6, 8 and 10, and year 6 data for the same grades received by June 11, 2009. The most common reason students were not assessed for BMI was absence from school. Fluctuation in the total number of public schools each year is due to school closings, new school openings and mergers. Only schools with students in even-number grades were included in this report. Source: Assessment of Childhood and Adolescent Obesity in Arkansas (Year 6, Fall 2008 – Spring 2009). Little Rock, AR: ACHI; September 2009.

Reasons for "Unable to Assess"

Reason	Year 1 ('03–'04)	Year 2 ('04–'05)	Year 3 ('05-'06)	Year 4 ('06-'07)	Year 5 ('07-'08)	Year 6 ('08-'09)
Absent from school	6.3%	7.7%	6.7%	8.1%	7.4%	7.0%
Not attending that school	3.8%	1.4%	0.4%	6.8%	3.4%	2.0%
Parent refused to allow measurement	3.7%	3.2%	3.4%	2.9%	4.1%	4.0%
Student refused measurement	1.7%	2.6%	2.7%	3.3%	2.3%	2.0%
Other	1.1%	0.6%	0.6%	0.8%	0.6%	1.6%
Disability prohibited measurement	0.2%	0.2%	0.2%	0.3%	0.2%	0.3%
Student was pregnant	0.1%	0.1%	0.1%	0.1%	0.04%	0.04%
Wt exceeded scale limits	N/A	N/A	N/A	0.03%	0.02%	0.03%

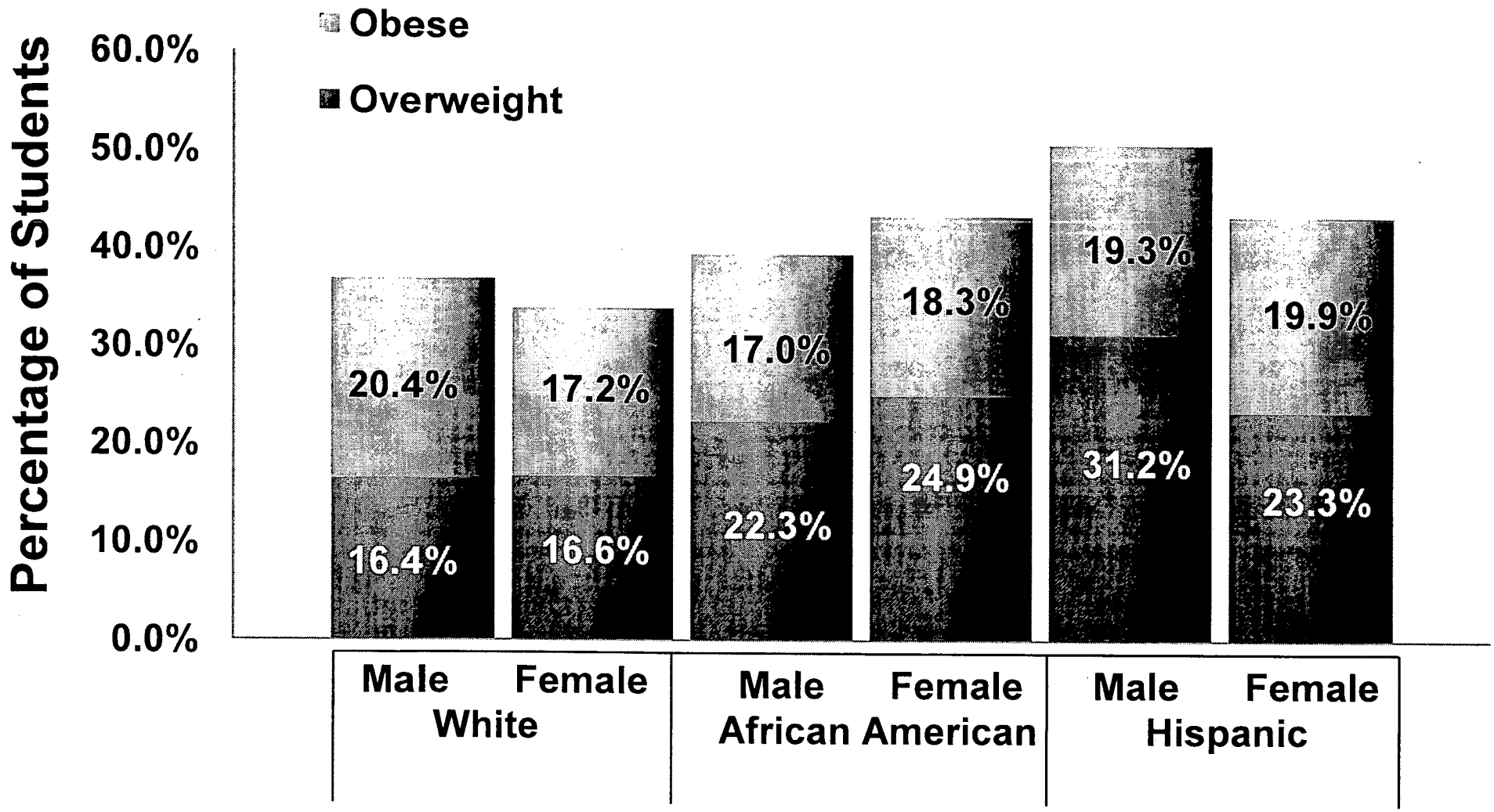
Data source: ACHI. *Assessment of Childhood and Adolescent Obesity in Arkansas (Year 6).* Little Rock, AR: ACHI; September 2009.

Percentage of students classified as overweight or obese by Arkansas public school district (2008–09)



Source: ACHI. *Assessment of Childhood and Adolescent Obesity in Arkansas (Year 6 Fall 2008–Spring 2009).* Little Rock, AR: ACHI; September 2009.

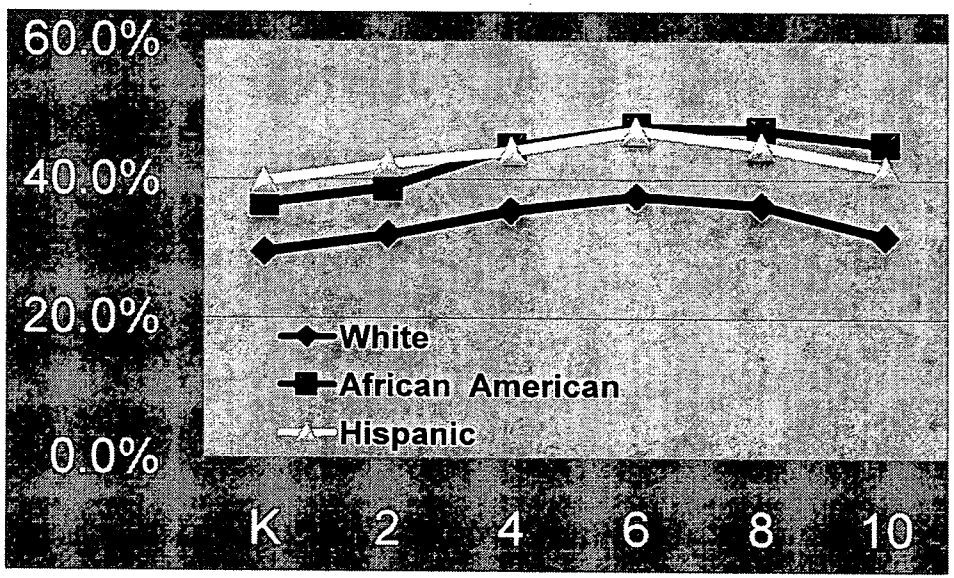
Percent by Gender and Ethnic Group (2008-2009)



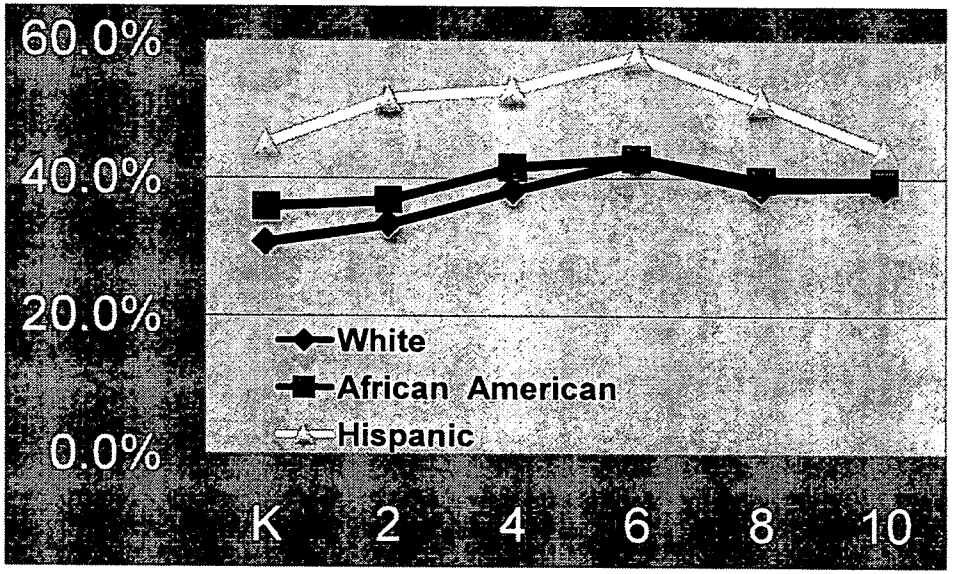
Data source: ACHI. *Assessment of Childhood and Adolescent Obesity in Arkansas (Year 6 Fall 2008–Spring 2009).* Little Rock, AR: ACHI; September 2009.

Percent Overweight or Obese by Gender, Ethnicity and Grade (2008-2009)

Female



Male



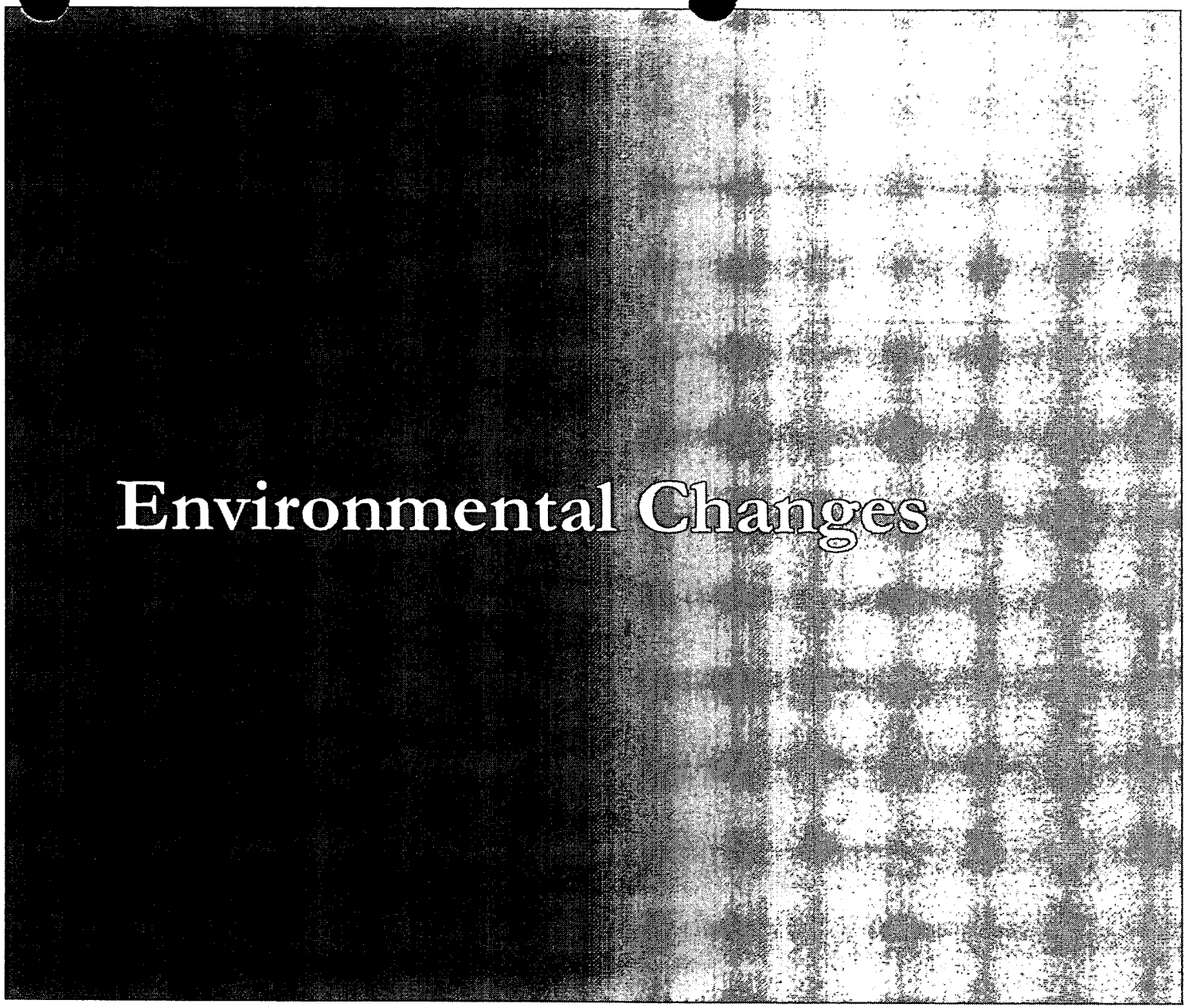
Source: ACHI. *Assessment of Childhood and Adolescent Obesity in Arkansas (Year 6 Fall 2008–Spring 2009).* Little Rock, AR: ACHI; September 2009.

UAMS College of Public Health Evaluation of Act 1220 (2006)

UAMS
FAY W. BOOZMAN COLLEGE OF PUBLIC HEALTH
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

- **Parents' awareness of obesity-related health problems increased (1/3 recognized problem > 2/3)**
- **95% of parents read some or all of the Child Health Report and 67% found the report helpful**
- **No feared consequences of BMI measurements**
- **Students reported purchasing more healthy drinks, such as water and other unsweetened beverages**
- **Innovations in schools and communities across the state – taste tests in cafeterias, curriculum changes**
- **Support of continued improvements to nutrition standards in school cafeterias**

Fay W. Boozman College of Public Health. Year Two Evaluation Arkansas Act 1220 of 2003 to Combat Childhood Obesity. http://www.uams.edu/coph/reports/Act1220Eval.pdf. Accessed 27 March, 2006.


Environmental Changes

Arkansas Board of Education Actions

- **Vending machines restricted until 30 minutes after lunch in all schools**
  - **12-ounce maximum beverage size**
  - **50% healthy options required**
- **No competitive foods in cafeterias**
- **Cafeteria food service education**
- **Nutrition and health curriculum changes**
- **30 minutes per day physical activity (K–12)**
  - **2007 changed to grades K–5**

Amending Act 1220 – Acts 201, 719, & 317 of 2007

- Periodicity of BMI assessments changed to every even year beginning in K thru 10th grade.
- Parents must provide an annual written refusal to keep child from participating.
- ADH nurses responsible for quality assurance to follow protocols.
- Adds 5 members to CHAC.
- Broadens CHAC scope to all school health.
- Eliminates Board of Ed physical activity requirements for all but K-5.

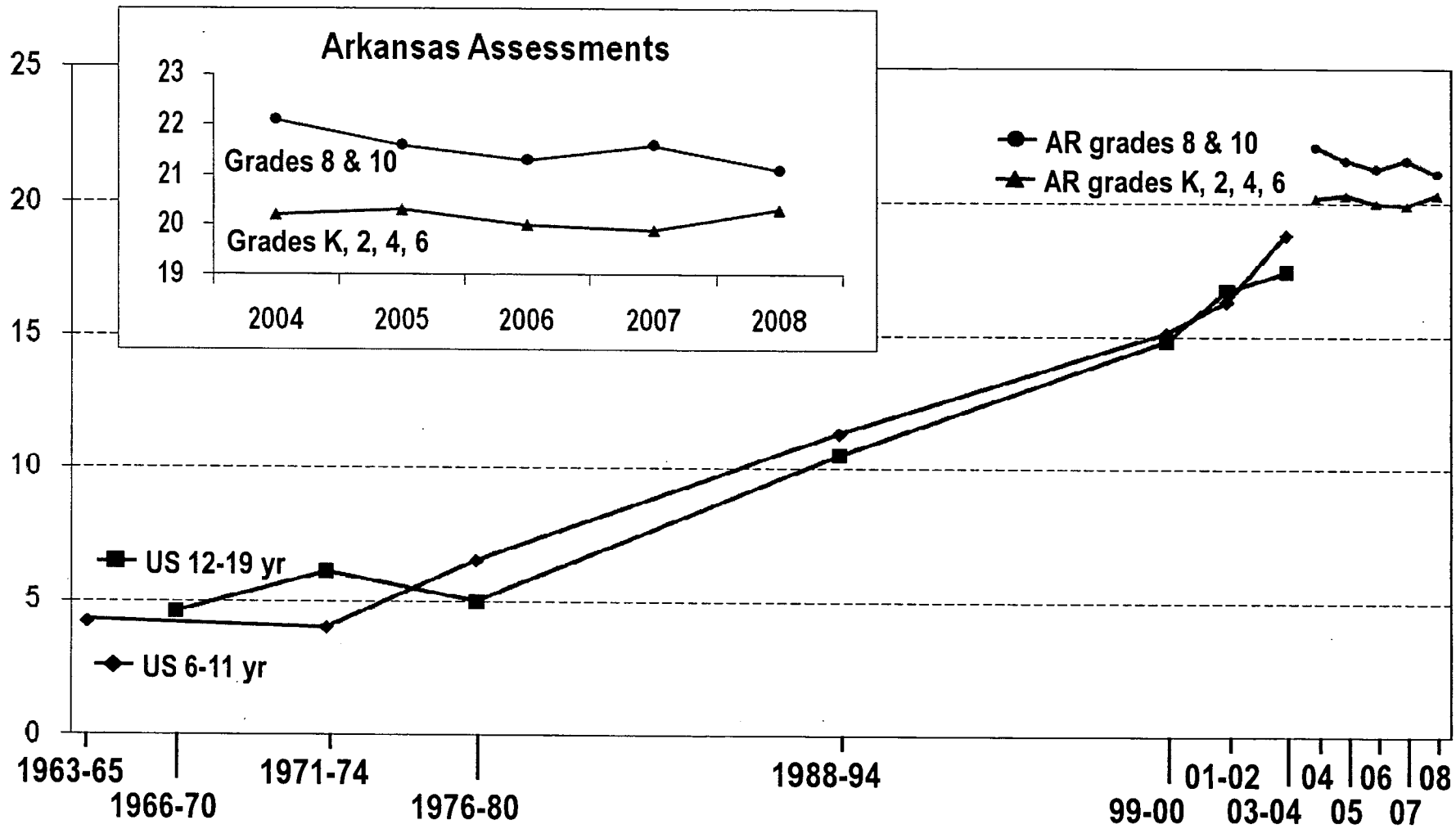
Environmental Response

- Development of first CME program for clinicians
- Regionalization of secondary and tertiary care (e.g., Fitness Clinic at AR Children's Hospital)
- Increased awareness of physical activity needs (Mini-marathon)
- Changes to built environment (e.g., world's longest pedestrian bridge)



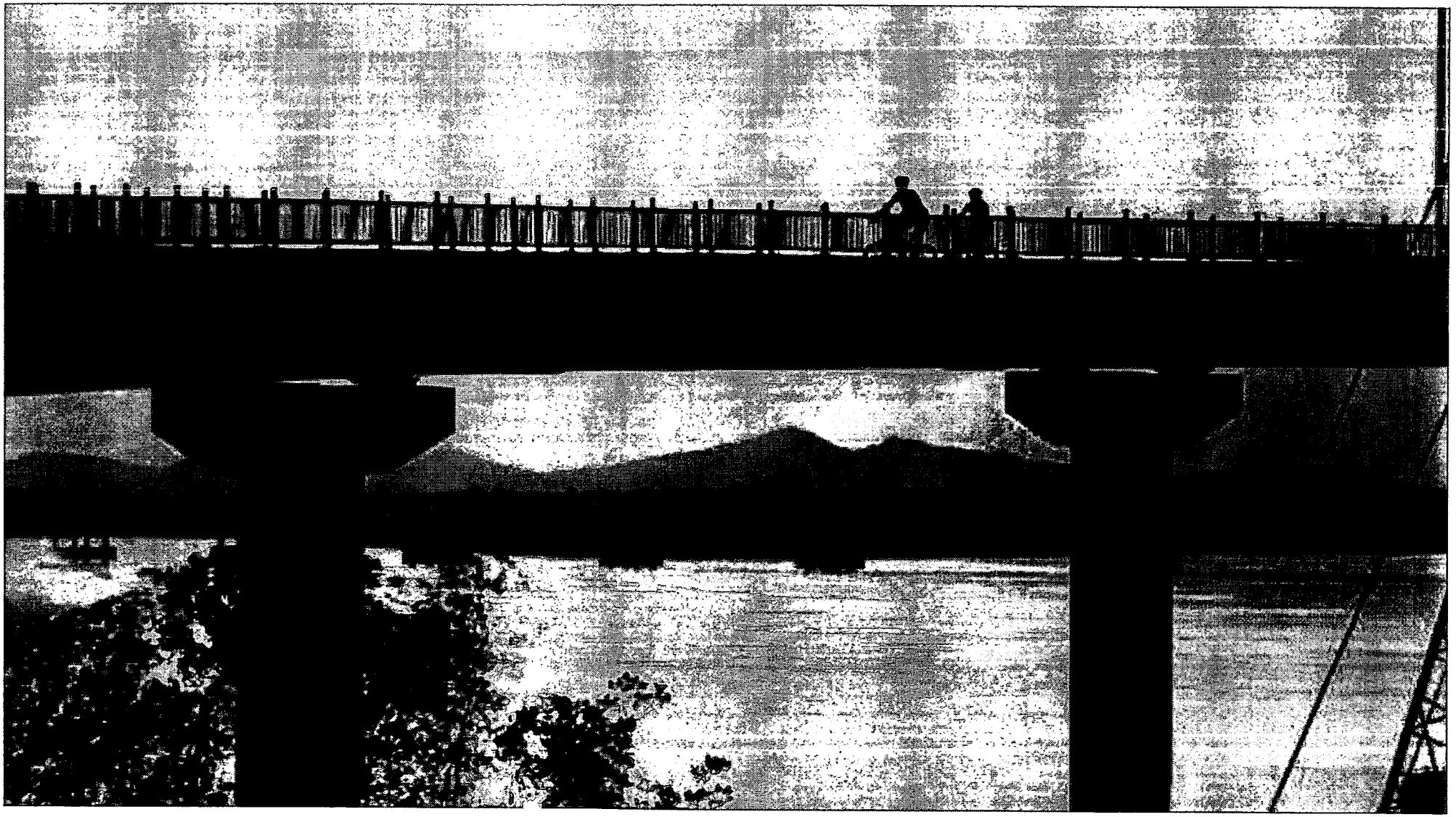
- School, community and faith-based initiatives
  - Arkansas Coalition for Obesity Prevention (ArCOP)
  - Child Wellness Intervention Program (CWIP)
  - Healthy Kids, Healthy Communities grantee site!

National and Arkansas Childhood Obesity Trends



Study data: AR annual average population assessed: Grades 8&10, N=54,564; Grades K,2,4,6, N=121,911
NHANES 03-04 sample size (weighted to national population): 6-11 yr, N=981; 12-19 yr, N=2,159
NHANES data sources: Ogden et al. *Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000.* JAMA 2002;288(14):1728-1732. Ogden et al. *Prevalence of Overweight and Obesity in the United States, 1999-2004.* JAMA 2006;295(13):1549-1555.
Arkansas data source: Arkansas Center for Health Improvement, Little Rock, AR, September 2008.

www.achi.net



Robert Wood Johnson Foundation Center to Prevent Childhood Obesity

Leadership provided by
the Arkansas Center for Health Improvement
in strategic partnership with PolicyLink

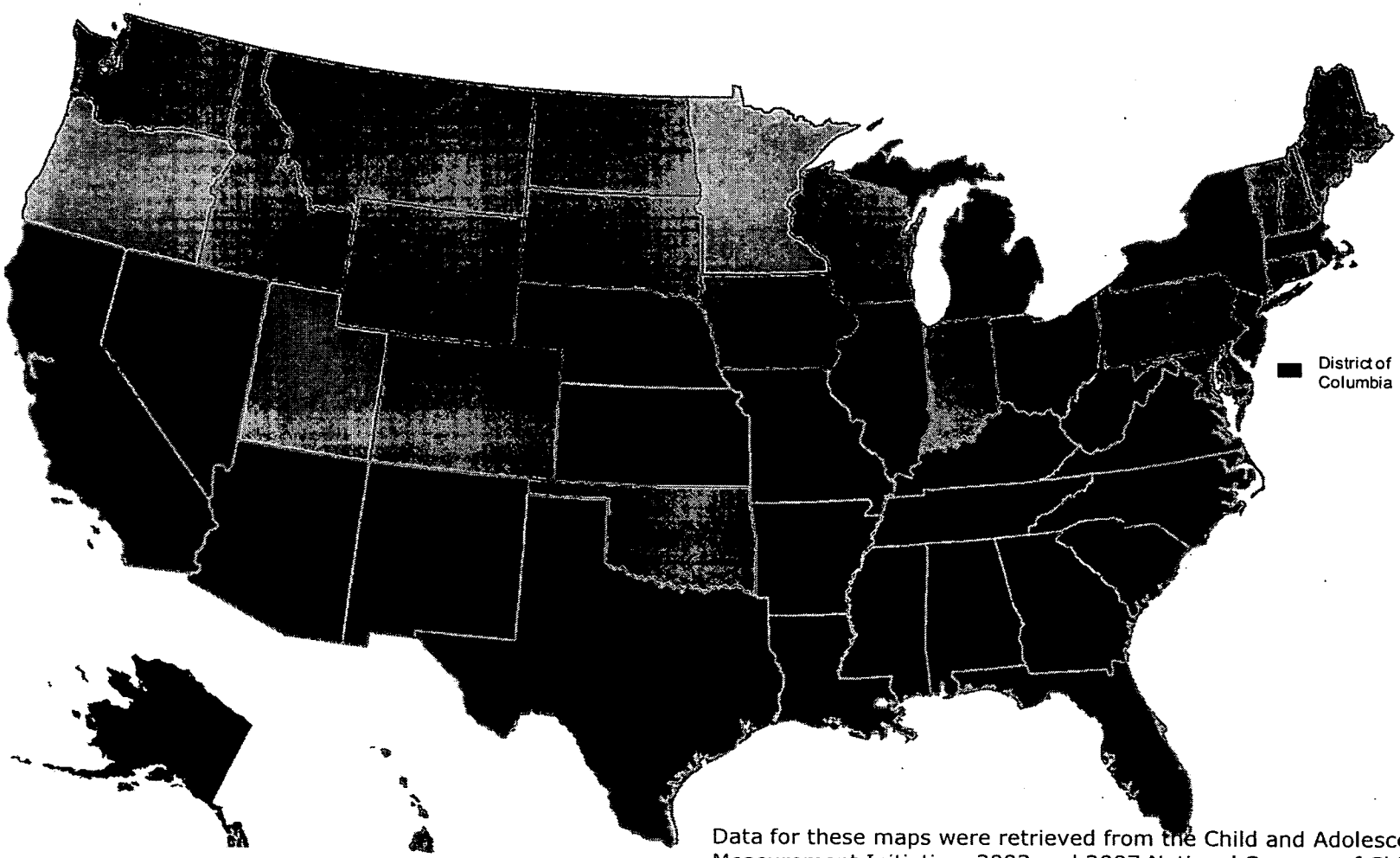
Goals of the RWJF Center

- Reduce the prevalence of overweight and obesity among children in the U.S.
- Decrease disparities in childhood obesity
  - Communities of color
  - Impoverished areas
  - Disproportionately affected regions
- Create systemic, sustainable changes

Why Childhood Obesity?



Percentage of Children who are Obese Aged 10–17 Years by State (2007)

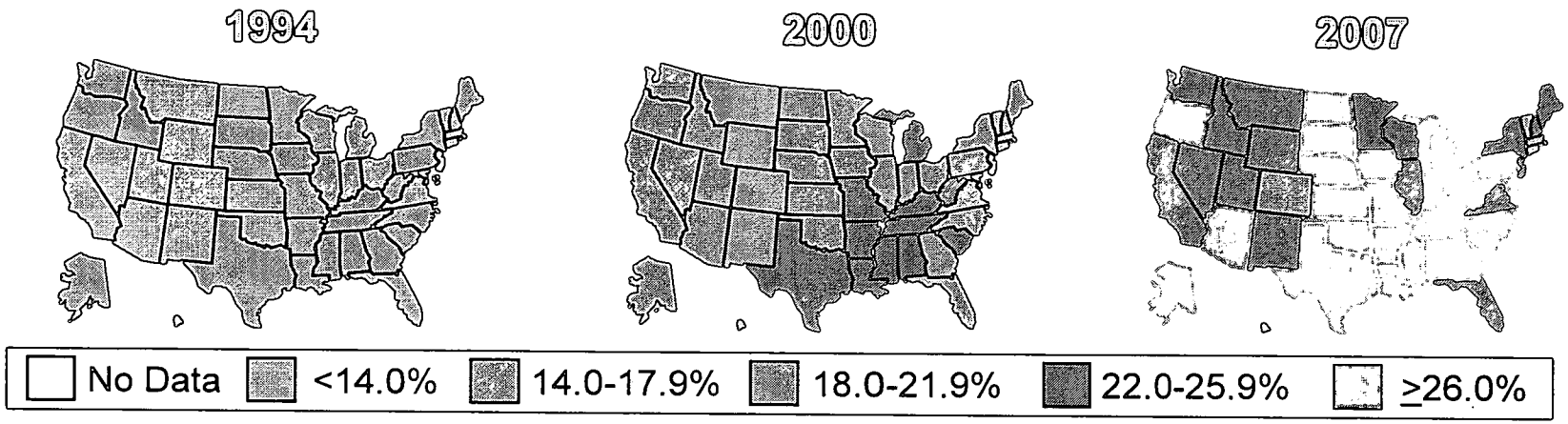


Percentage <10 10-14 15-19 ≥20

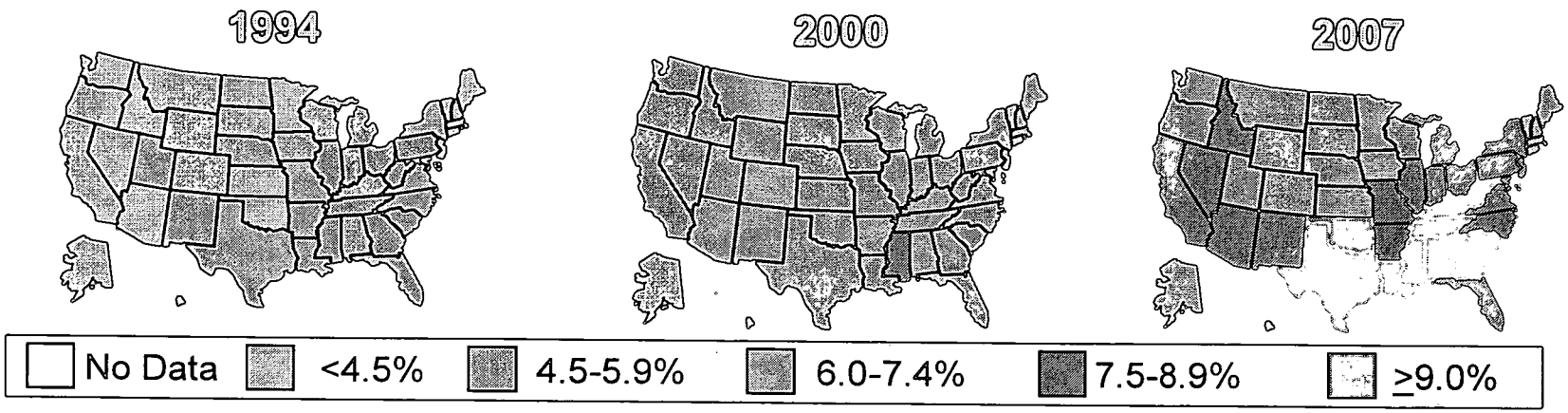
Data for these maps were retrieved from the Child and Adolescent Health Measurement Initiative, 2003 and 2007 National Surveys of Children's Health, Data Resource Center for Child and Adolescent Health website (accessed 10/03/08 and 5/26/09, www.nschdata.org).

Age-adjusted Percentage of U.S. Adults Who Were Obese or Who Had Diagnosed Diabetes

Obesity (BMI ≥30 kg/m²)



Diabetes



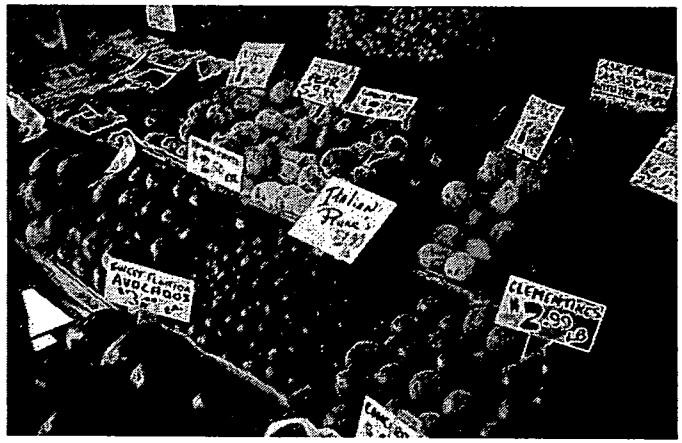
CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at http://www.cdc.gov/diabetes/statistics

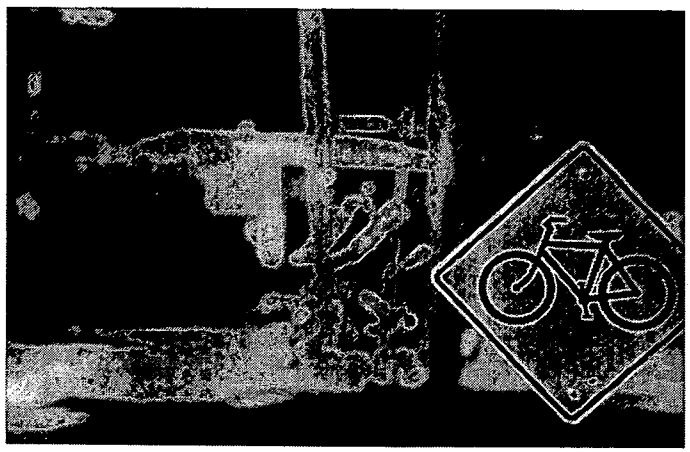
Causes of Obesity Epidemic: Possible Hypotheses

- Genetic shift in population
- Physiologic changes in population:
  - Prenatal imprinting
  - Brain development
  - Food addiction
- Energy imbalance



Energy Balance Framework of the RWJF Center





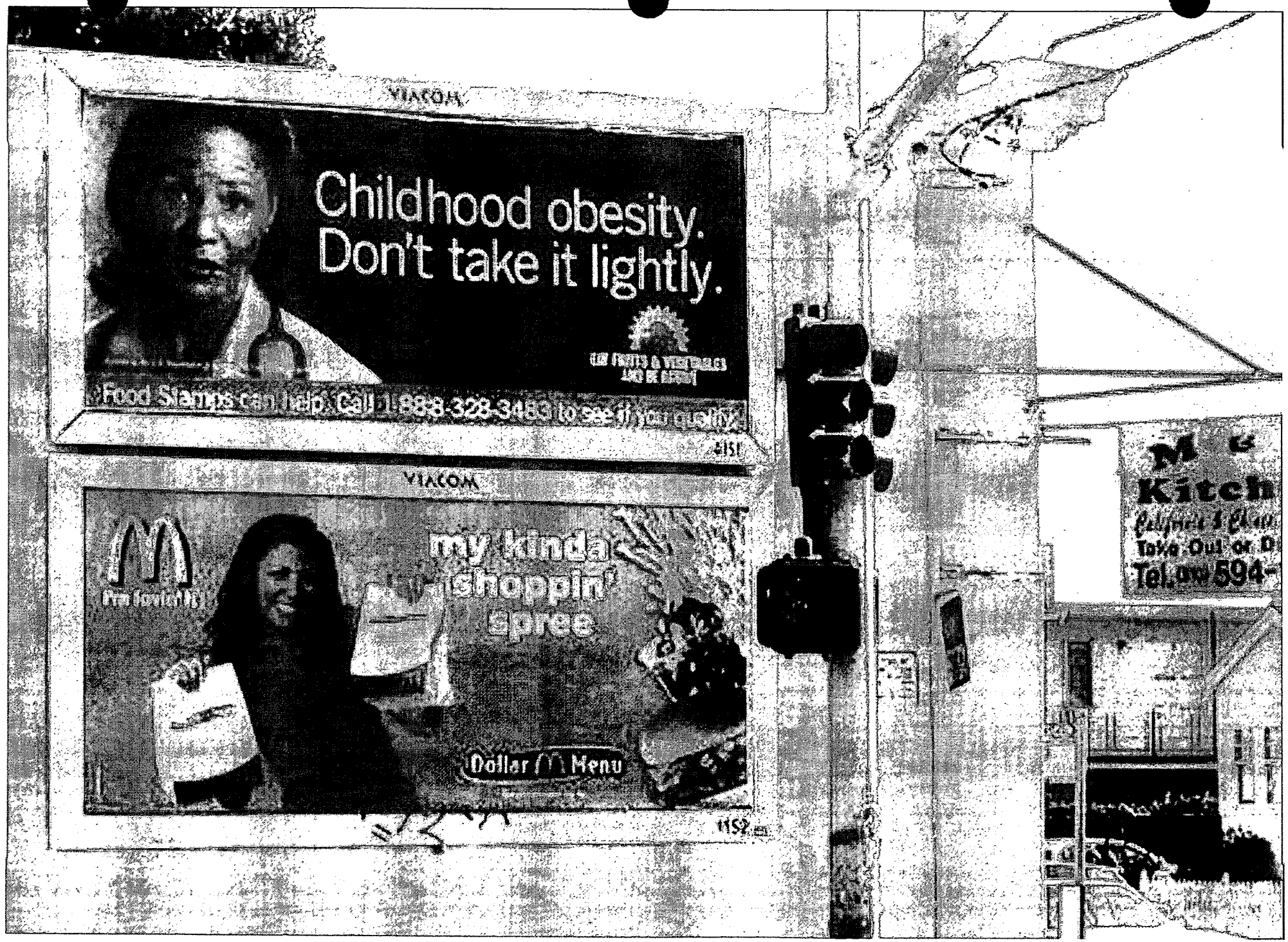
- Increasing children's consumption of healthy foods and beverages and decreasing consumption of unhealthy alternatives
- Increasing physical activity
- Building awareness and support

Factors Linked to Creating Energy Imbalance

- **Food Environment**
- **Built Environment**
  - Transportation
  - Parks
  - Safety

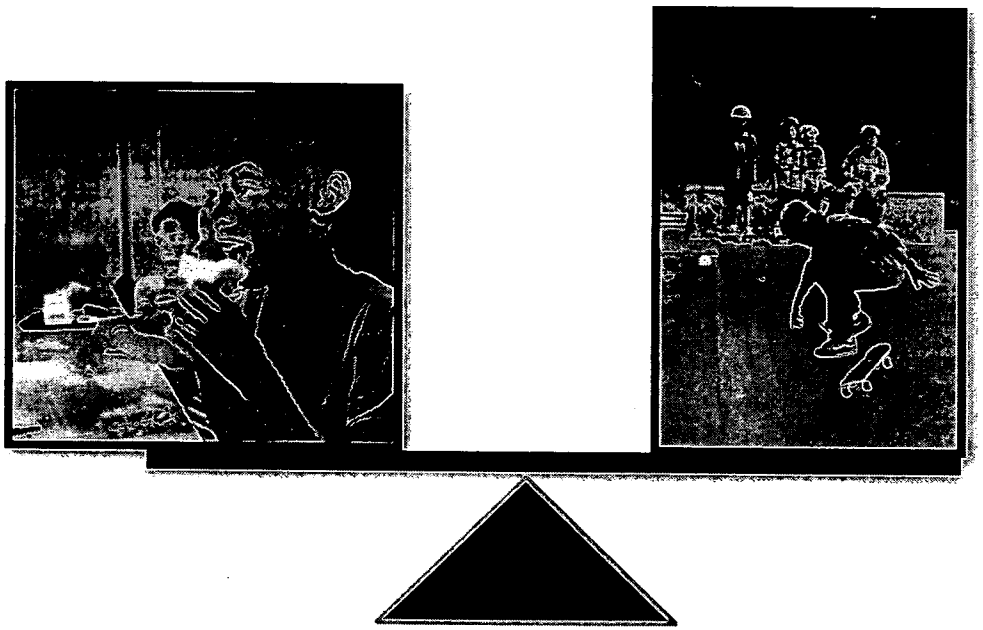


- **Education and the School Setting**
- **Health Care**


VIACOM
Childhood obesity.
Don't take it lightly.
VIACOM
my kinda
shoppin'
spree
Dollar Menu
Kitch
Take Out or D
Tel. no 594-

Policy Priorities for Energy Balance

- **Federal**
- **State**
- **Local**



Federal Policy Opportunities

- Child Nutrition and WIC



Federal Policy Opportunities

- Transportation



Federal Policy Opportunities



- K–12 Education

Federal Policy Opportunities

- Federal Trade Commission and Food Marketing



Federal Policy Opportunities

- Health Care
- Other Opportunities



State and Local Opportunities

- Institute of Medicine
  - *Local Government Actions to Prevent Childhood Obesity*
  - 58 action steps / 12 prioritized strategies
- Centers for Disease Control and Prevention
  - *Recommended Community Strategies and Measurements to Prevent Obesity* (7/09)
  - 24 Recommendations and assessments
- Leadership for Healthy Communities
  - *Action Strategies Toolkit* for local policy-makers (5/09)
  - 31 policy options and resources

IOM & CDC Recommended Strategies

Healthy Eating

- Incentives to attract supermarkets in underserved neighborhoods
- Discourage consumption of sugar-sweetened beverages and improve access to fresh drinking water
- Improve access to healthy foods from farms

IOM & CDC Recommended Strategies

- Improve and increase availability of affordable healthier food and beverage choices in public service venues including public schools
- Menu labeling

IOM & CDC Recommended Strategies

Physical Activity

- Joint use agreements
- Increase opportunities for physical activity in preschool, school, afterschool and child-care programs
- Improve safety and security of streets and park use, especially in higher-crime neighborhoods

IOM & CDC Recommended Strategies

- Develop safe and secure walking environments including safe routes to schools

Social Marketing

- Media campaigns to promote healthy eating and active living

Resources

RWJF Strategies/Programs

[Healthy Kids, Healthy America]

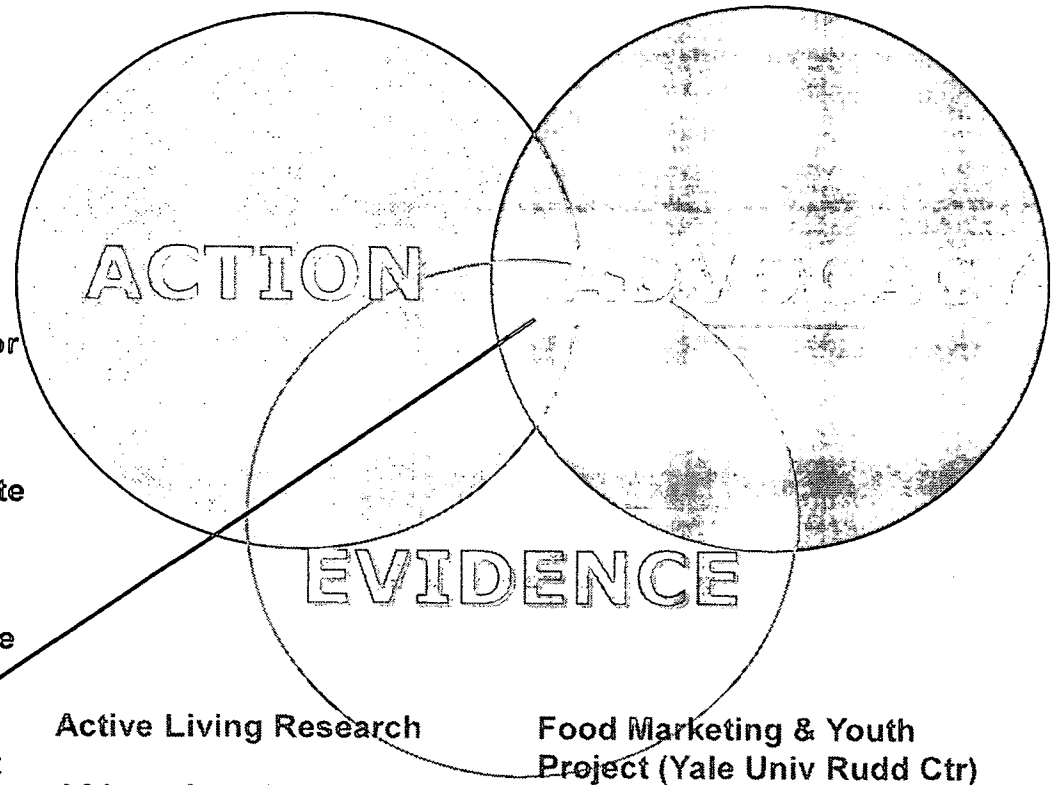
Healthy Kids, Healthy Communities

Healthy Schools Program (Alliance for a Healthier Generation)

New Jersey Partnership for Healthy Kids

Safe Routes to School National Partnership: State Network Project

Pioneering Healthier Communities: YMCA of the USA



RWJF Center to Prevent Childhood Obesity

IOM Standing Committee

Convergence Partnership

Active Living Research

African American Collaborative Obesity Research Network (AACORN)

Bridging the Gap

Food Marketing & Youth Project (Yale Univ Rudd Ctr)

Healthy Eating Research

Salud America!

National Collaborative on Childhood Obesity Research (NCCOR)

Communities Creating Healthy Environments

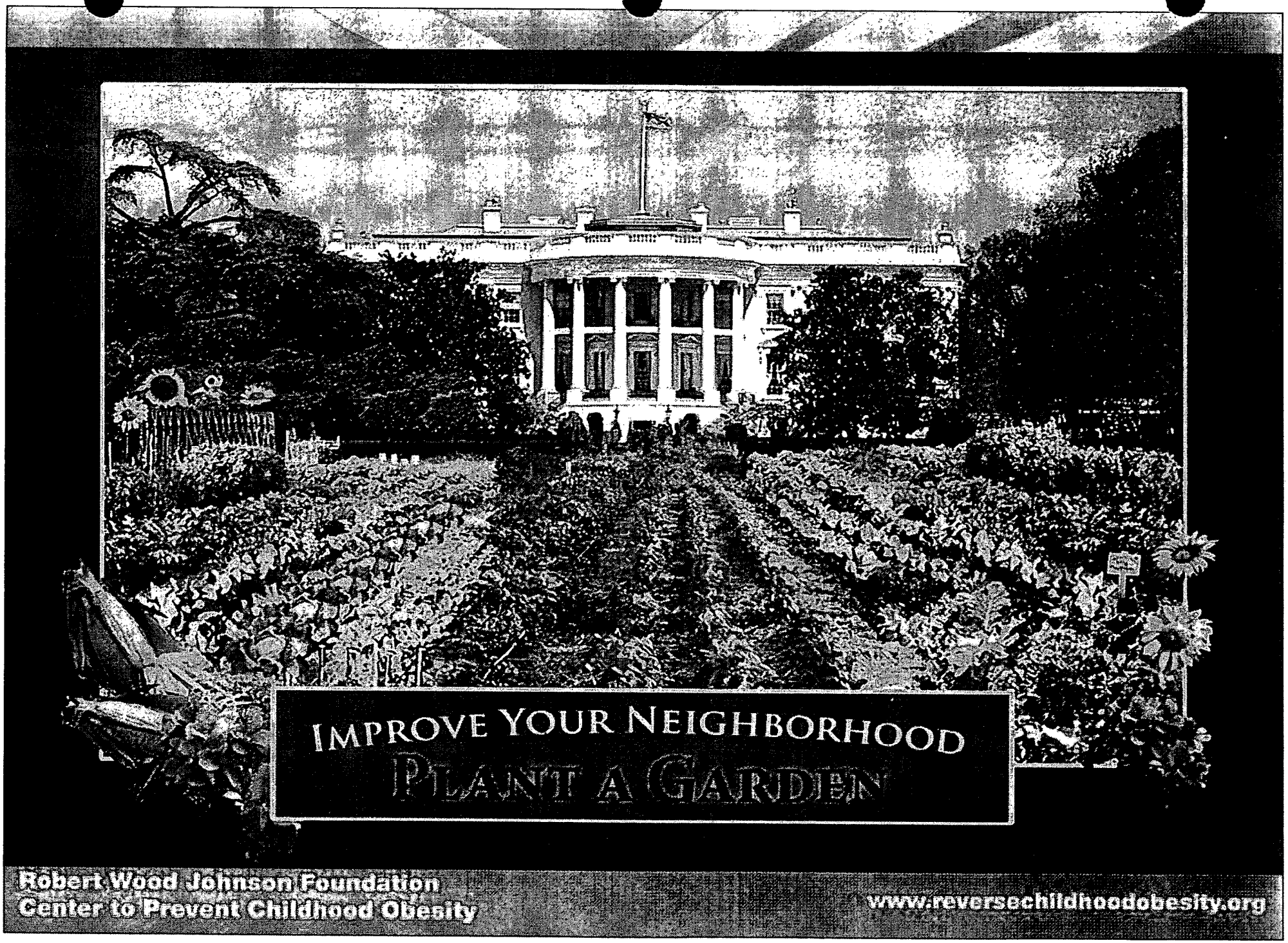
Faith-Based Advocacy: Galvanizing Communities to End Childhood Obesity

Leadership for Healthy Communities

Mobilizing Health Care Professionals as Community Leaders in the Fight Against Childhood Obesity

National Policy and Legal Analysis Network to Prevent Childhood Obesity

Campaign for Healthy Kids (Save the Children)


IMPROVE YOUR NEIGHBORHOOD
PLANT A GARDEN
Robert Wood Johnson Foundation
Center to Prevent Childhood Obesity
www.reversechildhoodobesity.org

Conclusion



- **Reversing the epidemic**
- **Targeting those most at risk**
  - Low-income, rural, children of color
- **Building a legacy of healthy communities**

Contact information

www.reversechildhoodobesity.org
paula@reversechildhoodobesity.org



Preventing Childhood Obesity: Physical Activity
Effective Policies and Built Environment Strategies

February 15, 2010



NC Legislative Childhood Obesity Task Force

ACTIVE LIVING BY DESIGN

Philip Bors, MPH
Project Officer
Active Living by Design

UNC

Kelly Evenson, Ph.D.
Research Associate Professor
Department of Epidemiology
NC Institute for Public Health
UNC Gillings School of Global Public Health

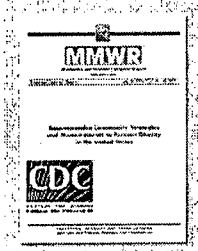
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Overview

1. Rationale
2. Movement of the Field
3. Community Influences on Physical Activity
4. Recommendations for North Carolina
   - Six key goals
5. Beyond Policy Creation

2

Why Policies and Built Environment?



"Reversing the U.S. obesity epidemic requires a comprehensive and coordinated approach that uses policy and environmental change to transform communities into places that support and promote healthy lifestyle choices for all U.S. residents.

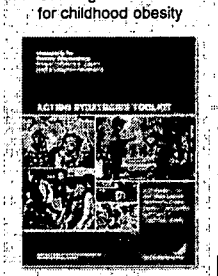
Environmental factors (including lack of access to full-service grocery stores, increasing costs of healthy foods and the lower cost of unhealthy foods, and lack of access to safe places to play and exercise) all contribute to the increase in obesity rates by inhibiting or preventing healthy eating and active living behaviors."

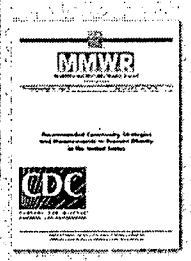
- Kahn, et al., MMWR, CDC

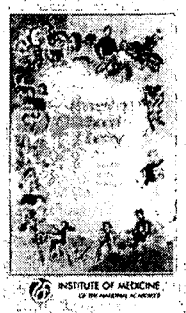
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From Science to Implementation

- Growing consensus re: the importance of policies and built environments for childhood obesity

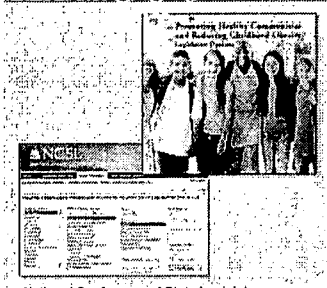






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Converging Opinion on State Action



National Conference of State Legislators

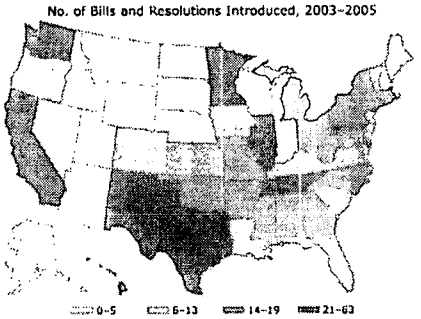
National Governor's Association



5

State Policy Activity: Childhood Obesity

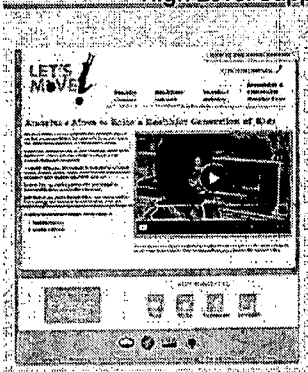
No. of Bills and Resolutions Introduced, 2003-2005

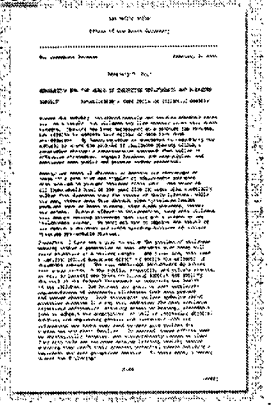


No. of Topic Areas Covered by Introduced Legislation, 2003-2005

Boehmer et al 2006

High Level Support





The Built Environment

It influences:

- What activity happens where
- How we move
- Access to opportunities and choices
- Community character

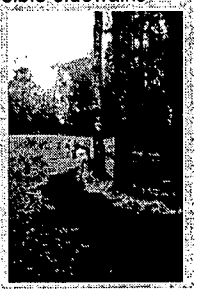




North Carolina Views

- In 2007, 60% of North Carolina adults reported that they would increase their physical activity if their community had more accessible sidewalks or trails for walking or bicycling.
  - Eastern NC (63%)
  - Piedmont (59%)
  - Western NC (53%)

NC BRFSS 2007



Children and Physical Activity

- Access to facilities like parks and time outdoors is associated with more activity for both children and adolescents
- More children walk to school where there are sidewalks and safety improvements
- Elementary and middle school students are more active at school with more facilities, equipment and supervision
- Parental concerns about traffic and "stranger danger" are clearly linked to children's activity levels; schools concern about liability





Sallis et al, 2001; 2000; 1993; Klesges et al, 1990; Baranowski et al, 1993; Ewing; Staunton et al, 2003; Boarnet et al, 2005; Jago I al, 2004; Gomez, 2004; IOM/TRB, 2005; Timperio et al, 2004

Recommended Direction for NC
Six Goals

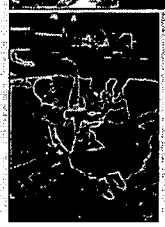
A. Increase safe opportunities for active travel – i.e. walking/bicycling

Goal 1: More walkable destinations
Goal 2: Safer routes to/from school
Goal 3: Safer routes in the community

B. Increase safe opportunities for play and physical activity

Goal 4: Create and maintain parks and open space
Goal 5: Create and maintain trails and greenways
Goal 6: Shared use of schools after hours/weekends

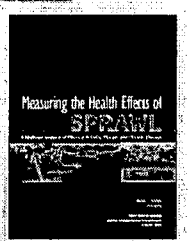




Increase Safe Opportunities for Active Travel

Goal 1: More walkable destinations

- Creating close-knit communities
- "Smart Growth" strategies, e.g. planning, zoning







Promising Policy State Actions

Increase safe opportunities for active travel

Goal 1: More walkable destinations

NC Chapter - American Planning Association

- Create and promote legislation requiring all NC communities to have current local comprehensive plans
- Land use management strategies that support healthy and environmentally friendly growth, (including multi-modal transportation and green communities)

Vermont: Act 183 (2009)

- Financial incentives for designated "growth centers," e.g. Tax Increment Financing districts, priority in some state grants.
- *"Growth centers"* Includes characteristics of Vermont's traditional villages and neighborhoods such as a mix of uses, high densities, and pedestrian scale. "Defined *"smart growth."* First one adopted by a state legislature as part of growth management legislation, provides guidance when reviewing applications for growth centers designation

Colorado: Established Office of Smart Growth

Wisconsin: Comprehensive Planning Law (s. 66)

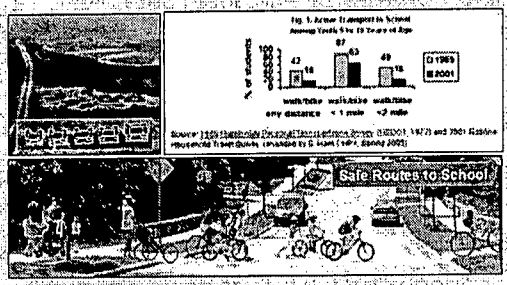
- Requires every town, village, city, county and regional planning commission to make decisions consistent with an adopted comprehensive plan by 2010. Nine required elements.

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Increase Safe Opportunities for Active Travel

Goal 2: Safer routes to/from school

- Safe Routes to School (SRTS)
- Liability/legal protection for schools for SRTS efforts
- Site selection in favor of walkable schools



Promising Policy State Actions

Increase safe opportunities for active travel

Goal 2: Safer routes to/from school

Safe Routes to School

North Carolina: $15M in federal funds for SRTS

- Two rounds of funding to municipalities for infrastructure ($300K) and non-infrastructure ($50K) grants. 22 projects selected in 2nd round totaling $3.9M.
- Projected North Carolina funds: $1.00M (FY05), $2.33M (FY06), $3.13M (FY07), $3.88M (FY08), $4.85M (FY09)
- $18 million requested in the 2nd round (5 times the $ available).

Other States: CA, WA also use state transportation dollars for SRTS programs (infrastructure and non-infrastructure.)

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Promising Policy State Actions

Increase safe opportunities for active travel

Goal 2: Safer routes to/from school

Other States (2003-05): 43 state bills and 4 resolutions were proposed regarding SRTS;12 state bills and 3 resolutions adopted (Boehmer et al 2006).

- Bicycle facilities
- Crossing guards
- Safety
- Traffic calming measures

Nevada AB 231 (2005): requires local and regional governmental agencies to conduct studies of SRTS in areas near the school

Texas 460 (1991, with a number of changes): schools must have a school crossing guard program

- Child safety fund: $1.50 vehicle registration and $25 speeding ticket in a school zone; funds go to local jurisdictions based on how they were collected
- Example: Austin using monies to fund crossing guards

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Promising Policy State Actions

Increase safe opportunities for active travel

Goal 2: Safer routes to/from school

School site selection



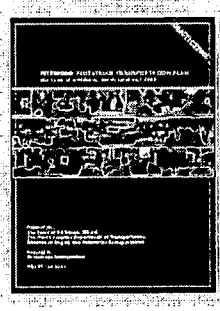
- US EPA – developing voluntary school siting guidelines
- Many states
  - Departments of Ed adopted Council of Educational Facility Planners International (CEFPI) guidelines for school construction (1953)
  - 10 acres for elementary, 20 for middle; 30 high school; +1 acre for every 100 students
  - No longer acreage specific, but minimums remain
- NC Facilities previous guide for school sites:
  - 10 acres for ES; 20 for MS; 30 HS; +1 acre for every 100 students
  - Acknowledges "tenets of smart growth" for finding "creative solutions"
  - Many school boards still use old acreage guidelines
- Maine – Adopted ABC's (Avoid sprawl, Be site savvy, Consult community); established maximum acreage guidelines

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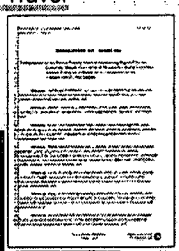
Increase Safe Opportunities for Active Travel

Goal 3: Safer routes in the community

- "Complete Streets"
- Ped/Bike master plans









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Promising Policy State Actions

Increase safe opportunities for active travel

Goal 3: Safer routes in the community

Complete Streets

North Carolina: (July 2009) NC DOT "Complete Streets Policy"
- "This policy requires that NCDOT's planners and designers will consider and incorporate multimodal alternatives in the design and improvement of all appropriate transportation projects within a growth area of a town or city unless exceptional circumstances exist."

NC DOT Complete Streets Advisory Committee
- currently developing DOT planning and design guidelines

Charlotte, NC – national model for policy/guidelines

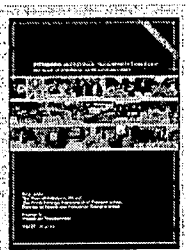
Massachusetts: DOT "Project Development and Design Guidebook" (2006)
- Established an eight-step decision-making procedure that sets multi-modal accommodation as a guiding principle. The needs of bicyclists, pedestrians, transit users, and disabled people are integrated into every aspect of design.

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Promising Policy State Actions

Increase safe opportunities for active travel

Goal 3: Safer routes in the community



Pedestrian and Bicycle Plans

A public document that typically:
- lays out a community's vision for future pedestrian and bicycling activity,
- identifies the actions required to realize that vision,
- ties actions to funding sources, and
- describes implementation and use.

Results from survey of municipalities in NC (Evenson et al. 2009)
- Policies, programs, promotions, and projects related to walking and bicycling all occurred more often in municipalities when they were part of the plan.
- Among those with a plan: how important is the plan to policy makers when making decisions on development and funding that may impact walkers or bikers?
  - 25% very important, 66% somewhat important

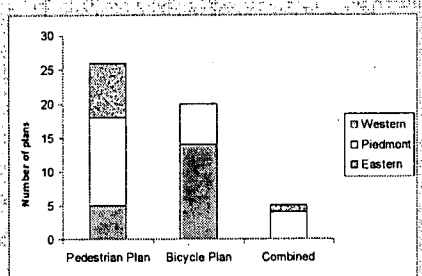
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Promising Policy State Actions

Increase safe opportunities for active travel

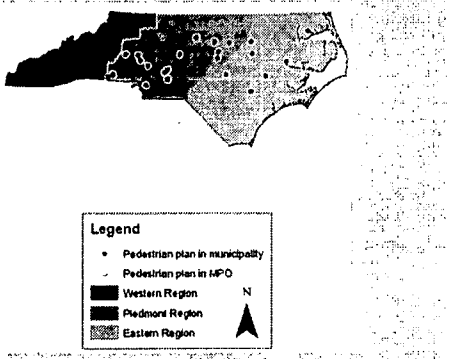
Goal 3: Safer routes in the community

Pedestrian and Bicycle Plans: (through 2008)
544 municipalities, 56 municipality plans; 72 total plans



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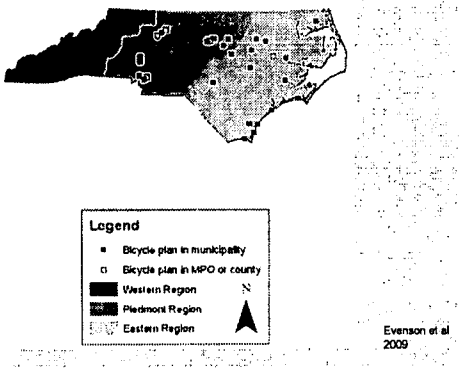
Pedestrian Plans in NC Through 2008



http://www.unc.edu/~kevenson/_NCPedBikePlans.pdf

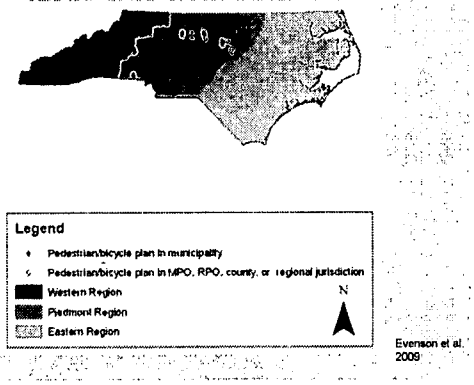
Evenson et al, 2009

Bicycle Plans in NC Through 2008



Evenson et al 2009

Combined (Ped/Bike) Plans in NC Through 2008



Evenson et al, 2009

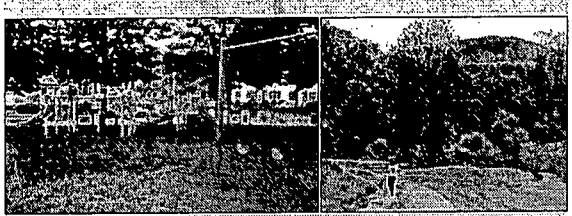
Summary Recommendations for Active Travel

1. Work with local planners to identify incentives and promising legislation for healthy land use practices
2. Continue to support SRTS within DOT; consider state funding in addition to federal funds
3. Update school site selection guidelines and incentives to favor walkable/bikeable schools
4. Continue to support complete streets at DOT; consider ways to assist localities with implementation/funding
5. Continue to support DOT ped/bike plans (existing plans will need to stay current)

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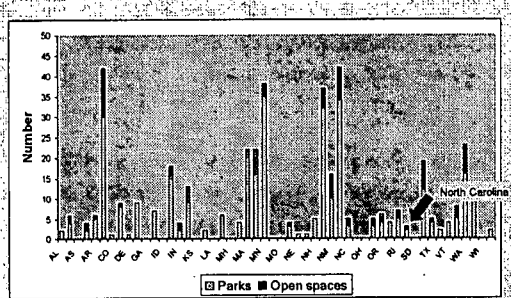
Increase Safe Opportunities for Play and Physical Activity

Goal 4. Create and maintain parks and open space



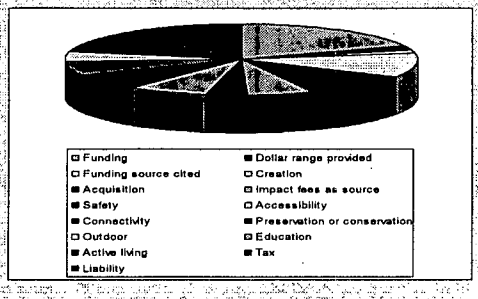
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Number of legislative policies on parks and open space in 50 states and District of Columbia, 2001-2007



Kruger et al. under review

Distribution of legislative policies on parks and open space by recreational environment feature, 2001-2007



Kruger et al. under review

Promising Policy State Actions

Increase safe opportunities for play and physical activity

Goal 4: Create and maintain parks and open space

- US survey of state and local park directors –
  - major challenges were funding for land, capitol expenditures/operations, and maintenance
- Funding source in NC:
  - NC Parks & Recreation Trust Fund (PARTF)
    - deadline just passed: received 87 applications for $25 million, $8 million to give out, requires a 50% match

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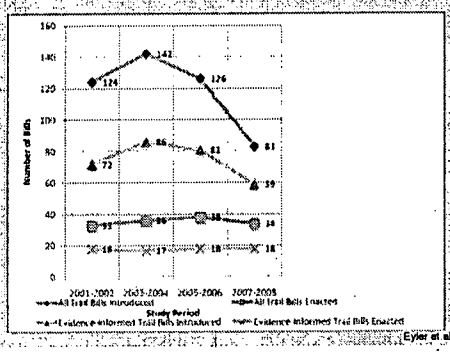
Increase Safe Opportunities for Play and Physical Activity

Goal 5: Create and maintain trails/greenways



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Number of total non-appropriations trail bills introduced and enacted and evidence-informed trail bills introduced and enacted by 2-year periods



Eyler et al. 2010

Promising Policy State Actions

Increase safe opportunities for play and physical activity

Goal 5. Create and maintain trails and greenways

Evidence informed policies

Funding

Louisiana HB2 (2007) allocated $400,000 to New Orleans for walking and bicycling path construction

Liability

Hawaii HB 1276 (2005) indemnifies land owners from liability for public use

Connectivity

Accessibility

Maintenance

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Increase Safe Opportunities for Play and Physical Activity

Goal 6: Shared use of schools after hours/weekends

- Funding for shared use of facilities, e.g. utilities, staffing
- Joint use agreements for school facilities after-hours



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Increase Safe Opportunities for Play and Physical Activity

Goal 6: Shared use of schools after hours/weekends

2009 nationwide survey of school principals whose schools were located in low income and/or minority communities

- 49% did not share recreational/sport facilities
- 82% were somewhat to very concerned about liability
- 83% believed stronger legislation is needed to better protect schools from liability claims

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Promising Policy State Actions

Increase safe opportunities for play and physical activity

Goal 6: Shared use of schools after hours/weekends

North Carolina – July 2009 - SECTION 1. G.S. 115C-12

- "To encourage local boards of education to enter into agreements regarding the joint use of facilities for physical activity. – The State Board of Education shall encourage local boards of education to enter into agreements with local governments and other entities regarding the joint use of their facilities for physical activity. The agreements should delineate opportunities, guidelines, and the roles and responsibilities of the parties, including responsibilities for maintenance and liability."

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Promising Policy State Actions

Increase safe opportunities for play and physical activity

Goal 6: Shared use of schools after hours/weekends

NPLAN Analysis (National Policy & Legal Analysis Network)

"Fifty-State Scan of Laws Addressing Community Use of Schools"

- States requiring use of school property by community: Alabama, Wash DC, Hawaii, Oklahoma
- Arkansas – uses a portion of tobacco tax for incentives for joint use of schools
- In North Carolina: State protects school board from liability "No liability may attach to the board of education, individually or collectively, for personal injury suffered by use of the school property." (NC General Statute §115C-524)

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Promising Policy State Actions

Increase safe opportunities for play and physical activity

Goal 6: Shared use of schools after hours/weekends

Strengthen liability to reduce this barrier through:
- recreational statutes: example – Idaho state policy
- other policies

Funding for shared use
- example – Arkansas using tobacco monies for this

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Summary Recommendations for Play and Physical Activity

1. Funding for new parks and trails, park renovations, maintenance and preserving rail corridors for potential greenways
2. Support parks/greenway master plans and implementation
3. Encourage subdivision regulations to include parks, trails, and greenways
4. Consider gaps at the county level, outside of municipalities, and across jurisdictions, enhance connectivity of trails/greenways, enhance shared park spaces
5. Stronger incentives for schools and parks to share space and schools to open to the public after hours (joint use)
6. Explore liability protections for schools re: joint use, including recreational user statutes
7. Creative mechanisms to help offset the added costs of extended use of school facilities

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Built Environment Areas Not Covered

- Neighborhood safety
- Access to private physical activity facilities
- Child care facilities
- Others

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Considerations Beyond Policy Creation

- Evidence based/informed policies
- Policy implementation
- Policy evaluation
- Surveillance
- Population impact

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Consider Policy Evaluation

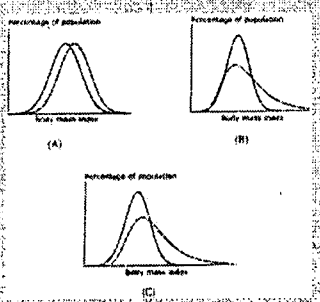
- 2005: NC State Board of Education passed the Healthy Active Children Policy to be implemented by the 2006-07 school year, requiring that all kindergarten through eighth grade children in the state receive a minimum of 30 minutes of moderate to vigorous physical activity each school day through physical education, recess, and other creative approaches.
- Evaluation: included a yearly progress report requirement at the school district (LEA) level
- Identified benefits and barriers to the policy; information used to help decide if the policy should be altered or continued



Consider Policy Implementation

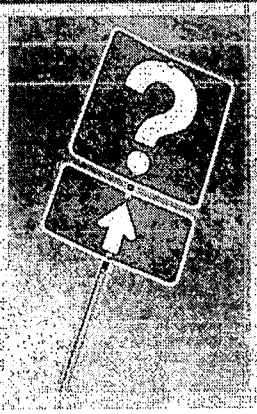
- **MO SB 291 (2008): School districts shall ensure that students in elementary schools participate in moderate physical activity for the entire school year, including students in alternative education programs. Students in the elementary schools shall participate in moderate physical activity for an average of one hundred fifty minutes per five-day school week, or an average of thirty minutes per day.**

Surveillance & Population Impact



Penman et al 2006; based on Rose 1985

Your Questions



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physical activity
policy - research - network

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Report to Legislative Task Force on Childhood Obesity

Elizabeth Cuervo Tilson, MD, MPH
Medical Director, Community Care of Wake and Johnston Counties

February 15th, 2010

Focus

- Primary Care Providers' Role
- BMI screening and more

Agenda

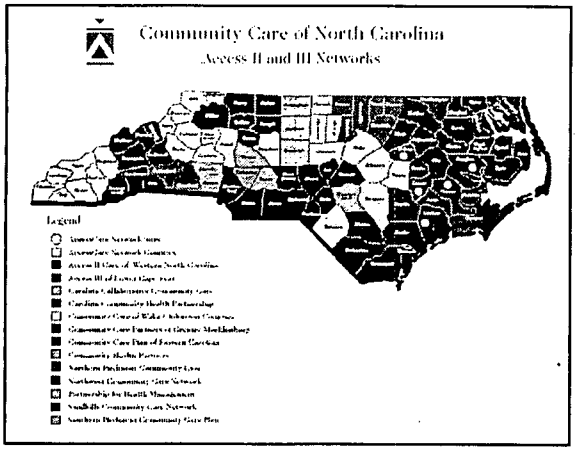
- Quick overview of Community Care of North Carolina (CCNC)
- Childhood obesity as it affects CCNC's role in managing health care costs
- Clinical Issues for CCNC physicians
- CCNC Childhood Obesity Initiative

Community Care of North Carolina

- A program of NCDHHS out of the Office of Rural Health and Community Care
- Medicaid contracts through CCNC to provide local clinical care coordination for Carolina Access Medicaid enrollees

Primary Goals

- Improve the care of the Medicaid population while controlling costs
- Develop Community Networks and local systems capable of and responsible for managing recipient care
- Fully develop and support the Primary Care Medical Home



CCNC

- 14 networks with more than 3500 primary care physicians
- 985,000+ Medicaid enrollees as of Feb 2010

Key Program Areas

- Chronic Disease Management Initiatives
  - Disease specific or co-morbid conditions
- Integration of Physical and Mental Health
- Prevention Initiatives
- Pharmacy Initiatives
- Access to Primary Care
- Support of IT Initiatives
- Nurse and Social Worker care management services
- Physician Engagement

Childhood obesity as it affects CCNC's role in improving quality and decreasing Medicaid costs

- Higher prevalence in lower socio-economic populations
- Concurrent co-morbidities (cost)
  - Sleep Apnea, Hypoventilation Syndrome
  - Slipped Capital Femoral Epiphysis
  - Nonalcoholic Fatty Liver Disease
  - Depression
  - Asthma
- Future co-morbidities (cost)- Diabetes, heart disease

Clinical Issues for CCNC physicians

- Often don't have tools/resources/training/time to address
- Different payors have different policies
- Medicaid Medical Nutritional Therapy benefits
  - Exclude nutritionists from directly billing
  - Limited to children and pregnant women
- Limitation of impacting obesity in purely clinical setting
- Hard to know of and link to resources

CCNC Childhood Obesity Initiatives

- Program funded by a KBR grant
- Jan 2008-June 2010
- 4 networks participated
  - **Access II Care of Western NC** (Transylvania, Henderson, Polk, McDowell, Mitchell, Yancey, Madison, Buncombe)
  - **Carolina Community Health Partnership** (Rutherford, Cleveland)
  - **Partnership for Health Management** (Randolph, Guilford, Rockingham)
  - **Community Care of Wake and Johnston Counties**

Program Elements

- Based on Best Practice Guidelines
  - 2007 "*Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity*"
  - NIGHQ *Implementation Guide from the Childhood Obesity Action Network*
  - U.S. Preventive Services Task Force *Recommendation on Pediatric Obesity Screening*
- Clinical Tools
  - Developed in partnership with the NC DPH and ESMM NC and distributed by CCNC networks
- Provider trainings
- Identification and linking to Community Resources
- Care management
- Pilot co-location models with nutritionists

Yr 1 Goals and Results for Participating Practices

- Goal - 75% complete a needs assessment
  - Result - 79-100% (95+ practices)
- Goal - 25% trained in the use of obesity screening tools
  - Result - 48-100% (69+ practices)
- *Goal - 25% actively using BMI screening
  - Result 58-80% (74+ practices)
- Goal - 50% with an established link to community resources for patient and family education
  - Result - 60% - 100% (94+ practices)

Year 2 goals

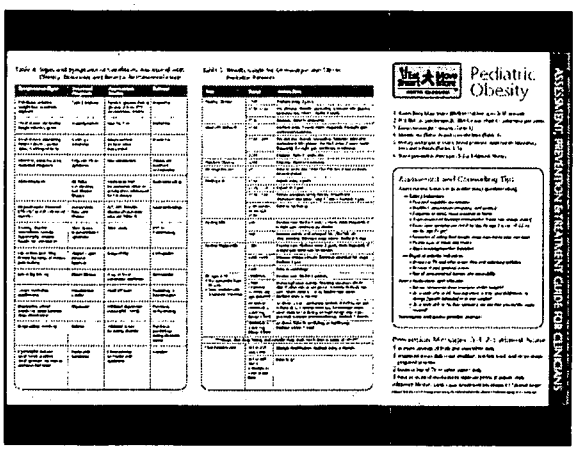
- 50% of practices trained in use of obesity screening tools
- 50% of practices actively using body mass index (BMI) screening.
- 75% of practices with an established link to community resources for patient and family education.

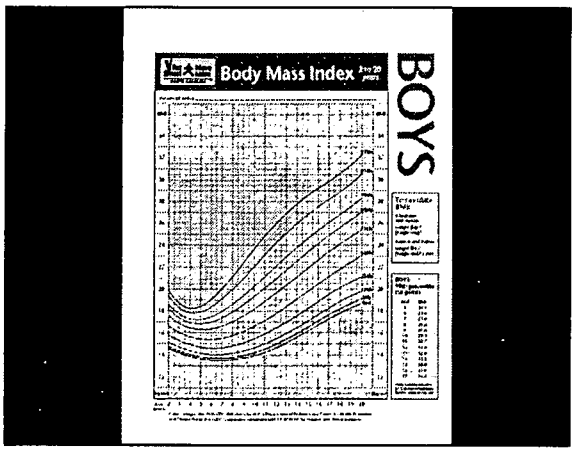
CCWJC Obesity Initiatives

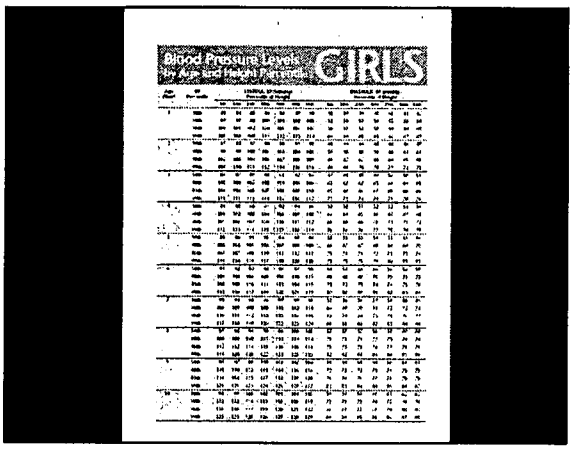
- Clinical Tools
- Co-located nutritionist
- Community Links
- Case Management
- Fostering Advocacy

Clinical Tools

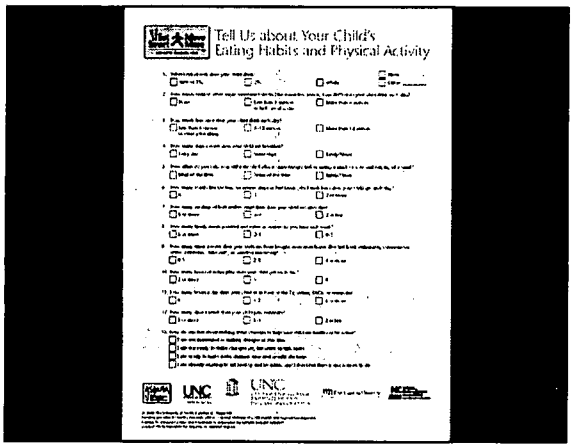
- Guidelines for Obesity Management
- Blood pressure and BMI charts
- Diet and exercise questionnaire and responses
- Prescription Pads (5-3-2-1-almost none messages)



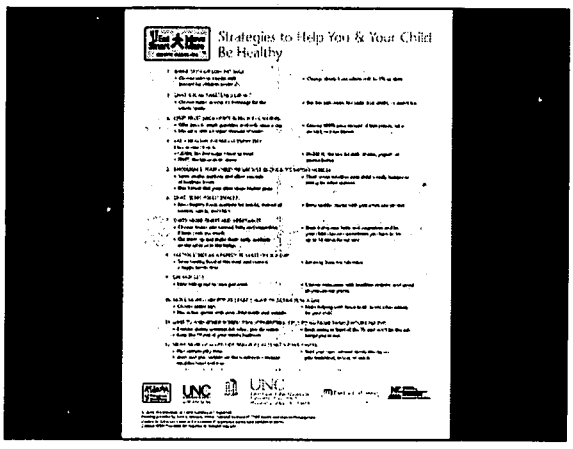




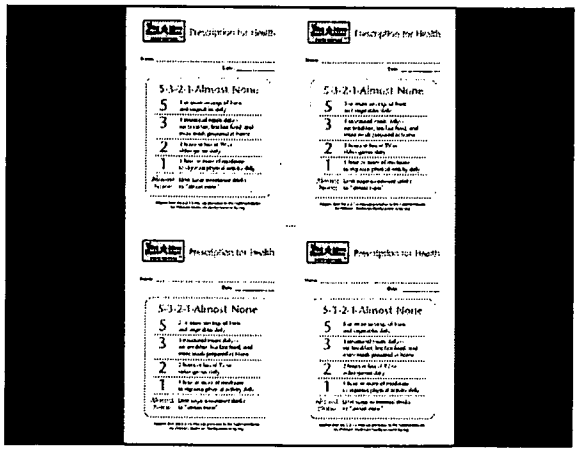
Blood Pressure Levels for GIRLS



Tell Us about Your Child's Eating Habits and Physical Activity



Strategies to Help You & Your Child Be Healthy



Additional Clinical Tools

- Motivational interviewing
- BMI wheels
- Sugar and fat displays
- Portion size and healthy meal planning tools
- Wake County Greenway guide

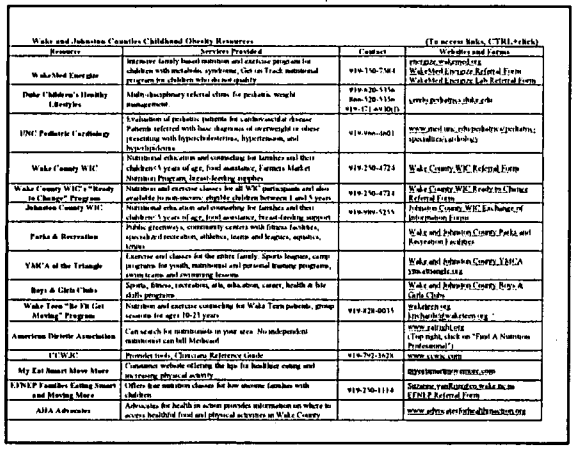
Co-located nutritionist

- To take advantage of Medicaid re-imbursement for Medical Nutritional Therapy (MNT), a dietician must bill within context of Medicaid provider.
- Piloting a co-located a nutritionist in a primary care practice
  - Clinically helpful?
  - Financially viable?

Community Links and Resources

Community Resources are listed on our website

www.ccwjc.com



Wake and Johnston Counties Childhood Obesity Resources (To access links, CTRL+click)

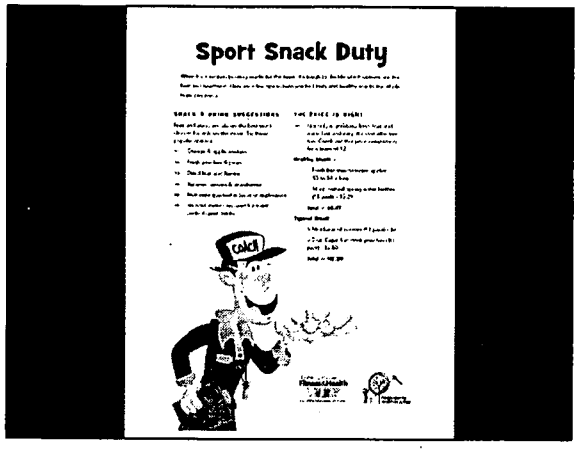
Resource	Services Provided	Contact	Website and Forms
WakeMed Energize	Intensive family based nutrition and exercise program for children with metabolic syndrome, Get on Track nutritional program for children who do not qualify	919-350-7484	energize.wakemed.org WakeMed Energize Referral Form WakeMed Energize Lab Referral Form
Duke Children's Healthy Lifestyles	Multi-disciplinary referral clinic for pediatric weight management	919-620-5156 800-320-5156 919-471-6930 (f)	
UNC Pediatric Cardiology	Evaluation of pediatric patients for cardiovascular disease. Patients referred with basic diagnosis of overweight or obese presenting with hypercholesterolemia, hypertension, and hypertriglyceridemia	919-966-4661	www.med.unc.edu/pediatrics/pediatric-specialties/cardiology
Wake County WIC	Nutritional education and counseling for families and their children 5 years of age, food assistance, Farmers Market Nutrition Program, breast-feeding supplies	919-250-4724	Wake County WIC Referral Form
Wake County WIC's "Ready to Change" Program	Nutrition and exercise classes for all WIC participants and also available to non-movers, eligible children between 1 and 5 years	919-250-4724	Wake County WIC Ready to Change Referral Form
Johnston County WIC	Nutritional education and counseling for families and their children 5 years of age, food assistance, breast-feeding support	919-989-5215	Johnston County WIC Exchange of Information Forms
Parks & Recreation	Public greenways, community centers with fitness facilities, specialized recreation, athletics, teams and leagues, aquatics, tennis		Wake and Johnston County Parks and Recreation Facilities
YMCA of the Triangle	Exercise and classes for the entire family. Sports leagues, camp programs for youth, nutritional and personal training programs, swim teams and swimming lessons		Wake and Johnston County YMCA ymcatriangle.org
Boys & Girls Clubs	Sports, fitness, recreation, arts, education, career, health & life skills programs		Wake and Johnston County Boys & Girls Clubs
Wake Teen "Be Fit Get Moving" Program	Nutrition and exercise counseling for Wake Teen patients, group sessions for ages 10-21 years	919-828-0035	waketeen.org letsbefit@waketeen.org
American Dietetic Association	Can search for nutritionists in your area. No independent nutritionist can bill Medicaid		www.eatright.org (Top right, click on "Find A Nutrition Professional")
FFWJC	Provides tools, Clinicians Reference Guide	919-792-3628	www.ccwjc.com
My Eat Smart Move More	Consumer website offering the tips for healthier eating and increasing physical activity		eatsmartmovemore.com
EFNEP Families Eating Smart and Moving More	Offers four nutrition classes for low income families with children	919-250-1114	Surname.familyname@wake.ncsu.edu EFNEP Referral Form
AHA Advocates	Advocates for health in action provides information on where to access healthful food and physical activities in Wake County		www.advocatesforhealthinaction.org

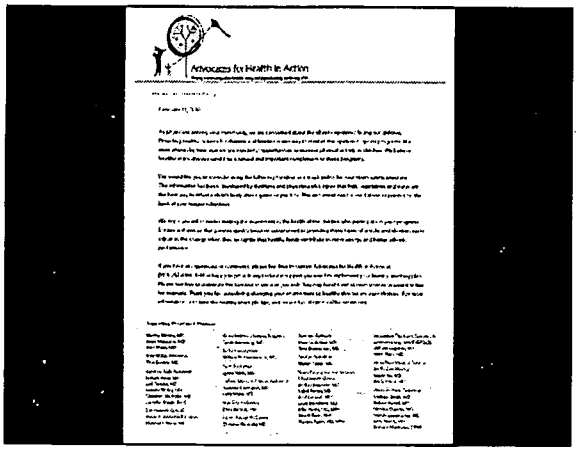
Care Management

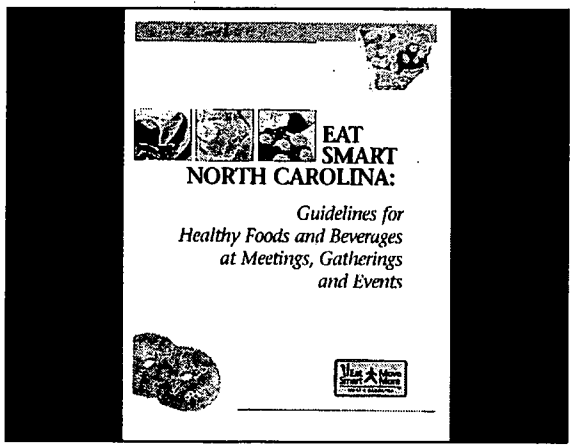
- Co-morbid care management of Asthma and obesity
- Home visits/pantry reviews
- Helping parents and children make better choices
- Link to community resources
- Referrals from obesity programs (e.g. ENERGIZE and Duke Healthy Lifestyles)

Fostering advocacy

- Partnering with Advocates for Health in Action
- Helping physicians engage in "a"dvocacy
- Healthy Snack Guide for youth sports programs
- Healthy Foods for Meetings guides
- Established our own Workplace wellness program
  - Can serve as model for other small businesses
- "Mobilizing Healthcare Professionals as Community Leaders in the Fight Against Childhood Obesity" grant







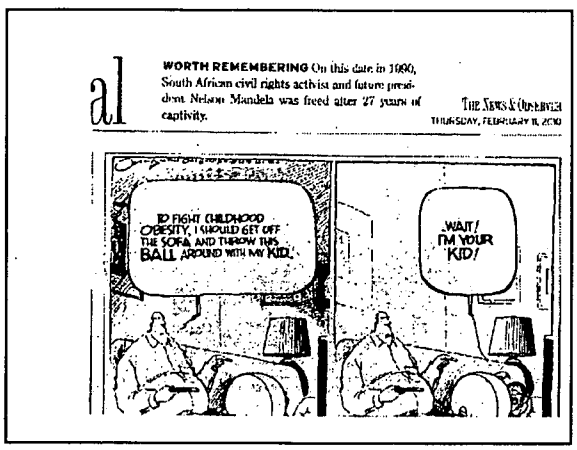
Suggestions/Next Steps

Recognize that obesity is a societal and environmental issue

- No **one** community sector can fix it on their own
- Need to have consistent messages and coordination across sectors
- Lead by example

Recognize that obesity is family issue

- Need to include families to impact childhood obesity
- Cover adults with Medicaid Medical Nutritional Therapy benefits



Facilitate primary care providers' role

- Replicate Best Practices in Childhood Obesity to other CCNC Networks/Practices
  - Need to consider where the resources would come from
- Align Medicaid policies with other payors (e.g. BCBS)
  - Consistent policies help practices align work flow and provide consistent care
- Quantify the clinical efficacy and financial sustainability of support by a nutritionist
  - Consider pros and cons of allowing nutritionist to directly bill Medicaid

Thank you and questions?

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NC Healthy Schools

Legislative Obesity Task Force
February 15, 2010

NC Department of Public Instruction

David Gardner
Section Chief, Healthy Schools



Outline

- NC Healthy Schools
- Healthful Living SCOS
- Healthy Active Children Policy
- 2009 HAC Policy Report Highlights
- Data Collection
- Challenges
- Opportunities
- Questions



NC Healthy Schools



NC Healthy Schools

- K-12 Curriculum & Instruction Div.
  - One State funded position (Health Ed.)
  - Four Federally funded positions
  - One position housed in DPH
- Cooperative Agreement from CDC/DASH – DPI and DHHS
- Promotes Coordinated School Health Approach (CSH) for LEA's and schools
- Collaborate with DPI Chief Health and Public Relations Officer



NC Healthy Schools

- Coordinated School Health
  - Health Education
  - Physical Education
  - Child Nutrition Services
  - Health Services
  - Healthy School Environment
  - Mental Health Services
  - Staff Wellness
  - Family and Community Involvement



NC Healthy Schools

- Provides support for the Healthful Living SCOS (HE and PE)
- Provides support for Driver Education, Athletics and Sports Medicine
- Administers the YRBS, School Health Profiles and Healthy Active Children surveys

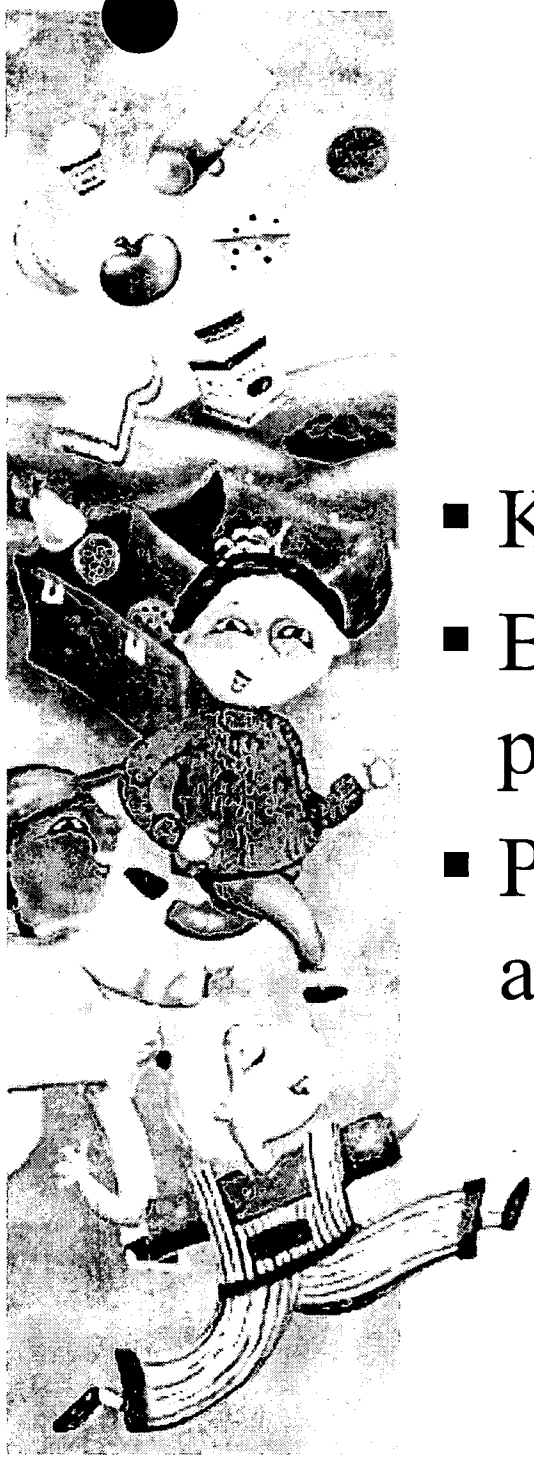


Healthful Living Standard Course of Study (SCOS)



Healthful Living Standard Course of Study

- A guide for teachers and students in the development of healthy behaviors, the teaching and learning of essential health related knowledge and skills and the establishment of active lifestyles



Healthful Living Standard Course of Study

- K – High School
- Blending of health education and physical education standards
- Promotes use of evidenced-based tools and instruction



Healthful Living Standard Course of Study

- Provides guidelines and framework for instruction
- Scope and sequence of instruction for K – HS
- Provides content strands for Physical Education and Health Education
- Includes instructional competencies and objectives



Healthful Living Standard Course of Study

- Aligned with National Physical Education and Health Education Standards
- Revised in 2006 with acknowledgement of increased child overweight and obesity
- Nutrition and Fitness specific objectives included with emphasis
- Revision of Essential Standards in progress Accountability and Curriculum Reform Effort (ACRE)



Healthful Living SCOS Physical Education

- Grades K-5
  - Licensed Physical Education Specialist and Classroom Teachers
  - Days per week with PE Specialist varies by LEA and school (no required #)
  - Minutes of instruction per day varies by LEA and school (no required #)
  - Focus includes movement and motor skills, health related fitness, sports literacy and personal responsibility



Healthful Living SCOS Physical Education

- Grades 6-8 – Middle School
  - Combined with Health Education as Healthful Living Education
  - Taught by licensed Physical Education specialist
  - Time divided between HE and PE
  - No required days or minutes per week
  - Focus includes personal fitness, lifetime activities, activities that offer challenges and enhance decision making skills



Healthful Living SCOS Physical Education

- High School
  - Combined with Physical Education as Healthful Living Education
  - Taught by Licensed Physical Education Specialist
  - One Unit of Healthful Living Education required for graduation
  - One semester of Physical Education and one semester of Health Education (traditional schedule)
  - Focus includes personal wellness, benefits of daily physical activity, and healthy weight management



Healthful Living SCOS Health Education

- Grades K-5
  - Health content primarily delivered by classroom teachers
  - No designated Health Education class
  - No required number of minutes
  - Focus includes, personal responsibility, servings and portion control, understanding of the My Pyramid, healthy weight management, nutrition labels



Healthful Living SCOS
Health Education

- Grades 6-8 (MS)
  - Combined with Physical Education as Healthful Living Education
  - Taught by licensed Health Specialist or Health and Physical Education Specialist
  - No required days or minutes of instruction
  - Focus includes Dietary Guidelines for Americans, role of nutrition and PA on weight management, balancing caloric intake with expenditure, eating disorders, media literacy

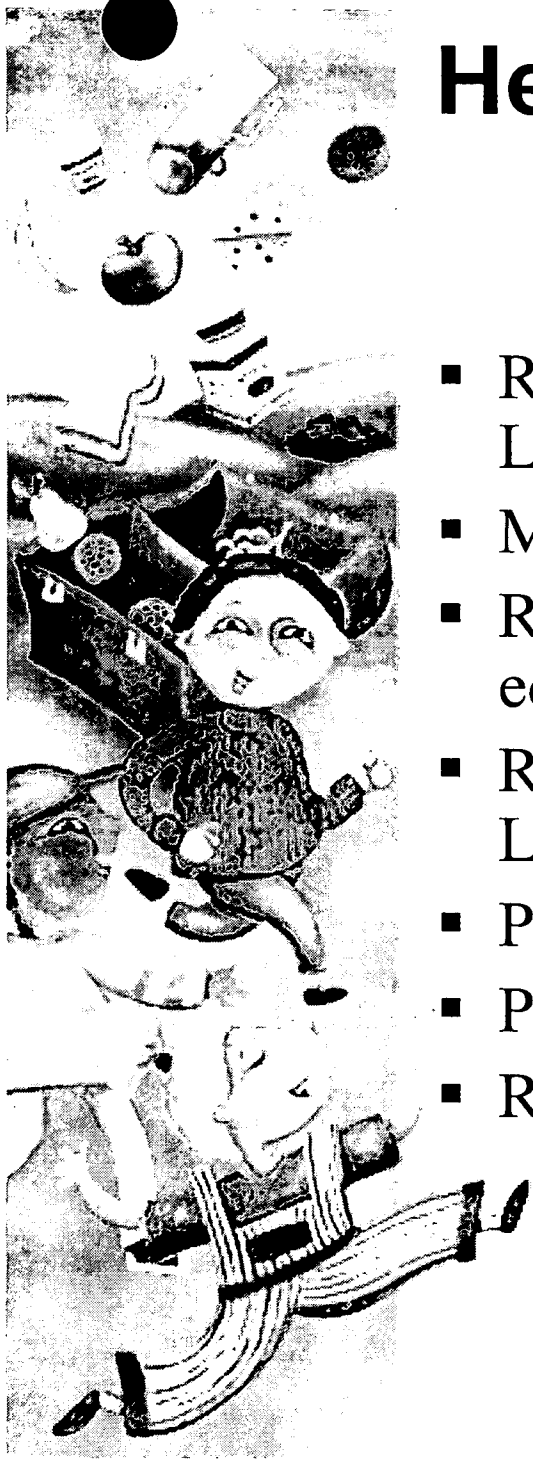


Healthful Living SCOS Health Education

- High School
  - Combined with Physical Education as Healthful Living Education
  - Taught by licensed Health Specialist or Health and Physical Education Specialist
  - One unit of Healthful Living Education required for graduation
  - One semester of Health Education and one semester of Physical Education (traditional schedule)
  - Focus includes personal weight management, analysis of popular weight loss plans, personal and consumer health, use of technology as a research tool



Healthy Active Children Policy (HAC)



Healthy Active Children Policy
SBE Policy GCS-S-000

- Requires School Health Advisory Councils in each LEA (SHACs)
- Mandates 30 minutes of physical activity daily (K-8)
- Recommends 150 minutes per week of physical education in elementary schools
- Recommends 225 minutes per week of Healthful Living Education in middle schools
- Protects recess and other PA time
- Promotes Coordinated School Health approach
- Requires annual report from LEA's to SBE



Healthy Active Children Policy

- 2009 HAC Policy Report Highlights
  - 95% survey response (106 of 112 LEA's)
  - Submitted by SHAC contact
  - Results reported to SBE
  - 86% of SHAC's have representatives from all 8 areas of CSH
  - 38% of SHAC's meet at least quarterly
  - 61% of SHAC's provide reports to local BOE

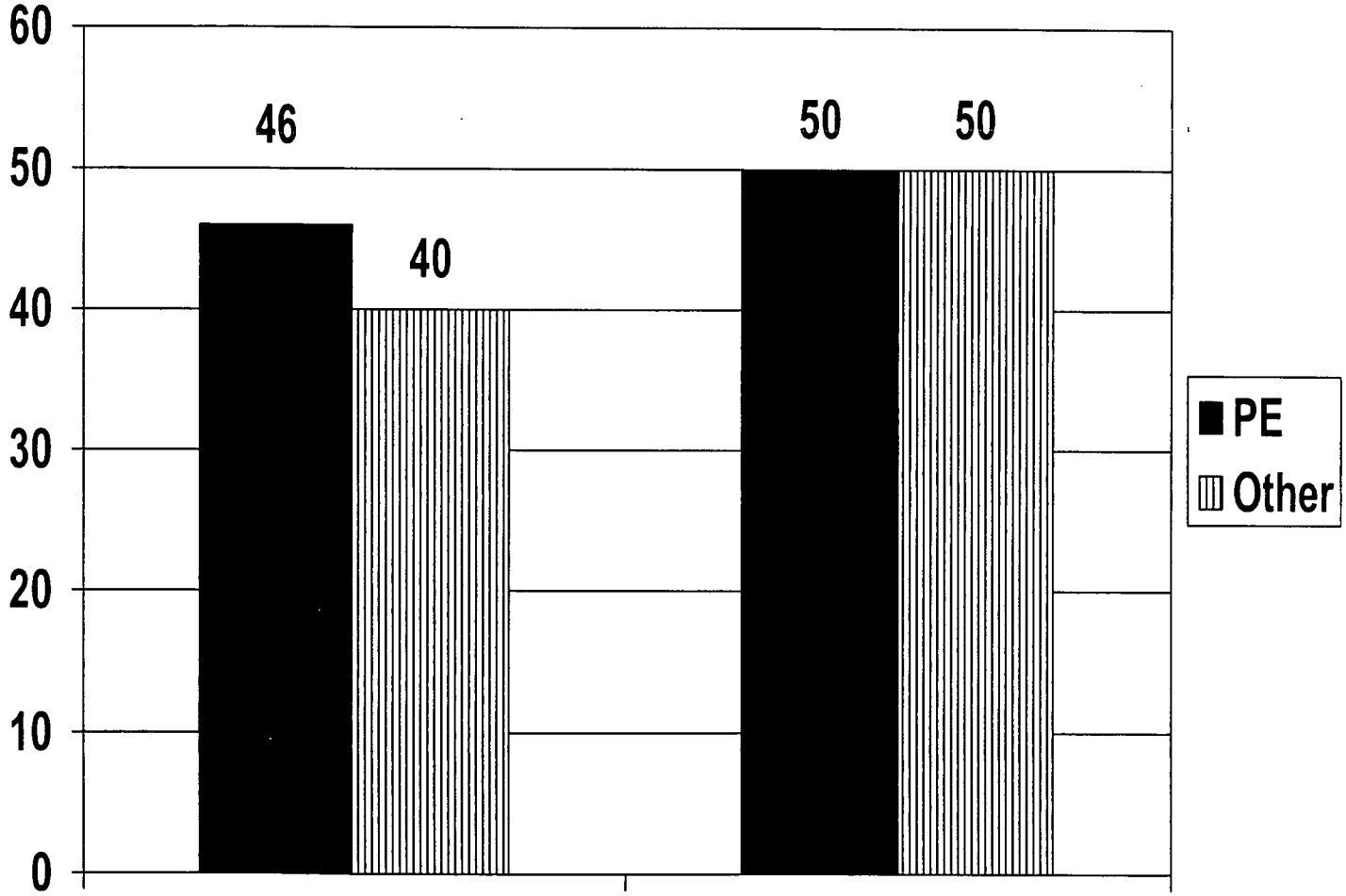


2009 HAC Policy Report Highlights



HAC Policy 2009 Survey

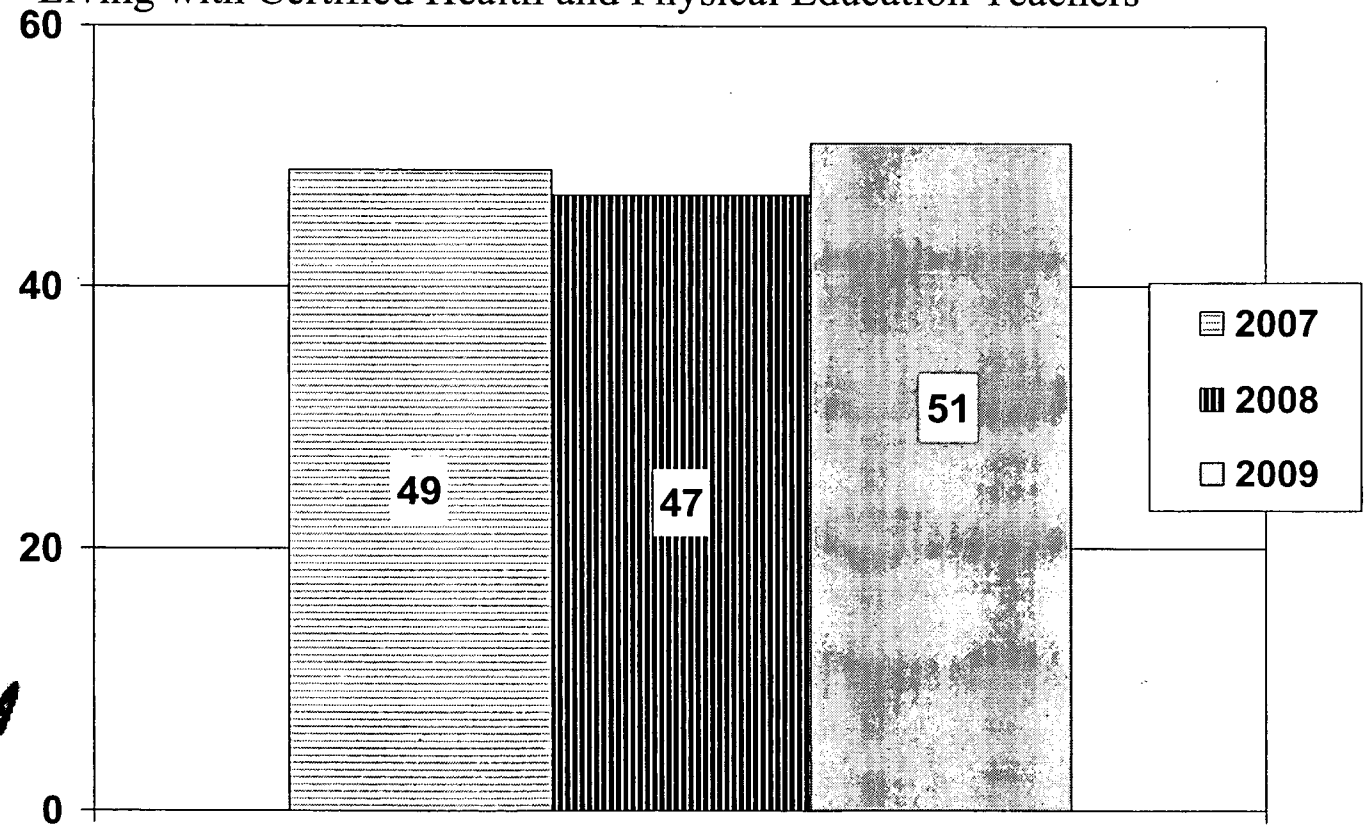
ALL Elementary Schools in LEA Providing 150 min. of PE per Week with Certified Physical Education Teacher

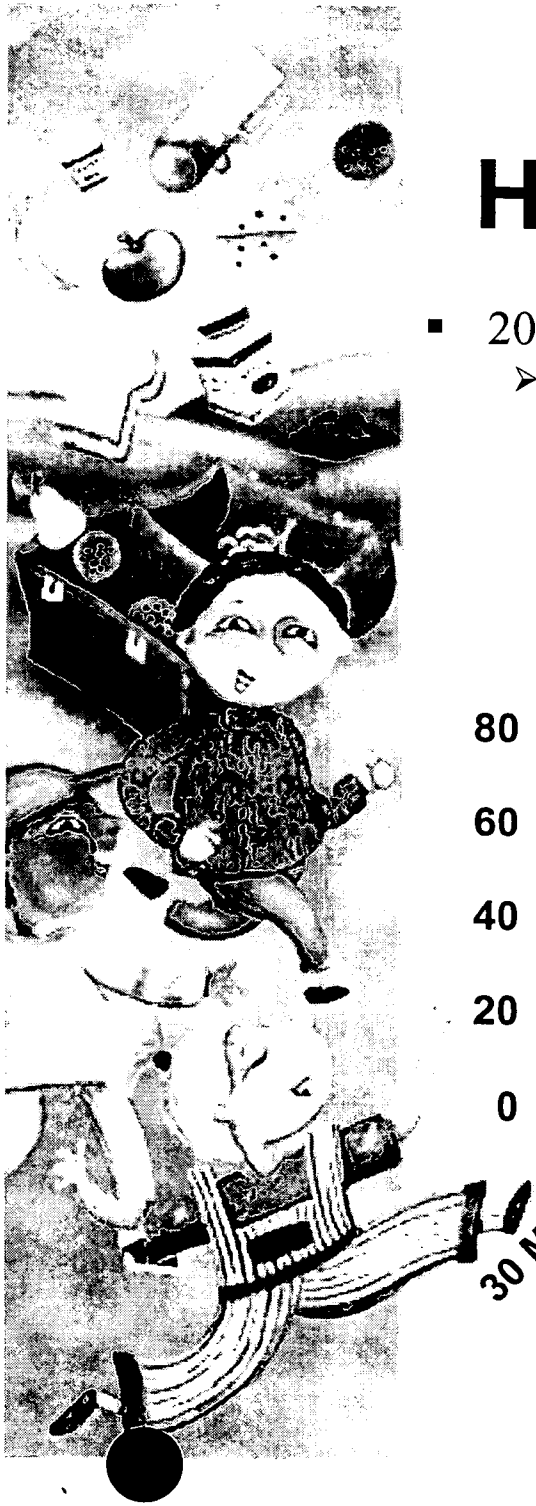




Healthy Active Children Policy 2009 Survey

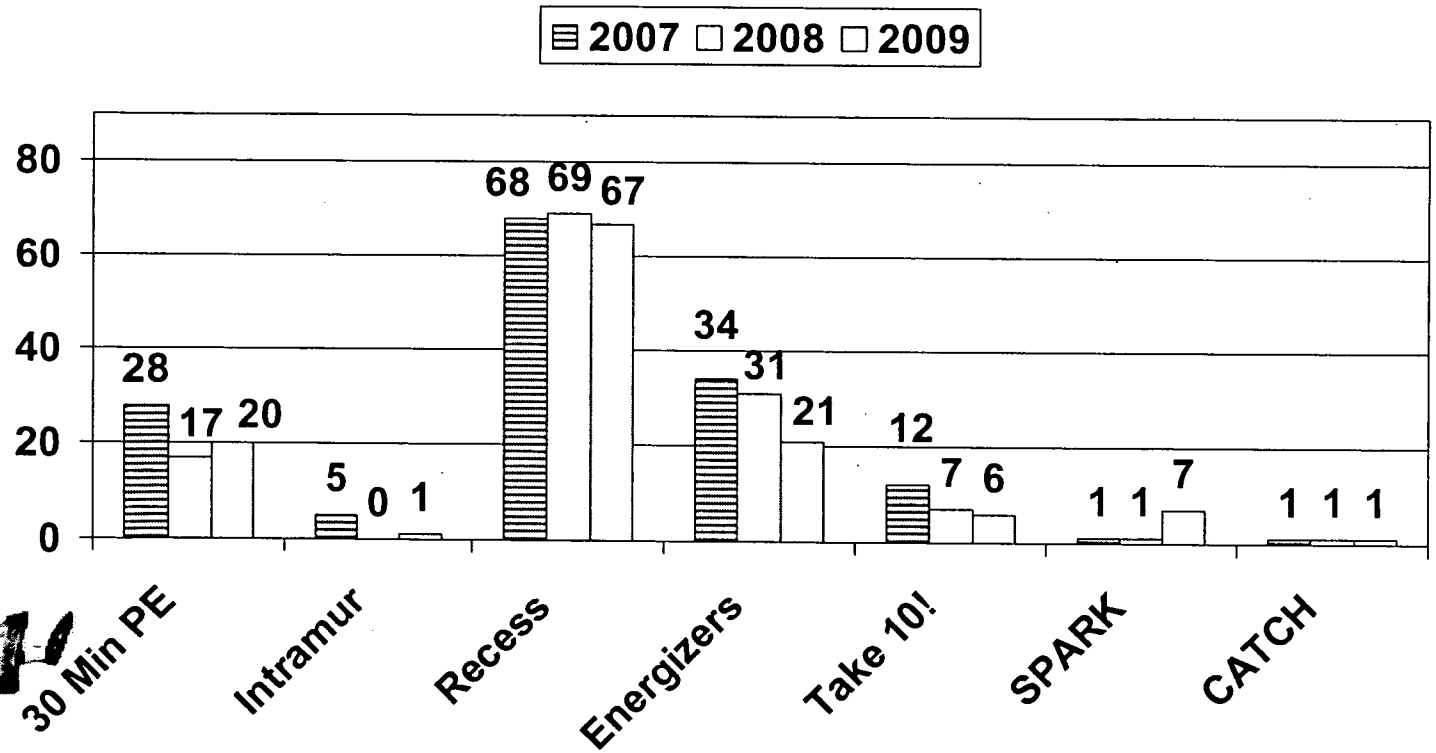
- **ALL** Middle Schools in LEA Providing 225 Minutes per Week of Healthful Living with Certified Health and Physical Education Teachers





Healthy Active Children Policy

- 2009 HAC Survey Highlights
  - Moderate to Vigorous Physical Activity (MVPA) opportunities offered by LEA's





Data Collection



Data Collection

- **Youth Risk Behavior Survey (YRBS)**

  CDC Selected Middle and High Schools – odd years

- **School Health Profiles**

  Principals and Lead Health Teacher in selected Middle Schools and High School – even years

- **School Level Impact Measures** (SLIMs)



Data Collection

- In-School Prevention of Disease (IsPOD)
  - NCAAHPERD Lead Investigator
  - Multi-year K-8 Physical Education focus
  - Kate B. Reynolds Charitable Trust - Funding
  - Statewide – all LEA's able to participate
  - Professional Development, Fitness Testing, Nutrition and Physical Activity survey, data collection and analysis



Data Collection

- IsPOD
  - Currently 64 LEA's participating to date
  - Over 47,000 students (August 2009)
  - Fitnessgram – Evidenced-based fitness assessment: BMI, Strength, Endurance, Cardiovascular Endurance, Flexibility
  - Training for Fitnessgram
  - SPARK – Evidence-based PE program
  - Training for SPARK



Challenges



Challenges

- Other School Priorities
- Healthful Living (PE & HE) Not Tested Areas
- PE – PA Confusion
- Too Little Time
- Too Few Qualified Teachers
- Inadequate Facilities and Equipment
- Merging of Education and Health Priorities



Challenges

- Disproportionate Emphasis on Athletics
- Size and Diversity of State
- Local Control Limitations



Opportunities



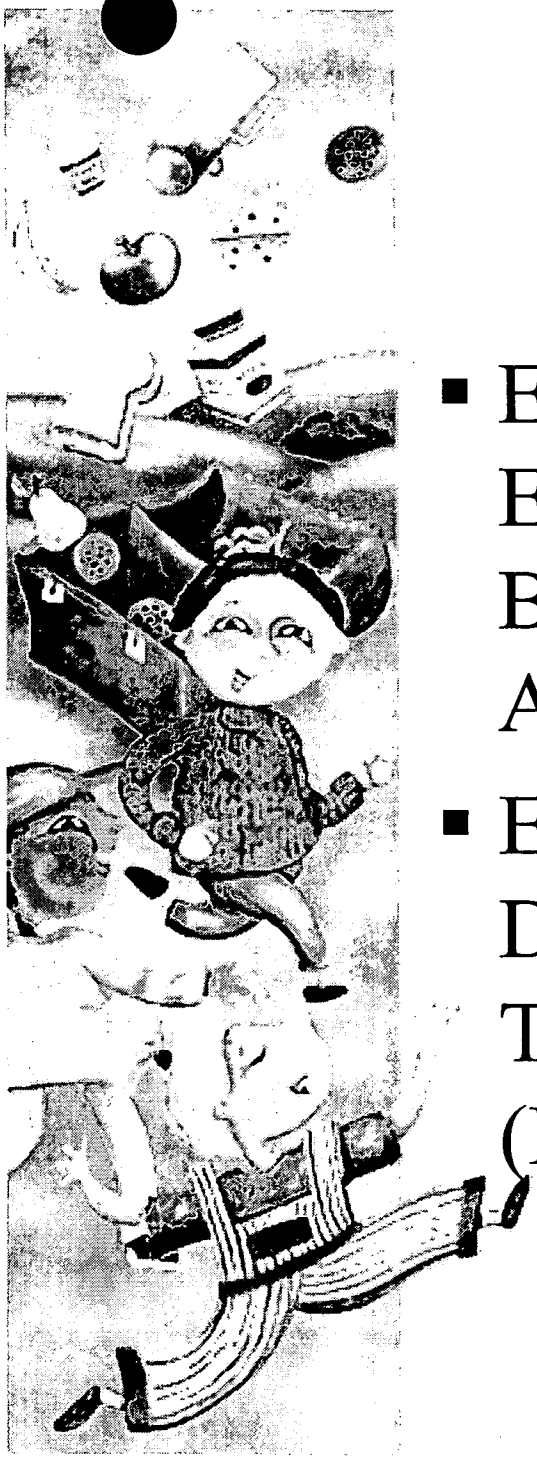
Opportunities

- Develop and Implement a K-12 Evidence-Based Assessment and Accountability Plan for Healthful Living Education
- Establish NC School Health Data Management System – NC Center for Health Statistics, NC WISE, IHE's



Opportunities

- Establish Healthy Schools Coordinator Positions in LEA's to Maximize CSH Approach
- Provide Healthy Schools = Successful Students Grants to Leverage Federal, Local, and Private Funding to Establish and Sustain Evidence-based Obesity Reduction and Prevention Initiatives



Opportunities

- Enact Policies to Encourage and Enhance Joint Use Agreements for PA Between Schools and Community Agencies
- Enact Policies That Enable School Districts to Plan and Build Schools That Are PA and Nutrition "Friendly" (Built Environment)



Opportunities

- Provide Supplements to PA Coordinators for Before and After School Programs
- Earmark Portion of Lottery to Improve Access to Pedestrian and Bike Lanes Serving Schools
- Reinstitute and Modify Physical Education Consultant Position at DPI



Questions

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MATCH-Motivating Adolescents with Technology to Choose HEALTH™

An Effective School-Based Childhood Obesity Intervention Educational Model

George "Tim" Hardison, Jr, MA
- MATCH Creator and Director

Suzanne Lazorick, MD, MPH
- Asst. Professor of Pediatrics and Public Health, ECU

Today's Objectives

- Brief historical perspective of NC obesity prevention efforts
- MATCH outcomes: BMI and aerobic fitness
- RTI projected Medicaid savings
- Overview of MATCH as an educational methodology
- Dr. Lazorick's evaluation

Charge of 2008 Task Force

- Evaluate obesity intervention efforts of DPH, DPI, and HWTF
- Report Recommendations framed with six initiatives
- Think Tank of Childhood Obesity grew out of Task Force
- MATCH was chosen as Middle School Intervention in Pilot

Interested Players

DPI

DPH

NWTF

RWJ

CDC

USDA

AMA

AHA

MATCH

Data-driven, Evidence-Based

"Educational Methodology"



1. Teacher Developed
2. Filters to prevent "Informational Overload"
3. Aligned with NCSCOS to teach EOG Test Skills
4. Interdisciplinary, relevant, fun!

Student



Behavior Modification

Factors influencing Childhood Obesity are so complex...

- So many angles to attack childhood obesity, from policy, planned environments, availability of healthier foods, more physical activity.
- It can be so complex, we attempt to do too much, in too many areas, and the effort becomes superficial...

---

the answer is simple....

- Individuals must CHOOSE to ***modify their behavior*** and be EDUCATED so they can make GOOD CHOICES.
- Then, **agencies, policies, and programs** can be **supportive** to assist individuals in making **behavioral change**.

Which Programs Work?

If Programs cannot contribute too...

- **Measureable changes** in BMI that are **sustained**...
- We are not reducing health risks...
- And we are not SAVING MONEY!

MATCH Success Rates with Overweight/Obese Seventh Graders from Inception (decreased BMI Z-scores)

	Baseline	Immediate Post	18m Post Baseline	30m Post Baseline
Cohort 1 2007 WMS	n=106 61% owob	70%	72%	75%
Cohort 2 2008 WMS	n=105 47% owob	66%	71%	
Cohort 3 2009 SBE Pilot	n=105 62% owob n=378 55% owob	66% (WMS)		

NOTE: at 18mo, 42% of those OW at baseline had decreased to Healthy Wt

(Pilot Schools decreased BMI Z-scores, $p<.05$)

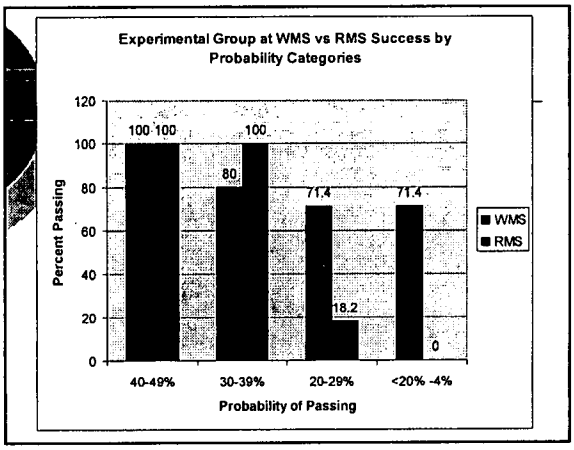
RTI Projected Savings in 7th Grade Medicaid Expenditures for Overweight

- Assuming one in four (25%) overweight adolescents will become normal weight adults
- 42% of the overweight (Cohort 1,2) moved in to normal weight.
- Intervention can be attributed to 17% of the change (low estimate)
- If MATCH were implemented statewide, would result in estimated range from 4-5,* up to 13-22,**million dollar savings per year.
- Savings would be cumulative per class per year (10 years would save in range of $230-460 m)

* Based on Buescher, *et al* 2008 (in 2003 dollars)
** Based on Pennington, *et al*, (personal communication, study in progress from 2007 Medicaid chart review by DHHS)

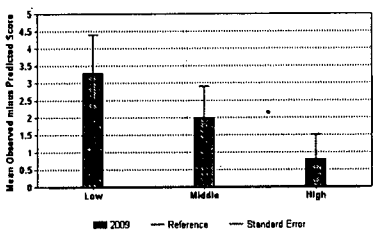
Unexpected Outcomes...

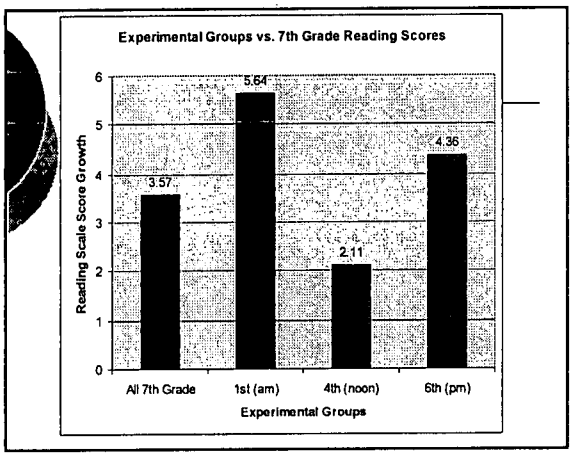
Do all students really need 90 minutes of math daily to improve?

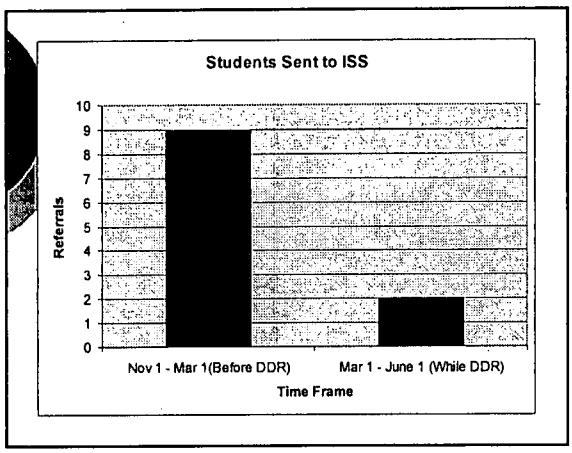


	EVAS8 Probability Ranges of Scoring Level 3 (Proficient) on Math EOG			
School	40-49%	30-39%	20-29%	<20% to >4%
WMS				
N	3	5	7	7
Sum of Probability (Expected)	1.37	1.84	1.69	0.78
Observed (pass)	3 (100.0%)	4 (80.0%)	5 (71.4%)	5 (71.4%)
Efficiency Ratio	2.19	2.18	3.31	6.45
RMS Control				
N	5	9	11	6
Sum of Probability (Expected)	1.86	3.23	2.64	.71
Observed (pass)	5 (100.0%)	11 (100.0%)	2 (18.2%)	0 (0.0%)
Efficiency Ratio	2.69	2.78	0.76	0.00

Lower Half at WMS Exceeds EVASS Projections







MATCH with Dropout Prevention Implications

- Potential savings increased tests scores, fewer retentions and discipline problems
- Improvement in areas which are predictors of students at risk for dropout
- Currently, each class of dropouts in NC (23,000) cost $169 million, and will cost the state $8 billion over their working lifetime.

MATCH

Motivating Adolescents with Technology to Choose HEALTH™

*... a personal **Wellness Program** for Students*

What Educators are thinking...

EOG's are a part AYP and NCLB

BMI's are not!

MATCH... a personal wellness program for students

- Encompasses objectives of CSHP, ESMM, HAC working with SHAC's
- Lessons and activities aligned with the NC Standard Course of Study
- Develops EOG Test Skills
- Developed to work with NCWISE
- Aligned with AMA Recommendations
- Provides early identification of "at risk" students for health issues.

MATCH

- Behavior modification program
- Uses incentive-based rewards based on personal goals
- Teaches students life-skills to make healthy decisions
- Health and choices are the focus- NOT "Weight"

Five "-ates" of MATCH

- Evaluate
- Educate
- Motivate
- Participate
- Celebrate

MATCH "5-ates": Evaluate- MATCH Measures

- Height and Weight
  - BMI calculation
- Blood pressure
- Physical Fitness
- Self report questionnaires
  - Physical Activity
  - Eating Habits: Quantity and Quality
  - Technology/screen Time Usage

MATCH "5-ates": Evaluate- Fitness Testing using Fitnessgram

- Cardio-Respiratory Endurance- PACER TEST
- Body Composition- BMI
- Low-back Flexibility- Sit-and-Reach Test
- Abdominal Endurance- Curl-ups
- Shoulder Endurance- Modified Pullups

Educational Components

- HORIZONTAL ALIGNMENT has characteristics of "thematic units"
- Relevant topics reinforced across curriculum with aligned lessons for skill development
- Opportunity for content-based writing.
- Computer Skills applied to classroom lessons using student's own data.
- Applies principles of Brain-Based Learning
- Incorporates multiple learning theories

MATCH "5-ates": Educate- Science Class

- "Body Systems" approach to wellness
- Teach aspects of exercise, nutrition, and related diseases while teaching corresponding body systems.
- This progression frames MATCH activities and other lessons
- Students evaluate current behavior patterns compared to desired healthy behaviors.

MATCH "5-ates": Educate

- Math- BMI calculation, percentages, formulas, ratio and proportion, caloric balance (check book skills)
- Language Arts- persuasive writing, journaling, contracts, non-fiction reading
- Technology Skills- database, spreadsheet, multimedia presentation skills,
- Healthful Living, fitness testing, personal fitness plans, nutrition education.

MATCH "5-ates": Motivate

- Individual plans
- Goal-setting
- Incentives, rewards and recognition based on progress
- Graphical analysis of personal results
- Accountability- taking personal responsibility for decisions and actions.

MATCH "5-ates": Participate

- Participation in a variety of age-appropriate programs to increase PA
- Behavioral skills to make informed, healthy decision, when presented "choices"
- Support system necessary to achieve success.
- This school has designated 30 minute noon physical activity program

Physical Activity Programs

- Walk to Raleigh
- 10-K Every Day
- Jump Rope "Throwdown"
- MATCH "Dance Off"
- Bikes, Blades, & Boards
- Relay for Life
- "Aerobic Dance
- 3 on 3 Basketball Tourneys
- "After-School Walk and Talk"
- Intramurals
- DDR
- Wii Fit, Wii Sport (grant funded 2008-9)

ECU Evaluation and Summary

- Evidence base for MATCH approach
- Explanation of results and limitations
- Policy implications
- Summary

National scientific review and academic dissemination

- Results have been/will be presented at:
  - American College of Preventive Medicine (2009)
  - Pediatric Academic Societies (2009,10)
  - National Initiative for Children's Healthcare Quality (2009,10)
  - CDC Weight of the Nation Conference (2009)
- Dr. Lazorick funded by Robert Wood Johnson Foundation to study MATCH
- Manuscript to be submitted next month to Journal of Pediatrics and Adolescent Medicine

Evidence base for MATCH methodology

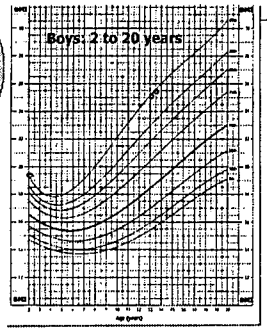
- Combines group education with strategies for individual behavior change
- Based on Social Cognitive Theory- the basis of effective clinical treatment
  - Goal setting, tracking, rewards
  - Social support
- Developmentally appropriate
- Aligned with the 2007 AMA Expert Panel Recommendations*

*Barlow S. Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Child and Adolescent Overweight and Obesity: Summary Report, (2007). *Pediatrics, 120.*

Explanation of MATCH Outcomes

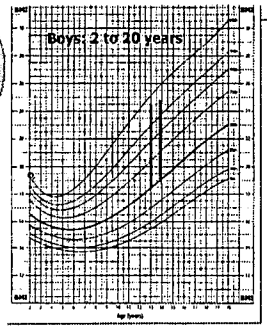
- Body Mass Index
  - What is an appropriate "outcome measure" in a short term intervention in adolescents?
  - Weight, Height and Body Mass Index are all still increasing at this age
- Fitness measures-
  - Cardiovascular Fitness, PACER test (*Fitnessgram*®)

For Children, BMI Changes with Age



- Between age 12-14 years, BMI will increase with normal growth.
- Expected BMI increase:
  - 14 weeks: 0.25
  - At 18 months: 1.5

BMI Z-Score



- To detect change over a short time period, BMI Z-score is the best measure*
- Z-Score is the number of standard deviations from the mean (50th%ile) BMI

*Ref: Paluch, R.A., Epstein, L.A., & Roemmich, J.H. (2007). *Am J Human Biol, 19*, 487-494.

Example of detecting change with BMI Z-score

	Ht (in)	Wt (lbs)	BMI	BMI %ile	BMI Z-Score
Baseline	63	168	29.76	97	1.98
Follow-up	63.5	171.5	29.9	97	1.89

Therefore- in MATCH we defined "success" as *any decrease* in BMI Z score for the overweight or obese students

BMI results- Overweight

	Cohort 1 (n=23; 21 at 1 year)		Cohort 2 (n=16; 15 at 1 year)	
	Post-MATCH	One-yr later	Post-MATCH	One-yr later
BMI Z-score change	-0.13 (<0.01)	-0.13 (0.12)	-0.14 (<0.001)	-0.17 (=0.03)
BMI %ile change	-2.58 (<0.01)	-3.8 (0.061)	-2.83 (<0.001)	-4.41 (=0.04)

Weight category results after 1 year- Overweight subgroup

- Cohort 1: Of 20 overweight at start, 7 were Healthy Weight at 1 year
- Cohort 2: Of 15 overweight at start, 8 were Healthy Weight at 1 year
- **Combined: 42.8% (15/35) of Overweight students achieved Healthy Weight after 1 year**

Cardiovascular Fitness Results- Cohort 3 (4 schools)

Schools	PACER Mean Change from Baseline (SD)
Williamston Middle	5.6** (12.7)
Roanoke Middle	7.9* (30.4)
Washington County Union	4.7** (10.7)
Ayden Middle	4.3* (12.2)

*Indicates Significance at the p<.05 Level
**Indicates Significance at the p<.001 Level

Teacher feedback

- Surveys and focus groups completed spring 2009 with all 7th grade teachers from 4 schools
- Teachers (n=22) say MATCH curriculum
  - fits within NCSCOS (91% yes)
  - takes same or less time to prepare lessons (81%)
  - should be expanded to other schools (100%)
  - is likely to achieve its goals (91%)
  - provided the teacher with better understanding of obesity (82%)

Limitations

- Follow up data are from single site intervention (small numbers) without control group
- Medicaid savings estimates based on limited information
  - Economist had few data sources for children to use to project cost/savings

Policy Implications

- Accountability for existing Healthful Living curriculum in Middle School
- Enforcement of existing 30 min daily physical activity in middle schools- as per HAC
- Optimizing time in PE class
- Enhancing school facilities for age-appropriate PA
- Improving nutritional offerings to support healthy choices

Summary

- **More study is needed, but after 3 years of development and evaluation, MATCH:**
  - Appears to be effective for obesity prevention **and for intervention** for kids already overweight
  - may have positive academic effects
  - can be implemented largely using existing resources
  - is ready for web-based roll out
  - is feasible to and recommended by administrators and teachers

For more information

on MATCH

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MATCH Creator and Director
timhardison@dishmail.net

Suzanne Lazorick, MD, MPH
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lazoricks@ecu.edu

Motivating Adolescents with Technology to Choose HEALTH – An Effective School-based Obesity Intervention

George "Tim". Hardison, Jr, MA,
tim.hardison@dishmail.net

Suzanne Lazorick, MD, MPH
lazoricks@ecu.edu

The MATCH Intervention

- 14 week, cross curricular wellness instruction in 7th grade
- Designed at 1 school in 2006 by teacher with wellness background
- Selected by SBE for pilot expansion in 2009; now funded in 5 schools by BCBSF
- Lessons coordinated *within* NC standard course of study; all class subjects involved; 30 minutes physical activity daily
- Baseline height, weight, health habits and fitness measures used for students to design their own goals
- Periodic rewards for progress to make fitness FUN; All students are treated the same
- Emphasis is on healthy behavior change, not weight
- Evidence-based: based on Social Cognitive Theory and consistent with 2007 Obesity Clinical Recommendations published in Dec. 2007 *Pediatrics*

Results from Evaluation by ECU

Success Rate- % with lower BMI Z score (moving closer to the mean BMI for age); ALL OVERWEIGHT		
	Cohort 1 (n=92)	Cohort 2 (n=105)
Post- MATCH	70% (n=56; mean BMI Change -0.057)	66% (n=50; -0.83)
One year later	72% (n=44; -0.78)	71% (n=41; -0.52)
% changing from Overweight to Healthy Weight category after 1 year: **42%**		

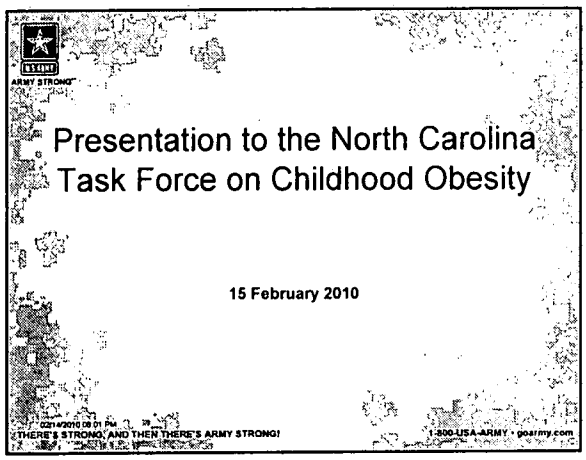
Potential Cost Savings based on reducing % Overweight childrer within Medicaid population; calculations by RTI economist

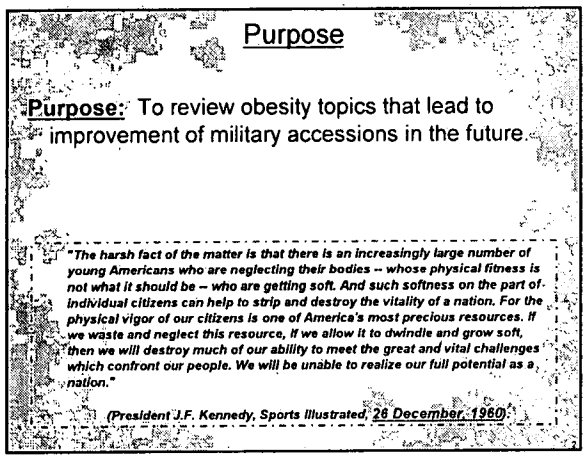
- Using Medicaid expenditure data: 2008 Buescher (published) and 2010 Pennington (in progress) studies; Based on VERY limited data;
- Assuming statewide implementation and effect of additional 17% of children through intervention would achieve Healthy Weight,
- Savings per year range from 4.1 to 22.5 milion dollars; In range of 180 million over 5 years

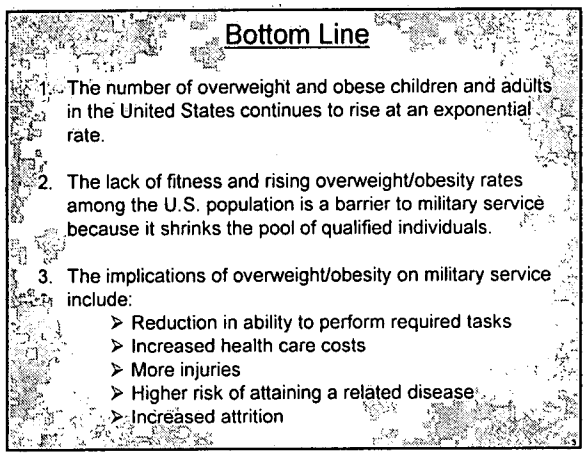
Policy Implications

- Accountability for middle school Healthful Living curriculum
- Enforcing 30 minutes daily physical activity in Middle School; optimizing PE class
- Enhancing school facilities for age-appropriate PA
- Improving school nutritional offerings to support healthy choices

EAST CAROLINA UNIVERSITY


ARMY STRONG
Presentation to the North Carolina Task Force on Childhood Obesity
15 February 2010
THERE'S STRONG, AND THEN THERE'S ARMY STRONG!
1-800-USA-ARMY • goarmy.com


Purpose
Purpose: To review obesity topics that lead to improvement of military accessions in the future.
"The harsh fact of the matter is that there is an increasingly large number of young Americans who are neglecting their bodies -- whose physical fitness is not what it should be -- who are getting soft. And such softness on the part of individual citizens can help to strip and destroy the vitality of a nation. For the physical vigor of our citizens is one of America's most precious resources. If we waste and neglect this resource, if we allow it to dwindle and grow soft, then we will destroy much of our ability to meet the great and vital challenges which confront our people. We will be unable to realize our full potential as a nation."
(President J.F. Kennedy, Sports Illustrated, 26 December, 1960)


Bottom Line
1. The number of overweight and obese children and adults in the United States continues to rise at an exponential rate.
2. The lack of fitness and rising overweight/obesity rates among the U.S. population is a barrier to military service because it shrinks the pool of qualified individuals.
3. The implications of overweight/obesity on military service include:
Reduction in ability to perform required tasks
Increased health care costs
More injuries
Higher risk of attaining a related disease
Increased attrition

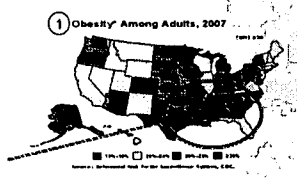
The Environment

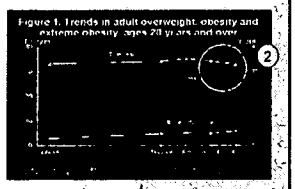
Health & Medical:

- Over half (63%) of 20-44 year olds are overweight or obese. Additionally, obesity presents comorbidity most often with the following diseases:
  - Increased risk and occurrence of Diabetes
  - Increased risk and occurrence of Cardiovascular Diseases
- (1) The most concentrated areas of obesity are in the mid-west and south-central regions of the U.S... ...areas that the Army typically depends on heavily for support.
- (2) Obesity trends indicate a reduction in overweight individuals with that population shifting to the obese category.
- The prevalence of childhood obesity and overweight is also on the rise with approximately one in five children between the ages of 6 and 19 are overweight.

Source: CDC, NCHS Obesity Brief Yanketovich Monitor 2008/2009

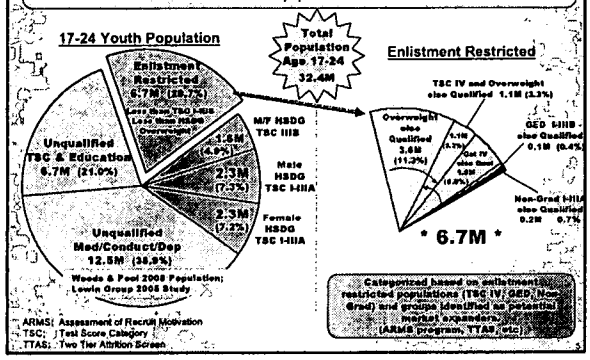
(1) Obesity* Among Adults, 2007





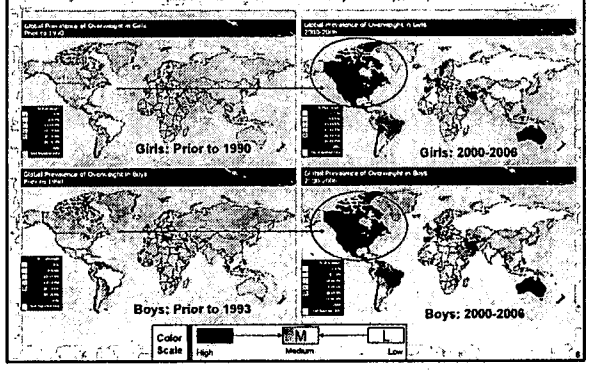
Enlistment Restricted Market

The overweight enlistment restricted population is responsible for nearly half of the individuals in this group; however, Army programs addressing each restricted group are not tailored based on population size.



International Comparison

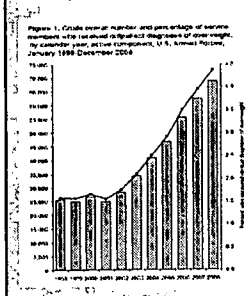
The United States continues to lead the way in the growing obesity epidemic, although it is spreading significantly on an international level.
(International Association for the Study of Obesity, IASO)

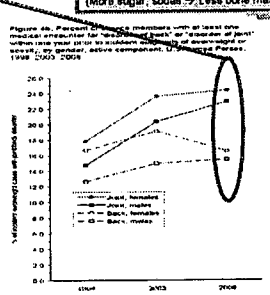


In-Service Implications

- In recent years, the Army has started to mirror the overweight/obesity growth rate of the general public.
  - Since 2003, the number of Soldiers diagnosed by a medical professional as overweight have nearly doubled.
  - Not surprisingly, the Army has also seen a significant increase in back and joint injuries during the same time period in three out of four categories.

(More sugar, sodas → Less bone mass)





Source: Medical Surveillance Monthly Report, Vol. 16, No. 1, Jan '09

Army Outreach Strategy

Pre-Prospect Outreach:	Prospects:	Future Soldiers:	Cadets/ OCS	Soldiers:	Influencers/ Family:
• Planning for Life •Hooah4Health website • JROTC	•ARMS Program: Overweight individuals must pass the ARMS test once before contracting & once before shipping 5.6% of recruits with an ARMS waiver are recycled at BCT compared to 3.1% for fully weight qualified recruits. Target Overlap	• FSTP: Physical Screening • ARMS Program: Overweight individuals must pass the ARMS test before shipping 5.6% of recruits with an ARMS waiver are recycled at BCT compared to 3.1% for fully weight qualified recruits.	• PT • Army Nutrition • Cadets/OCS candidates are periodically weighed and examined by physical therapists or trainers during the course of the program.	ARMY FIT Program: Army Nutrition: During Soldiers' off-duty hours, food choices can affect performance, as well as overall health.	•Hooah4Health website • MWR's Fit for Life Program

Pre-Prospects 12-16 | Prospects 17-24 | Prospects 25-29 | Future Soldiers/ Recruits | Cadets/Officer Candidates | Soldiers | Influencers Family

1. While the Army holds a requirement for Soldiers to maintain fitness standards, there is also great concern for individuals considering the Army, Army family members, and the general public.
2. Despite some gaps in health education and healthy eating directives, the Army as a whole along with localized leadership support continues to address the growing problem of obesity in the United States. LEADERSHIP is KEY before, during and after service.
3. There is a gap in the Army's ability to track the success or failure of fitness and diet initiatives created to assist Soldiers.

ARMS Instrument & Results

ARMS Instrument:
The Assessment of Recruit Motivation and Strength (ARMS) is a performance-based tool to screen in applicants who were otherwise disqualified for service. It is a three part assessment tailored to accurately assess individuals despite gender differences.

MEN	WOMEN
• 5-minute step test: – 16 inch step – 120 steps per minute – 1-minute resting pulse <180	• 5-minute step test: – 12 inch step – 120 steps per minute – 1-minute resting pulse <180
• Push-ups: 15 reps/1 minute	• Push-ups: 4 reps/1 minute
• Maximum body fat (Army Body Fat Test): 30%	• Maximum body fat (Army Body Fat Test): 36%

RESULTS:

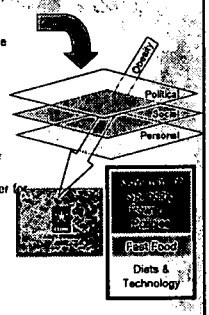
1. After a successful pilot study, the ARMS Program was implemented in FY07 for all three components of the Army.
2. No significant attrition differences between recruits with an ARMS waiver and weight qualified recruits have been identified to date.
3. Less than one percent (<1%) of ARMS accessions are discharged due to weight control failure.
4. Men with an ARMS waiver have been more likely to suffer heat and musculoskeletal injuries in basic training than weight qualified men.

Army Accessions with ARMS Waiver (FY07-FY08)

	Regular Army			Army Reserve			National Guard		
	2007	2008	Total	2007	2008	Total	2007	2008	Total
Men	784	658	1,442	173	173	346	537	566	1,103
Women	432	339	771	174	193	367	385	341	726
Total	1,216	997	2,213	347	366	713	922	907	1,829

Summary

- Obesity crosses multiple planes, hence complicating possible solutions.
- The obesity epidemic effects Army Accessions by:
  - Reducing the number of fully qualified individuals available to access.
  - Increasing the amount of resources expended to help individuals become qualified.
  - Increasing the risk of accession disqualification for other medical reasons (i.e. diabetes, asthma etc.).
- Snapshot of Individuals accessing into the Army with a waiver for weight disqualification:
  - Less likely to graduate IET the first time through
  - Had higher 36 month attrition rates
  - Were less likely to receive good conduct medal
  - Were more likely to have a bar to reenlistment
  - Were more likely to lose favorable personnel status
  - Were less likely to make E5 by 48 months



- Overweight/obesity in the military is associated with several different factors and existing Army programs are not sufficient to address the growing obesity problem in both the civilian and the Army population. The number of overweight Soldiers on active duty has nearly doubled in the past decade with relatable injuries on the rise.

10

Recommendations

- Increase outreach efforts to the total population to ensure both prospects and pre-prospects understand the value of fitness as a lifetime activity.
  - Engage influencers and local communities to set the example.
  - Be consistent in providing Soldiers with opportunities to engage in physical fitness and healthy eating options.
- Create new, flexible opportunities for deployed or special duty Soldiers (i.e., recruiters) to ensure they have the same opportunities as their peers.
- Continue the ARMS Pilot Program to provide an opportunity to future Soldiers allowed to access into the Army with substandard body fat conditions.
- Continue collaboration with federal programs (both local and national) in existence that if partnered with could potentially increase awareness and address the growing epidemic of *OBESITY*.

11

Army Preparatory School Strategy

- GED (APS-G)
- High School Diploma Charter (APS-D)
- ***Fitness Training Company (APS FiT-C)***

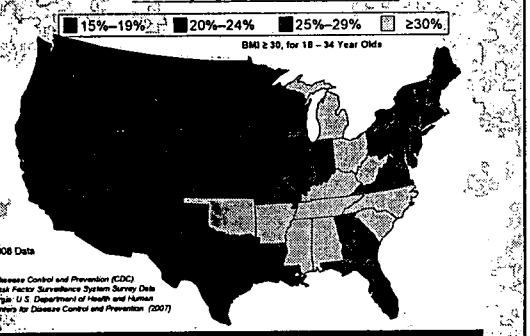
Health Issues

- Overweight/Obesity
  - As of 2002 47.4% of adults age 18-34 had a BMI of 25% or more
  - CDC projections indicate the 47.4% rate will likely increase to 53.6% by 2008
- Physical Fitness
  - 2001, 31.8% of 18-44 year olds report being physically inactive during their leisure time
  - 2005, 51.8% of 18-44 year olds report being physically inactive during their leisure time
- Medication Use
  - 2002, prescription medication usage at 27.1% for age 18-44; up from 21.5% in early 90's
  - 2003, 18.9% of high school students had been diagnosed with asthma; up over 2% from 02'
  - 2006, 16% of youths age 12-17 have a health condition requiring routine prescription meds

Source: Center for Disease Control (CDC)

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Obesity Trend Continues: 2008



TRENDS

- The proportion of obese Americans continues to increase.
- RAND estimates that by 2015, available population (for military service) could decline significantly.

Emerging FIT-C Strategy

Establish a metabolic weight loss and formal fitness program

a. TRADOC Surgeon has lead to establish concept

b. USAREC to establish minimum AFQT & educational requirements to obtain appropriate Return on Investment (ROI)

c. Expanded Market = overweight Soldiers with no additional waivers & high AFQT/GT scores or college diplomas?

d. Time required in class expected to be 4 weeks

e. Endstate may be successful completion of ARMS test

An Emerging FIT-C Strategy

Success Story -- 20/20 Lifestyles

- An established program in use by Microsoft Executives
- Medically Supervised metabolic weight loss and formal fitness program
- Only about 1% of people who lose weight can keep it off after 33 years
- Proposed FIT-C strategy currently has 48% success rate after 3 years – experts suggest that rate will climb to 60%(+) based upon our population

Background

20/20 Lifestyles – Microsoft Testimony

- Employees eligible IF body mass index of 30 or above
- Microsoft covers 80% of the cost of the program
- Microsoft Results:
  - 192% return on investment within 5 years
  - 800 participants lost a total of 26,000 pounds in one year
  - Average weight loss that year was 30 pounds per person
  - High cholesterol fell by 50%; high blood pressure by 30%
  - Significantly lower heath care costs

Obesity Treatment Programs

Programs in the World verses 20/20 Lifestyles

	20/20 Lifestyles	Other Programs
Initial Week	4-6 lbs	1-2 lbs
Weekly Weight Loss	2 lbs	<1 lbs
Weight Loss Maintained for 3 Years	48%	5-8%

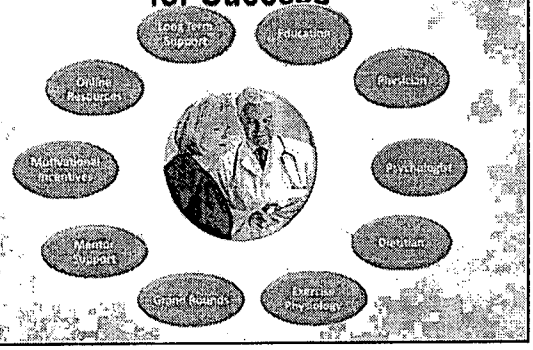
Of all the people who lose weight only 1-2% keep their weight off.

The Right Program

Treating obesity often corrects:

- Headaches
- Allergies
- GERD
- Stomach Ulcers
- Fatty Liver
- Sleep Disorder
- Stress Incontinence
- Osteoarthritis
- Gout
- Restless Leg Syndrome
- Pulmonary Hypertension
- Certain types of Diabetes

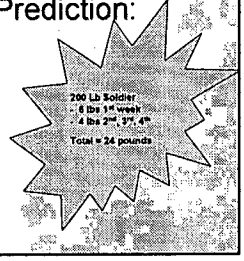
Integrated Care Model for Success



U.S. ARMY Weight Loss Program

Weekly Weight Loss Prediction:

- Initial: 2-3% body weight
- Weekly: 1-2% body weight



Proposed 4 week program

1. Initial information on the diet and how to get started will be given to the total group (50 or 60 recruits) on day number one. Review and discuss a video we have called, "Getting Started."
2. After the initial info is reviewed the dietitians will meet with workshops consisting on 10-12 people for one hour to teach and discuss the nutrition plan for advancement. These will be the same groups/workshops of 10-12 people who will spend one hour with the psychologist in workshop.
3. There will be individuals who will need one-on-one time with the dietitian and/or psychologist. This could be done in the evenings (after the evening meal) or several other times during the day. We believe this will be minimal but our desire is for 100% long term success.
4. Psychologists and dietitian sessions can flip flop. We would like to see each group three times per week. This will give them the education normally passed on in the 12 week program.
5. Psychologists and dietitians would still have one hour lectures during the day to the full group.
6. Dietitians (if possible) would like to be available in the mess hall when the recruits are eating.

For a program that is starting 50-60 people every week we will need to work with five dietitians and five psychologists.

Suggested Next Steps

20/20 Lifestyles Fully Funded Beta Study:

1) Personnel for Beta
   - 12 Men
   - 12 Women
2) Interview 40-50 people to find 24 for program
   - Your staff
   - Physician
   - Psychologist
   - Dietitian
   - Exercise Physiologist
3) We will also need:
   - Medical history (online)
   - Physical exam for their M.D.
   - Lab work (done by 20/20)
   - Sleep evaluation (done by 20/20)
4) Final selection will be done by the people who do the interviews

ARMY STRONG

Presentation to the North Carolina Task Force on Childhood Obesity

Questions?

STATE OF NORTH CAROLINA
NORTH CAROLINA
GENERAL ASSEMBLY
STATE LEGISLATIVE
BUILDING
RALEIGH, NORTH CAROLINA
27601

February 15, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R Purcell
Chairman, Representative Douglas Y Yongue

SUBJECT: **Meeting Notice for Tuesday, February 23, 2010**

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY: **Tuesday** **TIME:** **10:00 am – 3:00 pm**

DATE: **February 23, 2010**

LOCATION: **Room 643, Legislative Office Building**

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend.

Posted:

cc: Committee X
Record ____
Interested Parties X

2010

LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY

MINUTES

MINUTES

JOINT LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY
Tuesday, February 23, 2010, 10:00 a.m.
Room 643 Legislative Office Building

The Joint Legislative Task Force on Childhood Obesity met Tuesday, February 23, 2010 at 10 A. M. in Room 643 of the Legislative Office Building. Co-Chair Senator William Purcell presided. Co-Chair Representative Doug Yongue welcomed Representative Verla Insko who has been appointed recently to the Task Force, by House Speaker Joe Hackney.***(SEE ATTACHMENTS: Members and Guests Attending.)***

The meeting was devoted to the Food and Beverage Industry relationship with the issue of childhood obesity.

PRESENTATIONS

The Vice President for Governmental Affairs for the Campbell Soup Company, Kelly Johnston was the first presenter with information on the Children's Food and Beverage Advertising Initiative. This program is aimed at voluntary shifting the advertising of products that are for the 12 and under market. There are 16 food manufacturers who have joined and are advertising products that have fewer calories, fats, sodium and sugars to the children in this market. ***(SEE ATTACHMENT: CFABI Progress and Developments.)*** Co-Chair Senator Purcell noted that the Campbell Soup Plan in Maxton produces 7 million cans of soup per day and is considered on of the most efficient plants in the Campbell Soup Company system. That plant has been operating for 25 years.

In his introductions Mr. Johnson said the company produces over a hundred products with reduced sodium levels.He noted that a New Jersey wellness initiative "Shape New Jersey" is modeled after the North Carolina " Eat Smart, Move More" program.

The CFABI began in 2007 with eleven companies who made firm commitments with the Better Business Bureau about food advertising for children. While there has been a steady, slight decline in food advertising to children that is not the aim of the Initiative. The goal is to shift the advertising to more nutrient dense products. The CFABI is recognized as one of a number of tools To assist parents and schools considered in the attacking the issue of obesity.

The advertising uses science-based nutrition standards concerning the products tht are feature to promote. The standards are developed by organizations such as the Alliance for a Healthier Generation, the FDA and all tolled a total of 5 different standards. Kellogg's for instance made an agreement with the Center for Science in the Public Interest regarding sugars etc.

The standards usually run along the lines of 35% or less fat, 10% or less saturated fat, and 35% less total sugars by weight.

More than 100 products from the sixteen member companies have been re-formulated or created to meet the nutrition standards for child-directed advertising. Thirty products which already met or were changed to meet the standards underwent further modification. While there can be estimates of millions of dollars spent to re-formulated products, most of the proof would be proprietary data and so only ball park guesses can be made. Mr. Johnston's information was that as little as $100,000 or as much as $1,000,000 could be spent for each product or flavor of a product.

Mr. Johnston's information showed the different changes in product ingredients and advertising the companies had made. For instance, Burger King introduced a product called apple fries and reduced the salt in the company's chicken tenders. The McDonald kids meal of 1979 contained 630 calories. That was changed to 395 calories in 2009.

He told the Task Force about the New Jersey effort to reduce obesity " Shaping NJ" As mentioned earlier, this is modeled after the North Carolina "Eat Smart, Move More" The Centers for Disease Control has awarded New Jersey $4.1 million for 2008-2013. The focus is on policy and environmental changes. The behaviors that are targeted:

1. Increase breasfeedig
2. Increase physical actitivty
3. Increase vegetable/fruit consumption
4. Decrease consumption of sugar sweetened beverages
5. Reduce consumption of high energy dense foods
6. Decrease television viewing

The formal New Jersey state plan is due in June 2010.

Representative Weiss noted that companies working collectively to reduce calories or salt can work better than working alone. She asked if there was a way to forecast when people would move from "healthier" to "healthy'. Mr. Johnston said there is no replacement for salt. He said there was market resistance to products with less sodium; consumers believe the product will not taste as good. He said sea salt is a more expensive alternative.

Representative Grady asked if there is a relationship between Campbell Soup Company and school meals. Mr. Johnston said Campbell was not a major player in the school lunch business. He said there was a problem with the wide range of nutrition standards across the country. He hopes that Congress will develop a single nutrition standard across the country. He said that some healthier foods do cost more, for instance the sea-salt alternative that Campbell developed costs about three times as much as table salt. He said he could provide more information about Campbell Soup's school actitivty in North Carolina.

Co-Chair Representative Yongue asked if companies were producing healthier foods across the board, or limiting the efforts to certain segments. Mr. Johnston said some companies were still producing high-caloric products, but not advertising those items to kids.

Representative Insko asked if the companies could look at cane sugar as opposed to high fructose corn syrup; cane sugar is more expensive. She favors federal subsidies for cane sugar production. She also suggested that the presentation reflect caloric

properties, too. Mr. Johnston said that he would take that information back to the Company. He also said that his industry was working on a "front of package" ingredient label in conjunction with the Grocer Manufacturing Association and the Food and Drug Administration. He said there could be a proposal put forth in the next 4-6 weeks.

Co-Chair Senator Purcell introduced Butch Gunnells, President of the North Carolina Beverage Association and thanked him for earlier work concerning controls on products sold in vending machines in North Carolina schools. ***(SEE ATTACHMENT: Presentation to Childhood Task Force.)*** Mr. Gunnells said his presentation could take three points:

1. Changing beverage mix
2. Calorie content
3. Advertising to children

The Association is comprised of 17 bottling companies, including all the Coca-Cola and Pepsi-Cola bottlers and five impendent companies. Approximately 3 1/2 years ago, the beverage industry began a voluntary effort which would change the products available in schools. By the agreement, several companies agreed to stop selling full-calorie soft drinks in schools.

Prior to this, then Lt. Governor Beverly Purdue had created a Health and Wellness Trust Fund Study Committee on Childhood Obesity. Senator Purcell and Representative Insko were Chairs of that Study. In 2005 that study produced the law for statewide standards for school vending. The N. C. Beverage Association took the unprecedented stand in favor of the bill and lobbied for its passage. Nationally, the American Beverage Association companies joined in 2006 with the Alliance for a Healthier Generation to create school beverage guidelines that limit beverage calories and increase nutritious beverages in schools.

The presentation includes the guidelines for elementary, middle and high school operations. Between 2004 and the 2007-08 school years there was a 58% cut in total calories contained in beverages shipped to schools. And there was a 65% reduction in full-calorie beverages shipped to schools. As of the second year, 79% of all agreements between bottlers and schools are on track. The three-year audit is expected in March.

Co-Chair Yongue asked how effective the carry-over message from school to home might be concerning a continuing adherence to more nutritious drinks. Mr. Gunnells said he did not have such information.

Representative Weiss asked if there is an expectation of 100% adherence to the guidelines. Mr. Gunnells said he believed the final audit would show about 90% plus, but those figures are not available, but he did believe that North Carolina's adherence rate would be 100%.

Co-Char Senator Purcell asked about a need to raise the bottle drink tax to raise revenue to combat obesity. Mr. Gunnells said he didn't expect the Task Force to be shocked at his response. The position in opposition to such a tax, he said was based on the position that the industry is acting responsibly and the beverage industry believes such a tax would be discriminatory. He pointed out that there are a number of causes other than soft drinks for the problem of obesity. He said such a tax would "wipe out" the smaller companies in North Carolina. He noted that there is already a sales tax on soft drinks.

Representative Weiss asked what actions are being taken to reduce the sugar in sugar-sweetened soft drinks. .Mr. Gunnells said he did not have any scientific knowledge as to how much work is being done. He did say there are a lot of formulations and re-formulations being done. In a realistic position, he said that at the end of the day there still would be sugar sweetened soft drinks.

Suzanne Hobbs, Clinical Associate Professor and Director of the Doctoral Program in Program Leadership at UNC-Chapel Hill, spoke from the perspective of a consumer advocate. ***(SEE ATTCHMENT: North Carolina Task Force on Childhood Obesity.)*** A registered dietician, Ms. Hobbs also writes a column for the News and Observer in Raleigh. She said it is easier to overeat in North Carolina than it is to eat well.

She said focusing attention on schools does not add a new responsibility to schools since students get 30% to 50% of their daily calories at school. The USDA has received recommendations from the Institute of Medicine to make nutritional improvements in school meals:

1. More fruits and vegetables
2. Half the grains whole grain
3. Milk-either low or no fat
4. Only trans fat-free products
5. Limit sodium to 740 mg,
6. Maximum calorie targets

Ms. Hobbs said that since it might take the USDA several years to impose the standards that North Carolina should move now. She said the General Assembly should go ahead with the IOM recommendations. And she noted that the North Carolina IOM has published two reports concerning health prevention measures and the action plan. Ms. Hobbs said that the Center for Science in the Public Interest rated North Carolina schools at a "D" for nutritional standards in school meals. While the state has good elementary school guidelines, the middle school and high school guidelines are poor.

She said that wellness policies need to address better community engagement, implementation of school policies concerning vending and the like, and physical education segments.

She noted that school fundraisers which rely on such things as doughnuts and candy bars sends a wrong message concerning the support for nutrition policies. She advocates a state law that bans the marketing of non-nutritional food in schools.

Ms. Hobbs' data said that eating out is linked to obesity. There is very little nutrition information at the point of sale regarding calories or fats. American families ate out twice as much in 1995 than in 1978. Both fast food and dine-in restaurants are associated with higher caloric intake. She advocates menu labeling and says the National Restaurant Association is beginning to support such moves.

She saidt virtually all foods marketed to kids are unhealthy, although there is a slight change. According to her data food advertising aimed at kids totals $2 billion per year.

At least 25 states levy a tax on soft drinks with most of the money going to the general fund. She said that 1 cent per 12 ounces would produce $1.5 billion per year-nationally. In North Carolina a 2 cent tax would raise $91 million per year. Larger taxes may reduce intake.

Senator Tillman raised the point that an increased tax on soft drinks could raise revenue, but he questioned the gain if the levy resulted in lost jobs. Ms. Hobbs acknowledged such could be the case, but that the idea should be put forward for detailed discussion. Co-Chair Representative Yongue said that soft drinks were not the major part of the problem of childhood obesity. He said that other aspects needed to be addressed and he hoped that soft drinks would not be singled out. Ms. Hobbs agreed that childhood obesity was a complex problem with no single answer.

Representative Insko agreed there were many avenues to be explored. She said North Carolina should consider menu labeling, and said she would not have any trouble with a tax on high fructose beverages or like products.

Representative Brown noted the data showed Kentucky and Oregon achieved high grades for the efforts to combat childhood obesity and asked what those states might be doing. Ms Hobbs said she did not know the details, but that those states did not seem to have the financial difficulty North Carolina was facing in implementing anti-obesity initiatives.

Representative Weiss asked if counties could enact local ordnances to require menu labeling. Lee Dixon of the Fiscal Research said he didn't know what would prevent such ordnances, but that he would get a more definitive answer. The Representative also asked about the possibility of such labeling in state operated cafeterias. Senator Dannelly pointed out that in order for Dare County to enact an ordnance to ban the use of plastic bags; the State had to sign off on such an idea.

Hank Cardello, Chair of the Global Obesity Business Forum at UNC-Chapel Hill presented what he termed a series of practical solutions to combat childhood obesity. ***(SEE ATTACHMENT: Task Force on Childhood Obesity.)***

Mr. Cardello has experience with Coca Cola, General Mills, Anheuser-Busch and Sunkist bottling. He arranged his messge around three things that are derailing the effort to reach a solution to the problem of obesity.

1. The industry side
2. Health Advocates
3. Consumers

He said view points were polarized on the three sides and industry feels as if there is a target on its back. Consumers feel as though they are the victims and the health care community is in place to save the day.

The industry is striving to maintain market share and profitability. The motivation for the health advocates is just that: public health. The consumers are pictured as people who want to eat healthy foods. Mr. Cardello said the reality is that consumers want "taste".

The food and beverage industry tends to take a short term view to reach quarterly earnings etc. He said often times the health advocates tended to be a hard core group

which may exhibit 'purism'—every food must be the perfect food. The motivations are different and the personalities of each group are different.

For some change can be a problem and considered as a negative. In some instances change is viewed as pain. Mr. Cardello said this was especially true in the restaurant business. And the view is for the short term as mentioned earlier. The consumer is not regimented, doesn't make good choices and generally doesn't "get it".

Advocates tend to vilify other segments as the perpetrator. And profit margins are attacked. The nature of the proposals from the health advocates have tended to be punitive, to force change, a view of individual silos as pressure points, rather than on a holistic approach. One side is not fully appreciating the position of the other side.

Mr. Cardello says the consumers have a tough time with diets etc., anything to do with regimentation. Consumers may feel that industry needs to be more responsible in various areas: health, environment etc.

There are three types of consumers, thus a one-size-fits-all approach doesn't work.

1. The disciplined-can follow the rules-maybe ¼ of population
2. Situational—a little bit of discipline
3. Adaptables—life is open ended

He says that putting forth a purely disciplined approach to combat obesity will affect only that 25% of the population who have not problem with following rules. That approach doesn't apply all across the board. It becomes necessary to devise methods that would apply to the school setting and cross over to the school setting, too. Important to all of this, Mr. Cardello says, is the need to engage the food industry in an active way toward addressing the problem. He believes the industry is not fully involved and often is vilified about its practices.

He considers two issues: how to make people healthier, choose a lifestyle change and improve health conditions is a generational program. The second issue how to deal with the problem of childhood obesity can be considered a short term program.

Some industry initiatives that are going on include portion control packaging. The 100 calorie packs are selling and the manufacturers make more profit on these. As to charges that the profits margins were too great, Mr. Cardello said, "If the consumers feel the price is too high, they won't buy it." The industry is taking a pro-active position with the reduced calorie snacks and with restaurant products including branded drinks such as Coca Cola with a flavor ingredient. This creates a new drink with ½ the calories of an equivalent beverage with vitamin C and/or calcium. Again there is a premium price which equals higher profits.

In the past General Mills tried to lower the grams of sugar in some of its pre-sweetened cereals and the consumers wouldn't buy them. Now they are trying again to reduce the sugar in 10 of the company's cereals aiming for single digit grams of sugar per serving.

In a middle school in Minneapolis, the vending machine program was changed by increasing the total number of machines to 13. There were 3 price levels: bottled water, juices or sports drink and soft drinks. The soft drinks were the highest price items. Soft drink sales and calories went down, but profits went up by $4 thousand dollars.

In the area of Public Sector Initiatives, Mr. Cardello noted the efforts of First Lady Michelle Obama and the elements of her program:

1. Increase the # of USDA-accredited healthy schools
2. More physical activity
3. Better availability of healthy foods in low-income areas.

He said some school food service suppliers have agreed to cut fat and salt and increase the amount of whole grains and fruit. At the same he said the program does not address after school behavior and environment. He believes that there is a need for a supply-side calorie reduction component. The cost of the plan is $10 billion over 10- years.

The national legislation for menu labeling has received the support of the American Restaurant Association in part because of the possibility of a multitude of local and state laws seeking to accomplish the same purpose. While the application is for chains with 20 or more locations, there is little apparent impact on fast food restaurants.

In California trans fats were banned as of January 1, 2010 and calorie menus begin in 2011. The state is considering a soft drink tax. In Los Angeles there is a moratorium on new fast food stores in some districts. Vending machines in county buildings will be re-configured as to products available as contracts come for renewal.

Senator Dennis Kucinich proposes doing away with all advertising deductions for products supporting ads aimed at children for fast food, or foods of "poor nutritious quality". While this would produce revenue for the government, the food and advertising industry will resist.

Proposed soda taxes would reduce sugar beverage consumption and raise revenue. The beverage industry is resistant and there is some evidence that the tax would do much to reduce obesity.

Mr. Cardello proposes to bridge the gap with a plan:

1. Recognize that corporations must make profits
2. Corporations need to be part of the solution
3. Bottom-up consumer efforts need joint support
4. Move to lower obesity, not punish specific products
5. Keep it simple

To engage the food industry Mr. Cardello seeks a goal of lower the amount of calories available on a mass basis. He would involve the marketing ability of the food industry to help in educating consumers in healthy eating. At the same time, calories must be lowered to keep the tax deductions on advertising expenses. The ads themselves, at least 25% of them, must carry a tag for healthy lifestyle messages. (For instance "East Smart Move More")

In the discussion, Representative Weiss asked if Mr. Cardello's ideas would help childhood obesity. He said both adult and children would be helped but kids are the heaviest consumers. At the end of the day, he said the plan is to reduce calories.

Senator Walters said his county; Robeson reflects high poverty and poor health and asked how to educate the people there on the proposals. Mr. Cardello said the beginning was the school lunch fare. Students are a captive audience and they can be exposed to better foods in that setting. Food suppliers need to commit to foods with lower fat levels, lower calorie levels and the like. The vending machines can be reconfigured to provide lower calorie choices. He also stressed the need for physical activity as part of the

school day. The missing link is after school also needs to be involved. He said perhaps a bottler such as Coke might be willing to test market increases exposure for Coke Zero for example and see what happens.

Representative Insko said the past strategy has been to change the young people and form life-long food patterns. And she said the recognition was that it would take a generation to change. She asked if companies who provide a la carte items could be approached and asked to provide lower calorie foods. Mr. Cardello said yes, but that food service programs tended to be less interested in innovation and that profit margins were tighter. He reiterated the need to focus on calories. Representative Insko said that the focus on calories is a paradigm shift.

Representative England asked for thoughts on tagging local ads and grocery with the healthy messages. Mr. Cardello agreed.

Co-Chair Representative Yongue asked what the cost projections were if nothing was done about obesity. Mr. Cardello said the federal budget cost of obesity related problems was $147 billion. He projected that North Carolina's share would be about 5% of that figure. Co-Chair Yongue said the Task Force was looking for ways to save money.

Representative Grady posed the question, if there was a 10% tax on soft drinks, sugar beverage consumption would be reduced by 8%-10%, then how far along would that match. Mr. Cardello said he did not know exactly. Representative Grady followed by asking why there was so little relation with obesity reduction. Mr. Cardello said part of the reason was there were so many other beverages to use as an alternate.

Representative Hughes agreed with the difficulty in changing life style patterns. She said the grocery industry was doing part of the education with portion management. Mr. Cardello said the grocers could play a great role in the fight against obesity. The grocer controls what you see when you enter. The grocers could make sure that the products you see are of lower caloric values.

Senator Dannelly asked could school meals have lower calories without higher costs. Mr. Cardello said there were two steps: how to lower the calories overall. Often in the school it is what is available. The long term aim to get children inclined to eat properly comes after that at a price that will work in the system. He believes that will come product by product.As a follow-up, Senator Dannelly asked if the pilot project found any school that was able to serve healthier foods at the same or lower cost. Both Co-chair Senator Purcell and Dr. Lynn Harvey said the answer was no. Senator Dannelly said the result was that the State paid less to feed children foods that contribute to obesity and then pay more to treat the problems of obesity further down the road.

Roberta Friedman, Director of Public Policy for the Rudd Center for Food Policy and Obesity presented the Task Force with research done by the Center and others. ***(SEE ATTACHMENTS: Rudd Center, New England Journal of Medicine-Perspective, New England Journal of Medicine-Health Policy Report, Rudd Report, Soft Drink Taxes, American Journal of Public Health: Impact of Food Prices on Consumption.)*** The Rudd Center is based at Yale. She said the work of the Rudd Center was not aimed at academics. The aim is to make healthy choices easy such as:

1. Trans fat bans
2. Fluoride in drinking water

3. Airbags
4. No lead paint, gasoline.

She said today's default position was poor nutrition; the goal was to make good nutrition the default.

The policy recommendations are:

1. Ban all advertising on school campuses
2. Ban all food/beverage ads
3. Ban ads for products not allowed for sale on campus
4. Ban sale of non-nutritional products
5. Exclusive contracts would disallow sales and ads.

Ms. Friedman said she did not know of any other state that was working on these points.

In support for sugar sweetened beverage taxes, the Rudd Center notes that between 1970 and 2000 the per person consumption of sugar sweetened beverages increased by 70%. The Center states that soft drinks are the primary sources for added sugars in American diets. The Center's focus is on ALL sugar sweetened beverages: including tea, juices, vitamin water and power drinks.

The Rudd Center backs a 1-cent per ounce tax levied at the manufacturers for any product with sugar based sweeteners. The tax would reduce consumption and the revenue could be earmarked for obesity prevention.

The Center agrees with other research that suggests school nutrition is not a healthy environment. Furthermore, the Rudd Center has developed a code tool that allows schools to assess the local wellness policies.

The Center recommends for North Carolina calorie menus at drive thru lanes and other nutrition information on premises. Ms. Friedman said that menu labeling should include an anchor statement: "The recommended daily caloric intake for an average adult is 2000 calories." She said other data shows that when there is a menu label available, adults tend to order meals with an average 100 fewer calories for 3-6 year olds.

Representative Grady noted that since North Carolina does not put money into the school lunch program, there is no way to get an increase in federal reimbursements for fruits and vegetables. Ms. Friedman said she did not have much knowledge about the overall operation of the North Carolina school lunch program.

Representative Hughes asked about part of the data which said that children's healthy eating in school was maintained in the after school setting. Ms. Friedman said this was self-reported data taken from interviews with the children and their parents.

Co-Chair Representative Yongue followed a portion of Representative Grady's comment that part of the money the state receives from the federal government is appropriated before a meal is served. He said he hoped something from this Task Force could change that.

Co-Chair Senator Purcell thanked Lee Dixon and staff for arranging the speakers heard by the Task Force and thanked speakers for this meeting as an additional way of thanking all the speakers. He said this was the last meeting scheduled, but that another meeting would be held to consider possible legislative proposals from the Task Force. He asked members to forward to the staff any ideas they might have for consideration.

The meeting adjourned at 3:50 p.m.

Senator Bill Purcell, Co-Chair
Presiding

Katie Stanley

Katie Stanley, Committee Clerk

Representative Doug Yongue Co-Chair

Ted Harrison, Minutes

Task Force on Childhood Obesity
AGENDA

Tuesday, February 23, 2010
10:00 am
Legislative Office Building
Room 643

The Food and Beverage Industry

I. Introduction
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

II. Kelly Johnston, Vice President - Government Affairs, Campbell's Soup Company

III. Butch Gunnells, President, North Carolina Beverage Association

IV. ~~Susan~~ Suzanne Havala Hobbs, Clinical Associate Professor, Director - Doctoral Program in Health Leadership

Lunch Break

V. Hank Cardello, Chair, Global Obesity Business Forum, UNC Chapel Hill

VI. Roberta Friedman, Director of Policy, Rudd Center, Yale University

VII. Discussion

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — February 23, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rob Thompson	Covenant w/ NC's Children
	YAIO
Nick Dean	NCAAHPERD
Nathan Acosta	NCAAHPERD
Jenna Sorrells	NCAAHPERD NC. Alliance for Athletics Health, PE, Recreation & Dance
Rhianna Smith	UNC childrens Hospital
Erica Bartelt	UNC Children's Hospital
S Wilson	CHHS
Parvati Potnis	DHHS
Gene Causby	SFSNC
John Bowdish	Astra Zeneca

VISITOR REGISTRATION SHEET

Child Lead Ctr. — Name of Committee

2-23-10 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maria Hyundai	DHHS

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — February 23, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Farrell	TPG
Andrew Barnow	NCRMA
Amy McConkey	NC BCN Assoc
Butch Gunnells	NC Bev Assoc
Darren Clark	PepsiCo
George Suddath	PBV
Lewis C. Hall	CCHN
Sue Harrison	WCPSS
Suzanne Hobbs	UNC-CH
Robert Friedman	Yale University Rudd Center
Betsy Vetter	American Heart Assn

VISITOR REGISTRATION SHEET

Legislative Task Force on Childhood Obesity — February 23, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marye Freman	NCAE
Ruth Petersen	NC DPH
AE White	NC DPH
Jamie Cousins	NC DPH
Steve Shone	NC Pediatric Society
Jennifer MacDougall	BCBSNC Foundation
Lynn Harvey	NCDPI
Paula Hudson Collins	NCDPI/SBE
Carolyn Dunn	NC Cooperative Extension, NC State Univ.
Sheree Vodicka	NC DPH
Cathy Thomas	NC DPH

HOUSE PAGES

NAME OF COMMITTEE Child Obs't. DATE 2-23-10

1. Name: _____

   County: _____

   Sponsor: _____

2. Name: _____

   County: _____

   Sponsor: _____

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

SGT-AT-ARM

SENATE

1. Name: Frank Parro — Robert Young
2. Name: Bob Rossi — CHARLES HARPER
3. Name: Martha Parrish — CHESTER White
4. Name: _____

The Children's Food and Beverage Advertising Initiative: Progress and Developments

Kelly D. Johnston
Vice President – Government Affairs
Campbell Soup Company

North Carolina Legislative Task Force
On Childhood Obesity
February 23, 2010

CFBAI's 16 Participants



Agenda

- Participants meeting commitments & goals
  - Compliance is virtually 100%
  - Reasonable, recognizable nutritional standards
  - Numerous new & reformulated products
- Participants are responding to feedback
  - Enhancing Core Principles
  - Considering further changes
  - Scheduling additional reviews

CFBAI Goals

- Shift the mix of products advertised primarily to kids under 12 ("child-directed")
  - Fewer calories, and lower in fats, sodium, sugars
  - More nutrient dense
- Be part of the solution: support efforts of parents, schools

Campbell's

Campbell's LEGAL DEPARTMENT 4

CFBAI Compliance Summary for 2008

- High level of compliance
  - No violations on television
- Minor compliance issues promptly corrected
  - One radio, one print violations
  - Two elementary school issues
  - A few technical reporting issues
  - Two problems involving company-owned websites



Campbell's

Campbell's LEGAL DEPARTMENT 5

Child-Directed Sites & Advergames

- ≈ 40 company-owned, child-directed sites during 2008
- CFBAI Core Principles interactive game requirement
  - Games that incorporate a participant's food must include pledge-approved foods or HLM
  - No requirement that a game feature branded foods or HLM
  - Some games feature only generic food such as fruits and vegetables
  - Most interactive elements feature pledge-approved foods
- Some participant websites promote nutrition literacy & healthy eating
- Some promote physical activity (some do both)
  - Activity screen breaks, "Get Active" pledges, how-to instructions on outdoor games, Ad Council messages
  - One uses a "dashboard" that allows parental monitoring of kids' activities on the company's site

Campbell's

Campbell's LEGAL DEPARTMENT 6

The Landscape of Children's Advertising Is Changing

- **Before** (Pre-CFBAI) — Almost anything went regarding what was advertised
  - CARU Guidelines for *how* to advertise, but not *what* to advertise
    - Few companies had nutrition standards for child-directed advertising
    - No third party accountability on what was advertised
- **Now** — Science-based nutrition standards guide participants on what to advertise
  - BBB oversight provides transparency and accountability

Campbell's

Campbell's LEGAL DEPARTMENT 7

Nutrition Standards are Science Based

- Reasonable standards: familiar to nutrition professionals
  - Largely based on Dietary Guidelines for Americans 2005 and/or FDA's definitions
- "35, 10, 35" is common theme
  - ≤ 35% fat (or less), <10% sat fat, ≤35% total sugars by weight
    - Some variations in sugar, e.g., < 25 or 10% added sugars or ≤12 grams sugars (exclusive of naturally occurring sugars from dairy, fruit and vegetables)
  - Most have sodium standards
- Company-developed, science-based standards promote
  - Participation in program
  - Competition among participants
- Some have revised standards to make even more rigorous

Campbell's

Campbell's LEGAL DEPARTMENT 8

CSPI Press Release June 14, 2007

NEWSROOM

Kellogg Make-or Historic Settlement Agreement, Adopting Nutrition Standards For Marketing Foods To Children

- No more than 200 calories
- No more than zero grams of trans fat and no more than 2 grams of saturated fat
- No more than 230 milligrams of sodium (except for Eggo frozen waffles)
- No more than 12 grams of sugar (excluding sugar from fruit, dairy, and vegetables). Kellogg will continue its practice of not advertising to children under 6

"This important agreement represents a rising tide that should lift all boats," said Jacobson

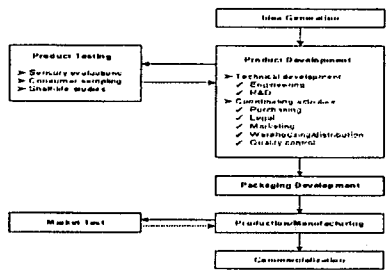
Campbell's

Campbell's LEGAL DEPARTMENT 9

Setting Standards → Change & Improvement

- More than **100** products have been reformulated or created to meet nutrition standards for child-directed advertising
- At least **30** products further enhanced
  - Already met standards or reformulated to meet standards and then further changed

Reformulation Process*



Cost of Reformulating Foods and Cosmetics (Prepared for FDA, 2002) available at http://www.foodsick.umn.edu/exclusives/CKE%20workbook/reformulation_costs_FR.pdf

Many Millions of Dollars Spent on Reformulation

- Proprietary data
- Based on confidential ball park estimates from a handful of companies
  - So, very conservative figure
- Costs vary
  - Depends on ingredient significance
  - Interaction with other ingredients
- Could be ≈ $100,000 or as much as $1,000,000, or more
  - For each product or each flavor of a product

Burger King Corp. Changes

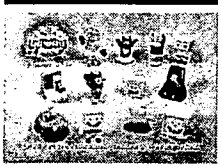
- New Product for Pledge Implementation (July 2008)
  - Apple Fries (fresh apples sliced to look like fries)
    - >29 million servings of BK Fresh Apple Fries sold since July 2008
- Enhanced its nutrition criteria for kids meals (Nov. 2008)
  - Added 600mg sodium limit & requirement that meals provide ≤ good source of at least 2 beneficial nutrients for kids
- New Kids Meals and Combos
  - Mac & Cheese Meal with apple fries & low-fat milk (July 2008)
  - Chicken Tenders with apple fries & fat-free milk (April 2009)
    - Reformulated Chicken Tenders, reducing sodium by about 1/3
  - Burger Shots Meal with apple fries & calcium-fortified apple juice
  - Hamburger Meal with apple fries & calcium-fortified apple juice
- Additional Changes
  - Reduced calories, fat & sodium in Mac & Cheese (Nov. 2008)
  - Replaced low-fat white milk with fat-free milk (April 2009)

Campbell's

LEGAL DEPARTMENT 13

Burger King Corp.
"SpongeBob: The Movie" – November 2004





- Advertised Kids Meal included:
  - Double Cheeseburger
  - French fries
  - Soft drink
  - Premium/toy

Campbell's

LEGAL DEPARTMENT 14

Burger King Corp.
"SpongeBob: Lost in Time" – February 2006





- Advertised Kids Meal included a variety of options
  - Cheeseburger
  - 4 pc. *Chicken Tenders*®
  - Mott's® Strawberry applesauce
  - French fries
  - Low-fat chocolate milk
  - Soft drink

Campbell's

LEGAL DEPARTMENT 15

Burger King Corp.
"SpongeBob vs. The Big One" – April 2009





- Advertised Kids Meals meet strict nutrition criteria: e.g.,
  - BK Burger Shots® 2-pack
  - Minute Maid® Calcium-fortified Apple Juice
  - BK® Fresh Apple Fries with low-fat caramel packet



Campbell's

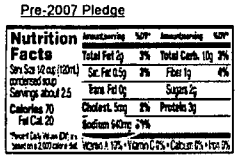
Campbell's Changes

- **25** SKUs reformulated or new products formulated to meet nutrition standards
  - **1** soup reformulated (2x: first to 25% less sodium, then to 480mg)
  - **12** kids soups reformulated to 480mg sodium
    - FDA "healthy" level for individual foods
    - Originally most kids' soups qualified because 25% less sodium than reference product
  - **2** canned pastas (sodium reductions)
  - **8** snack cracker SKUs (fat reductions)
  - **2** new snack cracker flavors

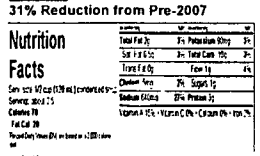
Campbell's

Chicken & Stars Soup 31% to 49% Sodium Reduction

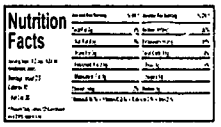
Pre-2007 Pledge



July 2007
31% Reduction from Pre-2007



Current Formulation
49% Reduction from Pre-2007



Campbell's

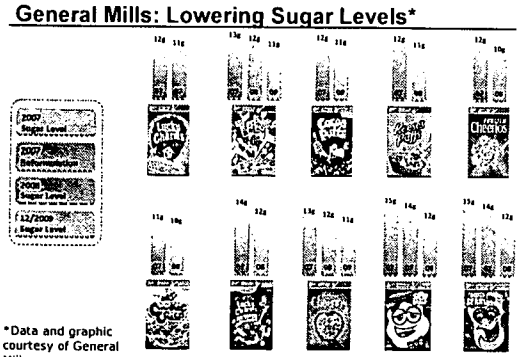
General Mills Changes

- Reformulated 7 products to meet standards
  - Yoplait Trix Yogurt (5 flavors)
  - Chocolate Lucky Charms
  - Trix cereal
- Introduced 7 new products
- Reformulated 4 kids cereals that are not advertised to kids
  - 3 cereals → sugars reduced from 15g to 12g
  - 1 cereal → sugars reduced from 13g to 12g
    - Reduced again 12g →11g
- Further reformulated 15 products that already met standards
  - 8 Yoplait Gogurt SKUs (calories, fat and sat fat reduced)
  - 7 cereals
    - 4 cereals → sugars reduced from 12g to 11g
    - 1 cereal → sugars reduced from 12g to 10g
    - 1 cereal → sugars reduced from 11g to 10g
    - 1 cereal → sodium reduced from 190mg to 160mg

Campbell's

Campbell's LEGAL DEPARTMENT 19

General Mills: Lowering Sugar Levels*



*Data and graphic courtesy of General Mills

Campbell's

Campbell's LEGAL DEPARTMENT 20

Kellogg Company Changes

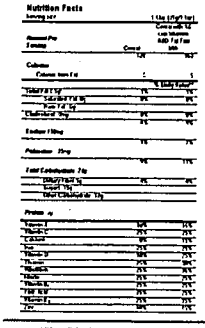
- Reformulated **10** SKUs to meet standard
  - 4 Cereals (e.g., Apple Jacks)
  - 1 Toaster Pastry
  - 5 Yogo Bits Snacks
- Enhanced **3** SKUs that already were reformulated to meet standard
  - Added *fiber* ("nutrient shortfall" for children) at 10% DV or higher

Campbell's

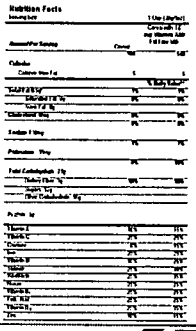
Campbell's LEGAL DEPARTMENT 21

Apple Jacks® Cereal 20% Sugar Reduction

Pre-2007 Pledge



Current Formulation



McDonald's Changes

- Happy Meal Advertising now **always** includes **apple dippers** and **low-fat milk**
  - No child-directed generic brand advertising
- More than **100 million** orders of Apple Dippers purchased in Happy Meals since January 2008.
- **New Meal Combination** introduced May 2008 to meet standards
  - Snack wrap (chicken), with low-fat yogurt parfait (includes > half serving of fruit), and water

Changes in McDonald's Advertising

1979



630 Calories

2009



395 calories

455 calories - Hamburger

Nutritional Snapshot of CFBAI Participant Child-Directed Ads/Products

Total Number of CFBAI Ads



Total Number of CFBAI Products



Number that met study criteria
Number that did not meet study criteria

Study Criteria:
1. At Least a Good Source of a Nutrient Shortfall for Children, or
2. A Food Group to be Encouraged

Other Snapshot Study Findings

- Whole Grain
  - 35% of participant ads were for products or meals that included ≥ 8 grams whole grain
- Yogurt Products
  - 12% of participant ads featured or included yogurt products
- Vegetables
  - 7% of participants ads were for products that included ≥ a half serving of vegetables
- Apples & Milk
  - 28% of participant ads included apples and milk

Nutritional Profile of 37 Cereals on CFBAI List

- There are more cereals with ≤ 10 grams of sugar than there are cereals with 12 grams
  - Almost 2/3 have 11 grams or less
  - Almost half have no more than 35% sugar by weight and others very close to that threshold
  - Cereal accounts for just five percent of the sugar in kids' diets
- All provide essential minerals and vitamins
  - Vast majority are a "good" source (10% DV) of a "nutrient shortfall" for children
  - Vast majority are a good source of Vitamin D
- More than half provide 8 grams whole grains per serving
- Virtually all meet FDA's definition for "healthy" nutrient content (based on RACC)
  - All meet definition per labeled serving

Going Forward

- Listening to feedback
- Revising the "Core Principles"
  - Changes to baseline requirements
  - Media coverage significantly expanded
    - Includes more digital and mobile mediums
  - Effective January 1, 2010
- Discussing other changes
- Planning a nutrition science review

Core Commitment Changes

- Changes to baseline commitments:
  - Increasing commitment level to 100% from 50%
  - Requiring that advertising commitment be met solely through healthier dietary choices or better-for-you products

Scope of Coverage Changes

- More Venues: More Digital/Mobile Media
  - Interactive games in all formats that are provided free or at nominal charge (not just online games)
  - Video & computer games rated "Early Childhood" or "EC"
  - Other video/computer games that are age-graded on the label or packaging as being primarily directed to children under 12
  - DVDs of G rated movies that are primarily child directed
  - Other DVDs whose content is primarily child directed
  - Mobile media (cell phones, PDAs) when advertising is primarily child directed
- Word of mouth advertising that is primarily child directed

Next Steps

- Planning "Nutrition Science Review" (Fall/Winter 2010)
  - CFBAI participant reps and company nutritionists will review
    - SNAC Pac recommendations
    - Dietary Guidelines for Americans 2010
    - FDA (FOP proposal)
    - Other relevant authoritative nutrition science developments
- Considering changes for definition of "child-directed" advertising

Conclusion

- **Progress.** Since launch significant improvement in nutrition profiles
  - **To Date.** More than 130 reformulated, new or enhanced products
  - **Future Changes.** Reformulation and innovation will continue
- **Expanded Market Coverage.** Effective Jan. 1, 2010, child-directed advertising in more venues covered

SHAPINGNJ: The State Partnership for Nutrition, Physical Activity & Obesity Program (NPAO)

SHAPINGNJ

- NJ Department of Health & Senior Services, Office of Nutrition and Fitness
  - Awarded $4.1 million funding from the Centers for Disease Control & Prevention 2008-2013
  - Focus on Policy and Environmental Change (*Making the Healthy Choice the Easy Choice*)
  - Populations at Risk of Health Disparities
  - Address 6 Specific Behaviors/4 settings

The Office of Nutrition and Fitness (ONF)

Target Behaviors

1. Increase breastfeeding - initiation, duration, and exclusivity
2. Increase physical activity
3. Increase consumption of fruits and vegetables
4. Decrease consumption of sugar sweetened beverages
5. Reduce consumption of high energy dense foods
6. Decrease television viewing

The Office of Nutrition and Fitness (ONF)



Four Settings: Provide a role for everyone

Community | Healthcare | School | Work Site



SHAPINGNJ

SHAPINGNJ

- ***Year 1:*** Develop partnerships with organizations throughout NJ
  - 68 signed agreements
- ***Year 2:*** Convene workgroups, review existing data, select strategies
  - write state obesity prevention plan, due June 30, 2010
- ***Year 3:*** Implementation

www.shapingnj.gov

The Office of Nutrition and Fitness (ONF)

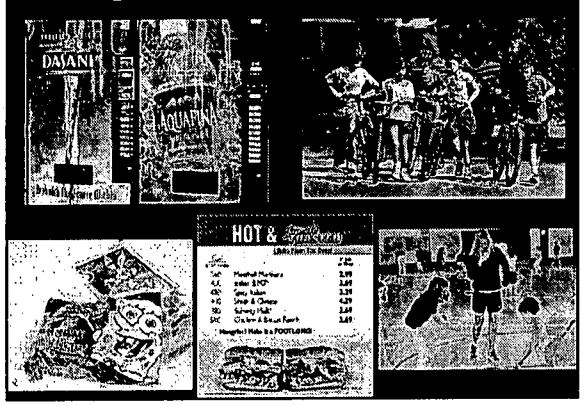
North Carolina Legislative Task Force on Childhood Obesity



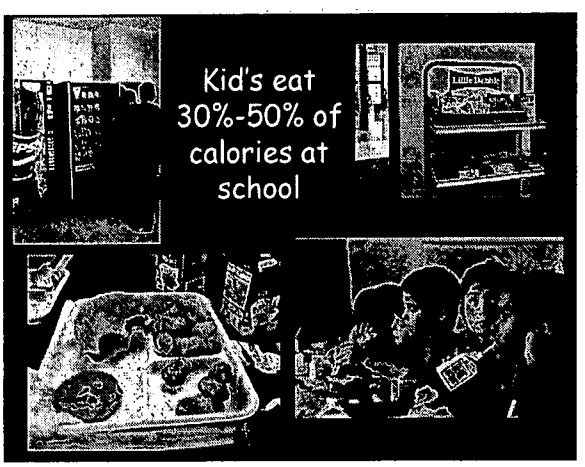
UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

Suzanne Havala Hobbs, DrPH, MS, RD, FADA
Clinical Associate Professor
Director, Doctoral Program in Health Leadership
Department of Health Policy and Management and
Department of Nutrition

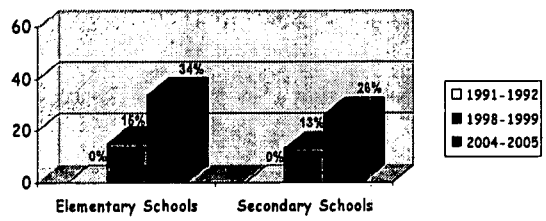
Progress on addressing obesity



Kid's eat 30%-50% of calories at school



Schools Serving Lunches that Meet Saturated Fat Standard



IOM Recommendations for School Meals

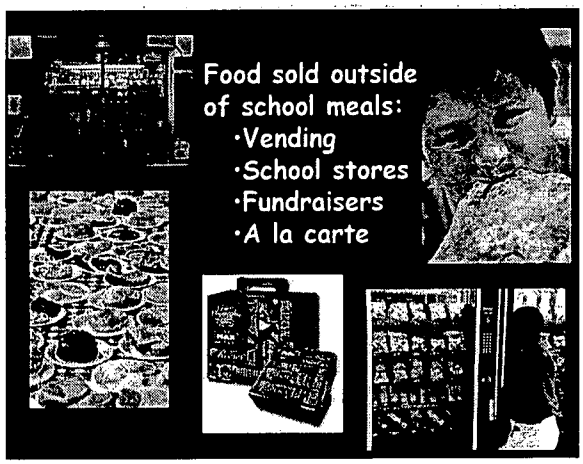
- Increase fruits and vegetables
- Make half grains whole grain
- Milk must be low or no fat
- Use only trans-free products
- Limit sodium to 740 mg
- Set maximum calorie targets

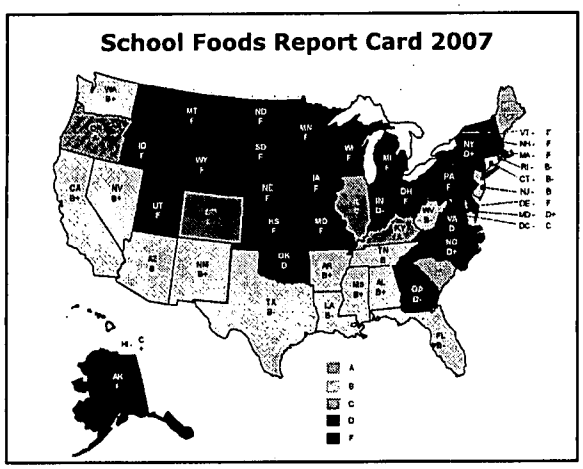
Strengthen Efforts to Improve School Meals

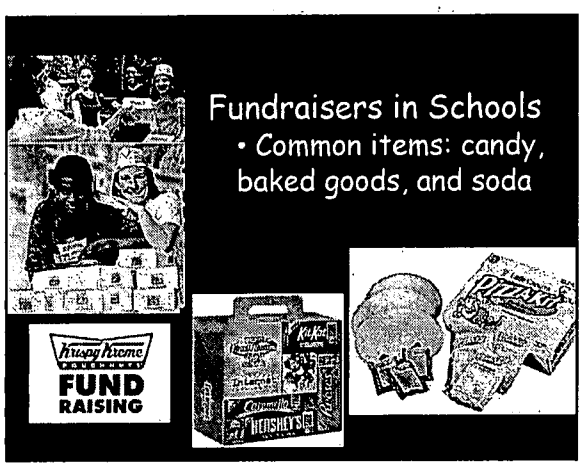
NC Institute of Medicine

- Healthy Foundations for Healthy Youth: Report of the NCIOM Task Force on Adolescent Health
- Prevention for the Health of North Carolina: Prevention Action Plan



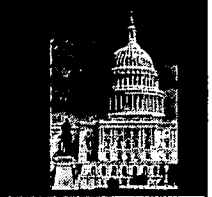

Food sold outside of school meals:
·Vending
·School stores
·Fundraisers
·A la carte


School Foods Report Card 2007


Fundraisers in Schools
• Common items: candy, baked goods, and soda
Krispy Kreme
FUND RAISING
HERSHEY'S

School Wellness Policies

- Requirements
  - Address nutrition education, physical activity, and other wellness activities
  - Set nutrition guidelines for all foods available on each school campus during the school day
  - Involve parents, students, school food personnel, school board, administrators, public





Wellness policies are not reaching their full potential

They fall short on:

- Community engagement
- Implementation and evaluation
  - Nationally, 20-30% of districts have nutrition standards for vending , a la carte, etc.
- Physical education
- Marketing to children

Strengthen Local School Wellness Policies

Act on NC IOM recommendation to expand NC Healthy Schools Partnership to include local healthy schools coordinator in each local education agency

(Recommendation 5.2 Adolescent Health report)

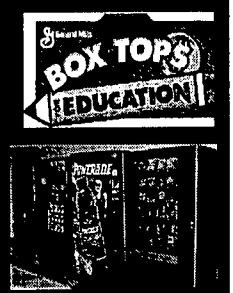




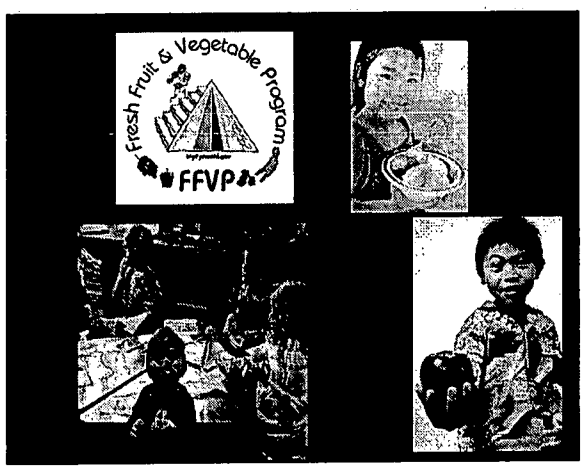
Remove Junk-Food Marketing from Schools

Don't market, sell, or give away low nutrition foods/brands:

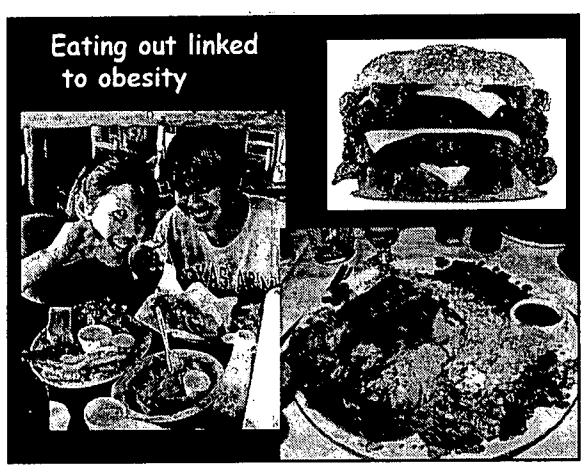
- sales
- school fundraisers
- placing logos, spokes-characters, etc. on vending machines, in books and curricula, and on scoreboards, buses, or other school property
- educational incentive programs
- supplies for labels/proof of purchase programs
- on Channel One
- free samples or coupons



1. Channel One Network®



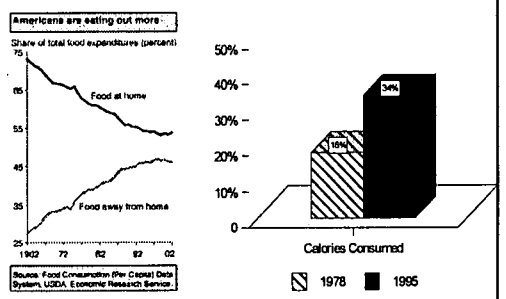
Eating out linked to obesity



Restaurant foods

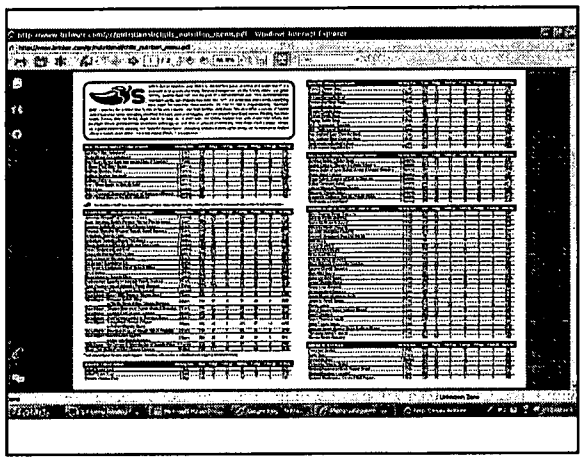
Appetizers	Calories	Sat + Trans Fat (g)
Buffalo Wings (12) w/ Dressing	1,010	22
Stuffed Potato Skins (8)	1,120	40
Cheese Fries (4 c) w/ Dressing	3,010	91
Entrees		
French Toast w/ Syrup & Margarine	910	13
Caesar Salad w/Chicken	1,010	13
Spaghetti with Meatballs	1,160	10
Fresh Chicken and Broccoli Pasta	1,170	55 (total fat)
Chicken and Biscuits	2,500	NA
Meals		
Chicken Ranch Sandwich & Fries	1,580	16
Double Whopper w/ Cheese King Size Value Meal	1,980	42
Fried Seafood Platter	2,170	39
Sweets		
Cinnabon (1)	730	14
Fudge Brownie Sundae	1,130	30
Cheesecake Factory Carrot Cake (1 s)	1,560	23

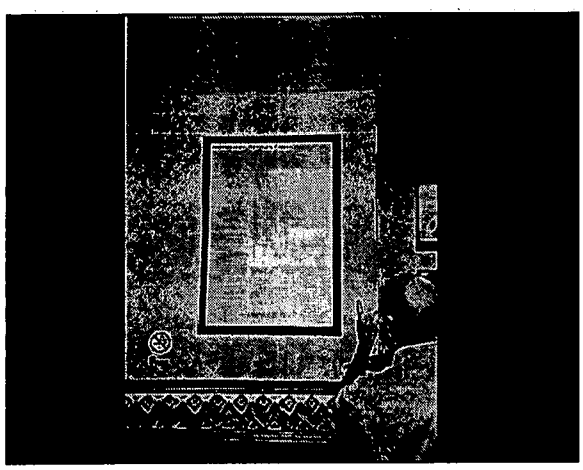
Away-from-Home Food Consumption Has Doubled

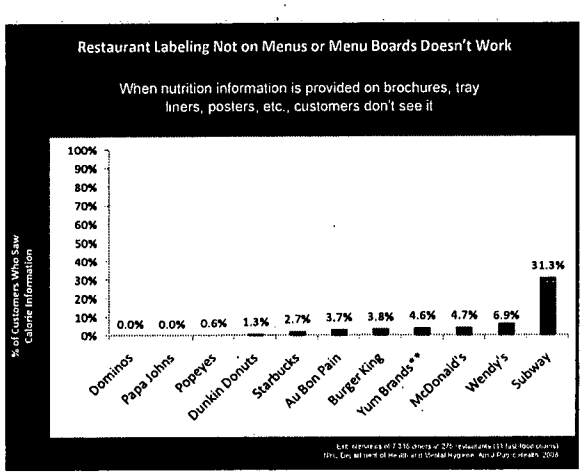


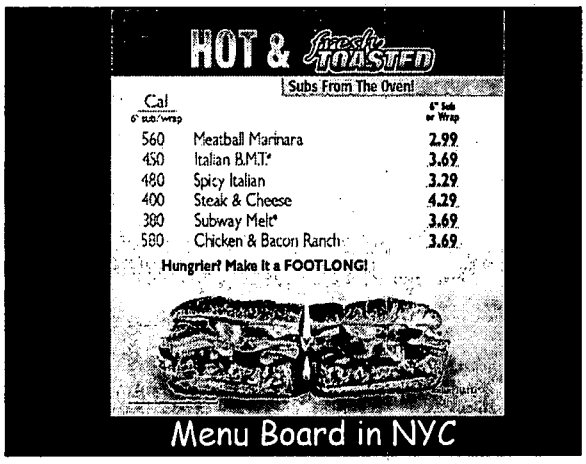
Chain Restaurants Serve Food Associated with Higher Caloric Intake & Obesity

- **Fast food → higher calorie intake**
  - Adults: 205 more calories/day
  - Children: 155 more calories/day
  - At once/week, would lead to 3 pound weight gain/year
- **More fast food → more obesity**
  - Adults: 27-31% increase in overweight
  - Young children: twice as likely to be obese
  - Among adolescents, more days of fast food predicts increases in BMI
- **Sit-down chains are also a problem**
  - Meals selected at Chili's, Denny's and Outback Steakhouse had more calories than McDonald's and Taco Bell

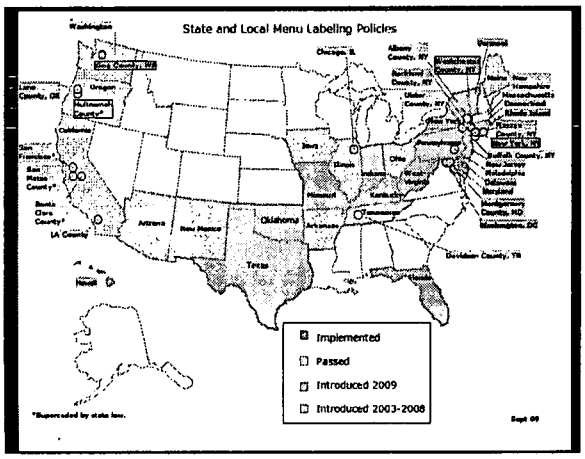





Restaurant Labeling Not on Menus or Menu Boards Doesn't Work
When nutrition information is provided on brochures, tray liners, posters, etc., customers don't see it
% of Customers Who Saw Calorie Information
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0.0%
0.0%
0.6%
1.3%
2.7%
3.7%
3.8%
4.6%
4.7%
6.9%
31.3%
Dominos
Papa Johns
Popeyes
Dunkin Donuts
Starbucks
Au Bon Pain
Burger King
Yum Brands**
McDonald's
Wendy's
Subway

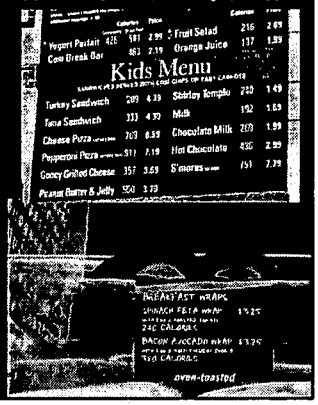


Menu Board in NYC

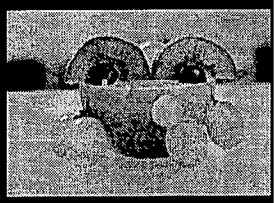


Menu Labeling in Health Reform

- Only chains; ≥20 outlets
- Standard menu items - not custom orders, specials
- Calories on menus, menu boards and food tags
- Other nutrition info on brochures, posters, etc.
- Is feasible; allows for reasonable variation
- Cost is modest compared to other costs of doing business
- National uniformity



Improve menus:



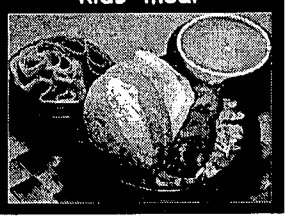
- reformulate existing items
  - calories, saturated fat, trans, sodium
  - leaner meats, lower fat dairy
- add whole grains
- add more fruits and vegetables – with interesting recipes
- add new healthy entrees



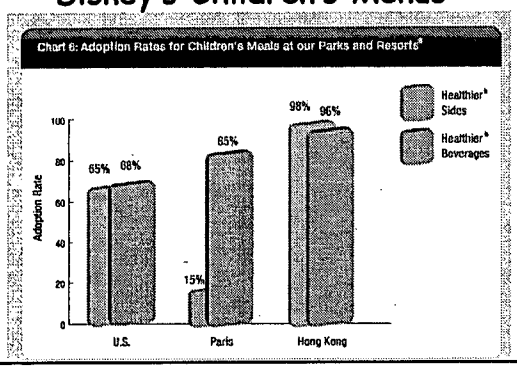
Current default kids' meal



Healthy default kids' meal



Healthy Default Options on Disney's Children's Menus

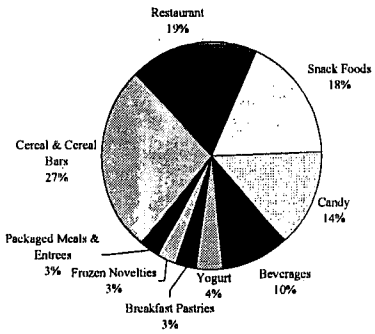


Food Marketing Is Effective

- Studies show marketing gets children's attention & affects food choices, food preferences, purchase requests, diets & health
  - Watching TV linked to obesity
- Kids misled by and don't understand advertising
- Parents know marketing works

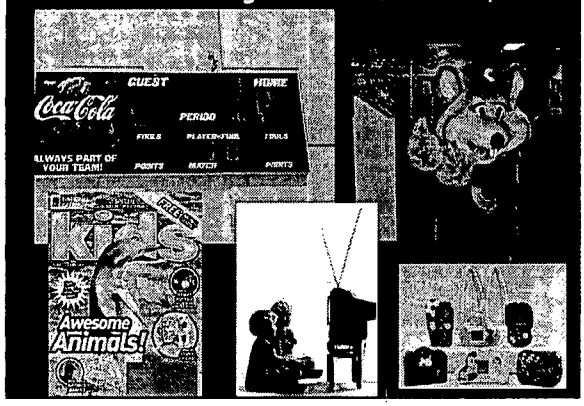


Saturday AM TV Ads



Batada, Seitz, Story & Wootan, JADA, 2008.

Food marketing to kids: $2 billion/year



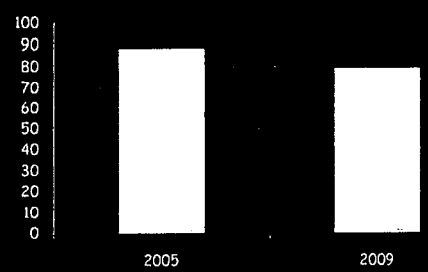
Children's Food and Beverage Advertising Initiative

Current participants include:

- Burger King
- Cadbury Adams
- Campbell Soup Company
- Coca-Cola Company
- ConAgra Foods
- Dannon
- General Mills
- Hershey
- Kellogg
- Kraft Foods
- Mars
- McDonald's USA
- Nestlé USA
- PepsiCo
- Post Foods
- Unilever United States

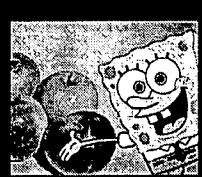
TV Ad on Nickelodeon

for foods of poor nutritional quality



Encourage companies to adopt strong marketing policies

- Prohibit junk food marketing in schools
- Counter advertising
- Host a meeting with governor
- Hold a hearing
- Write to companies
- Pass a resolution
- Use the bully pulpit, press conferences, radio interviews



Soft drink taxes

- Current funding for nutrition and physical activity is inadequate
- 25 states and Chicago have soft drink taxes
  - Some state soda taxes are earmarked
- 1¢/12 oz. soft drink = $1.5 billion per year nationally
  - NC: 2 cent tax could raise $91 M/yr
- Taxes to reduce intake
  - 10% tax = 8% decreased intake
  - NC: 10% tax = $185 M/yr





NORTH CAROLINA
BEVERAGE
ASSOCIATION

Presentation to Childhood Obesity Task Force

February 23, 2010

North Carolina Beverage Association

- The North Carolina Beverage Association is comprised of 17 companies that produce and distribute a wide range of non-alcoholic beverages.

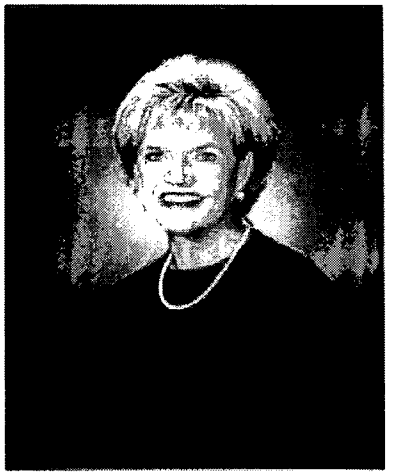
- Members include all of the Cola-Cola and Pepsi-Cola bottlers, and five independent bottlers.

NORTH CAROLINA BEVERAGE ASSOCIATION

NC Beverage Industry Led the Way

- 2003: North Carolina Health and Wellness Trust Fund Study Committee on Childhood Obesity
  - Formed by Lt. Gov. Bev Perdue

NORTH CAROLINA Health Wellness TRUST FUND



- 2005: Committee recommends legislation to establish a statewide standard for vended beverages and snack foods sold in public schools.

Statewide Standard for School Vending

- Senate Bill 961 / Session Law 2005-253.
  - Sen. Purcell and Rep. Insko were primary sponsors.

- The NC Beverage Association supported proposal and joined in efforts to pass the bill.



National Voluntary Commitment Emerges

- Following NC's lead, in May of 2006...

  the American Beverage Association and its member companies teamed up with the Alliance for a Healthier Generation to develop new School Beverage Guidelines that limit calories and increase nutritious beverages in schools.

NORTH CAROLINA BEVERAGE ASSOCIATION

School Beverage Guidelines

Summary



- Reduce the number of calories children consume through beverages
- Provide a broader range of lower-calorie and smaller portion beverage choices
- Remove full calorie soft drinks from all schools

School Beverage Guidelines: Specifics

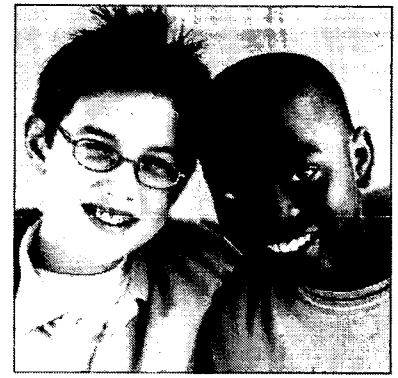
Elementary School

- Bottled water
- Up to 8 ounce servings of milk and 100% juice
- Low fat and non fat regular and flavored milk and nutritionally equivalent (per USDA) milk alternatives with up to 150 calories per 8oz.
- 100% juice with no added sweeteners, up to 120 calories per 8oz., and with at least 10% DV of 3 or more vitamins and minerals



School Beverage Guidelines: Specifics

Middle School



- Same as elementary school except juice and milk can be sold in 10 oz. servings

- As a practical matter, if middle school and high school students have shared access to areas on a common campus or in common buildings, then the school community has the right to adopt the higher standards.

School Beverage Guidelines: Specifics

High School

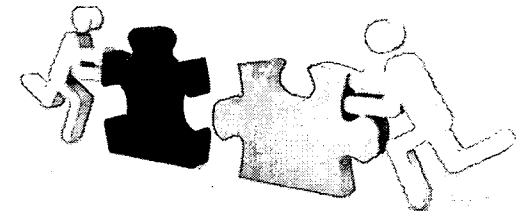
- Bottled water
- No or low calorie beverages with up to 10 calories/8 oz. (e.g., diet soft drinks, teas, fitness waters, sports drinks)
- Up to 12 oz. servings of milk, light juice, 100% juice
- Low fat and no fat regular and flavored milk and nutritionally equivalent (per USDA) milk alternatives with up to 150 calories/8 oz.
- 100% juice with no added sweeteners, up to 120 calories/8oz., and at least 10% DV of 3 or more vitamins and minerals
- Other drinks with no more than 66 calories/8 oz.

School Beverage Guidelines

www.schoolbeverages.com

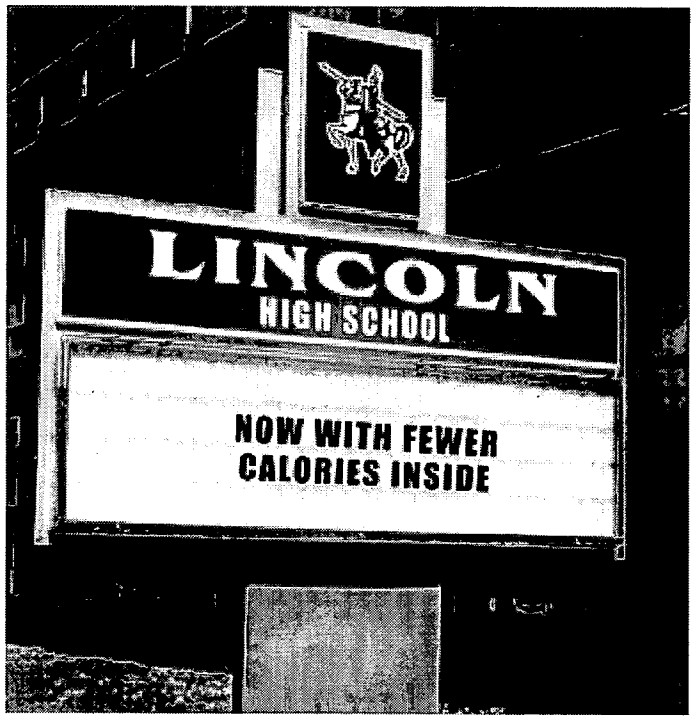
- At least 50% of beverages must be water and no- or low-calorie options
- Apply to beverages sold on school grounds during the regular and extended school day.
- Do not apply to school-related events where parents and other adults are part of an audience or are selling beverages as boosters before or after an event or during intermission (e.g., school plays, band concerts)

Making it Happen



- Beverage companies have spent hundred of hours training their marketing and sales teams
- These teams have reached out to educate school partners.
- Our companies are reformulating products, creating new package sizes to meet the smaller portion requirements, and retrofitting vending machines to accommodate changes in package sizes.

Key Points from School Beverage Guidelines Second Year Progress Report



- ✓ ***Calories are coming out of schools.*** There was a <u>58% cut</u> in total calories contained in all beverages shipped to schools between 2004 and the 2007-8 school year.

- ✓ ***The school beverage landscape is changing.*** There was a <u>65% reduction</u> in shipments of full-calorie soft drinks to schools.

Key Points from School Beverage Guidelines Second Year Progress Report, cont.

- ✓ ***School agreements are on track.*** In the second year, 79% of all agreements between bottlers and school districts have achieved compliance with the guidelines, on track for the 3-year implementation plan.

- ✓ ***Stay Tuned.*** Final audited results should be announced next week.



Let's Move! Campaign Involvement

ABA's Clear on Calories Initiative



Clear on Calories Initiative

Implementation begins this year with completion in 2012

- **Product labels:** Total calorie counts will be displayed on the front of labels for the entire container, up to and including 20-ounce products. A 12-ounce serving size will be used in displaying calories for multi-serve beverage packages (such as 2-liter bottles).
- **Vending Machines:** Total calorie counts for the entire container will be displayed on the beverage selection buttons of vending machines controlled by the companies.
- **Fountain Machines:** Calorie counts will be shown prominently on fountain beverage machines controlled by the companies. be shown prominently on fountain beverage machines controlled by the companies.

Responsible Marketing

International Council of Beverages Associations 2008 Agreement

- Beverage companies voluntarily agree to eliminate the advertising and marketing of a wide range of beverages, including carbonated soft drinks, to any audience that is comprised predominantly of children under 12.
- The policy applies to TV, radio, print, Internet, phone messaging and cinema (including product placement).

Responsible Marketing

Third Party Audit Released in Nov. 2009

- Performed by Accenture
- Extremely high compliance rates
- Report Available online at the following link: http://www.icba-net.org/documents/ICBAComplianceReportonMarketingtoChildren.pdf

Thank you!

Butch Gunnells

President

NC Beverage Association

919-828-2737

butch@ncbev.org

NORTH CAROLINA BEVERAGE ASSOCIATION

General Assembly of North Carolina

Taskforce on Childhood Obesity

Hank Cardello
February 23, 2010

General Assembly of North Carolina

Outline

I. The forces derailing a solution to obesity
   - Industry
   - Health advocates
   - Consumers

II. Overview of select initiatives
   - Industry
   - Public Sector

III. Bridging the Gap: Calorie Reduction Incentive Plan

What's Not Working?

Polarized Viewpoints Hindering Progress



versus



Obesity Playing Field
Perceived Roles







- Food & Beverage Cos.
- Restaurants





"Victims"

- Consumers

Obesity Playing Field
Perceived Roles







- Food & Beverage Cos.
- Restaurants

"Defenders"





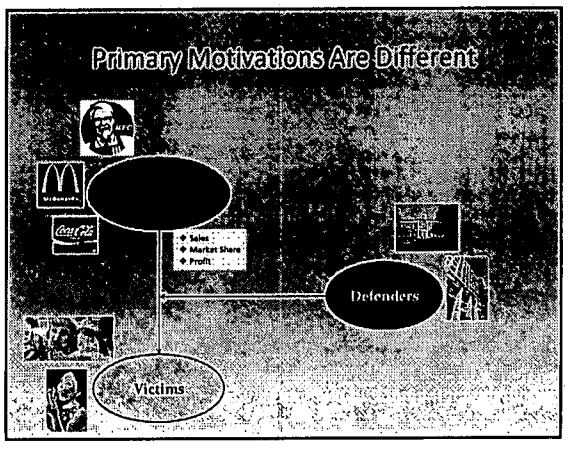
- Government
- Advocates
- Researchers
- Health Care community

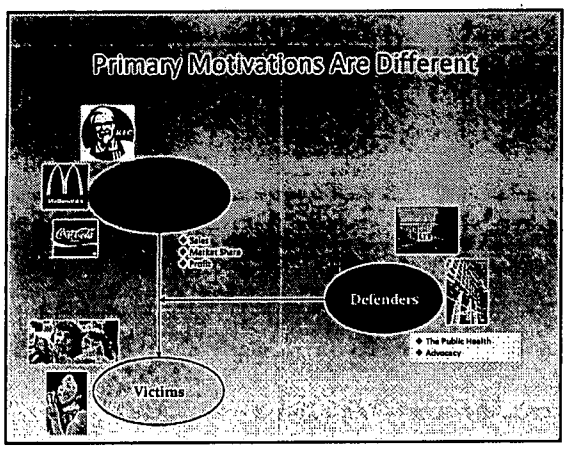


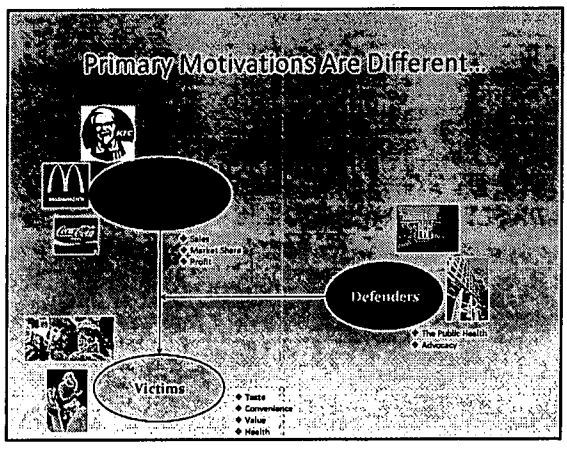


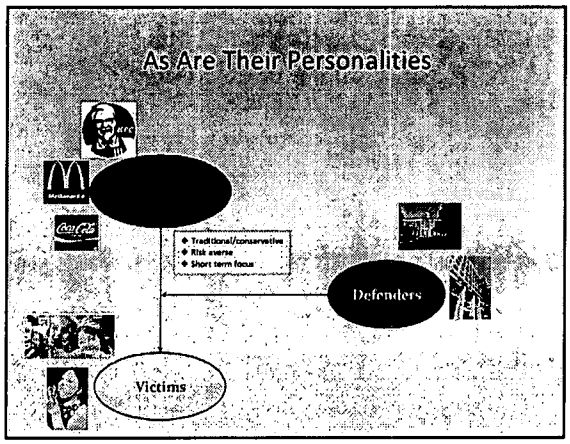
"Victims"

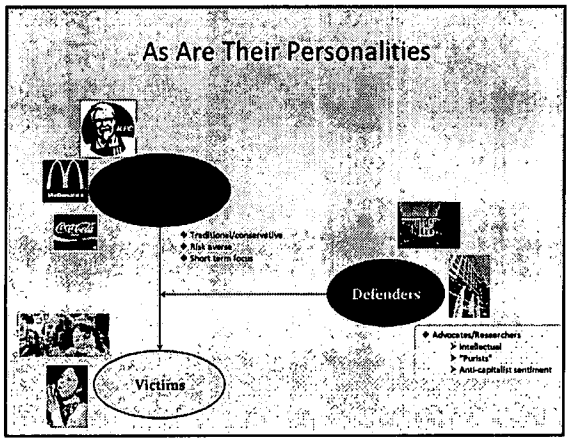
- Consumers

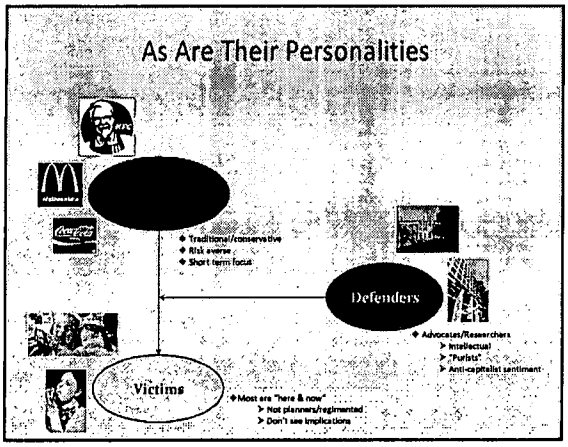

Primary Motivations Are Different
Sales
Market Share
Profit
Defenders
Victims


Primary Motivations Are Different
Defenders
The Public Health
Advocacy
Victims

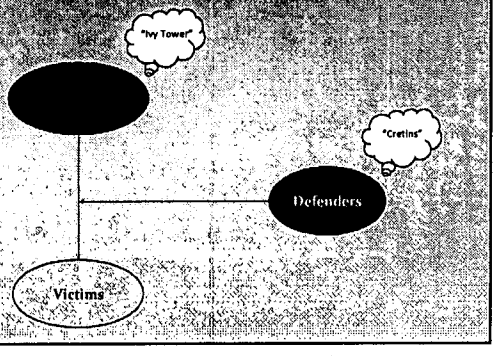

Primary Motivations Are Different...
Defenders
The Public Health
Advocacy
Victims
Taste
Convenience
Value
Health


As Are Their Personalities
Traditional/conservative
Risk averse
Short term focus
Defenders
Victims


As Are Their Personalities
Traditional/conservative
Risk averse
Short term focus
Defenders
Advocates/Researchers
Intellectual
"Purists"
Anti-capitalist sentiment
Victims


As Are Their Personalities
Traditional/conservative
Risk averse
Short term focus
Defenders
Advocates/Researchers
Intellectual
"Purists"
Anti-capitalist sentiment
Victims
Most are "here & now"
Not planners/regimented
Don't see implications

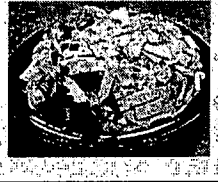
The Result



How Situation Plays Out

Food Industry Position

- We offer healthier options
- Consumers must be responsible for their choices
- Advocates trying to harm our business models





How Situation Plays Out

Food Industry Approach

- Continued resistance to change Change = Pain
  - Increased costs
  - Ingredients
  - Profit Margins
  - Way of business





How Situation Plays Out

Advocate Positions

- Entire categories are inherently "bad"






- The profit motive is perpetuating obesity
- Food industry resists change vehemently

↓

Frustration

How Situation Plays Out

Advocate Approach

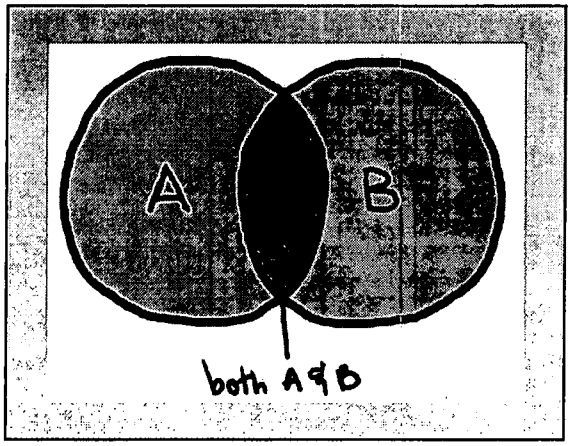
- Advance initiatives that are:
  - Punitive
  - Force change
  - Single category/ingredient focused

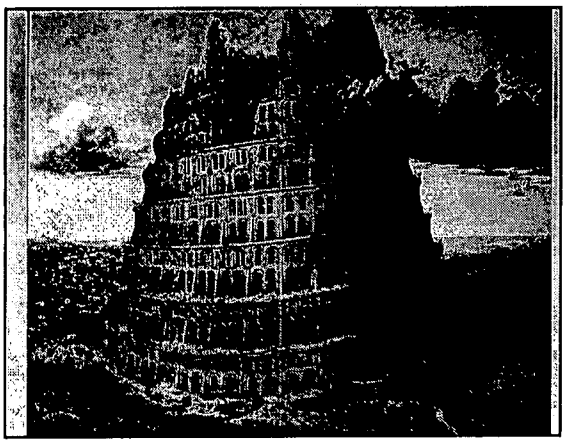
THE WALL STREET JOURNAL. The New York Times

"Soda Tax Weighed to Pay for Health Care"

"Salt: The Forgotten Killer"

"Fructose-Sweetened Beverages Linked to Heart Risks"





How Situation Plays Out

The Consumer

- Poor track record with diets and exercise
- Majority not "walking their talk"
  - Only ~ 25% following a healthy lifestyle

Why?

Consumer Segments

Disciplined
Logical
Hard rules
Organized
Conflict OK





Consumer Segments

Disciplined	Situational
Logical	Transitional
Hard rules	Forward looking
Organized	Chameleon
Conflict OK	

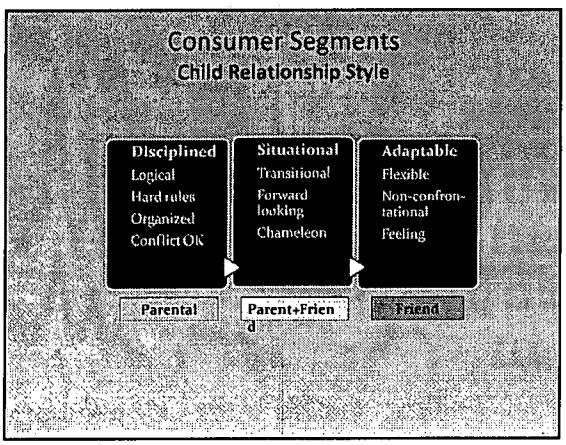
Consumer Segments

Disciplined	Situational	Adaptable
Logical	Transitional	Flexible
Hard rules	Forward looking	Non-confron-tational
Organized	Chameleon	Feeling
Conflict OK		

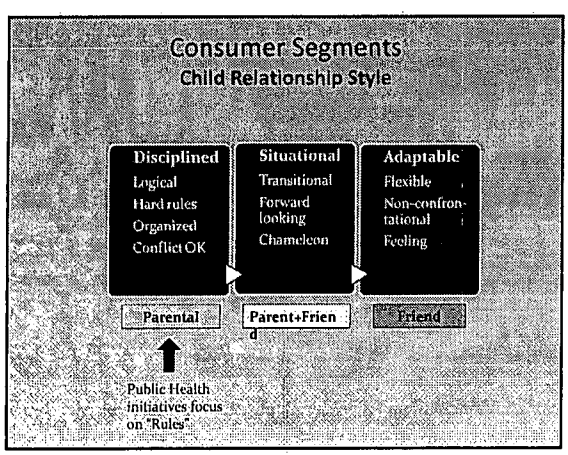
"Extreme" Adaptables



Consumer Segments
Child Relationship Style



Consumer Segments
Child Relationship Style



Implications

- Current polarized approaches have/will not solve obesity crisis
- Relying on consumer to change behavior is an uphill battle
  - After-school eating behavior less likely to be enforced among non-"Disciplines"
- Biggest impact can come from the food industry
  - Key: must see their way to making a profit

Without the food industry's direct involvement, a solution will be elusive

Select Food Industry Initiatives

1. Portion-controlled Packaging

- Studies show that 100-calorie packs are effective

"People ate 120 calories a day less when eating from 100-calorie packs than when they were given the regular packages"

- Reduced-calorie packs are profitable
  - Higher per ounce pricing

Reduced-calorie Products for Kids

Beverages





Reduced-calorie Products for Kids
Snacks



2. Restaurant Products for Kids

Kid's Meals

- Between 300-400 calories
  - McDonald's 400-600 calories



2. Restaurant Products for Kids

Specialty Kid's Beverages

a SPLASH OF fun FOR KIDS!

- Branded product as base + Flavor ingredient(s) + Fruit garnish = New Beverage
- ½ calories of equivalent beverages
- Each contains a nutritional element e.g., Calcium, Vitamin C
- Premium price = higher profits



3. Cereal Initiative

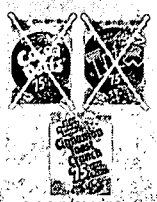
- In the past, General Mills has attempted to lower the sugar in its pre-sweetened cereals



9 gm/serving



6 gm/serving



2-3 gm/serving

3. Cereal Initiative

- General Mills recommitted to reducing sugar in 10 pre-sweetened cereals
  - Goal: Reduction to single-digit grams of sugar per serving
  - Yale's Rudd Center: "The least-healthy breakfast cereals are the most frequently and aggressively marketed directly to children."



Why?

"It's just good business"

- Steve Sanger, former CEO

4. School Vending

Alliance for a Healthier Generation

❑ National School Vending Program

- ❖ Beverage calories shipped to schools down 58%
- ❖ 65% of vending machines changed over
- ❖ 79% of schools in compliance with Guidelines

4. School Vending

Program Can Be Profitable

- ❖ Action: Set 3 levels of pricing:
  - ➢ Bottled water: $0.75
  - ➢ Juices/sports drinks: $1.00
  - ➢ Soft drinks: $1.25
- ❖ Results:
  - ➢ Added 9 more vending machines
  - ➢ Soft drink sales (and calories) down
  - ➢ Profits up $4K



Source: Minneapolis School District Test

5. Advertising to Children

- ❖ Several major food corporations committed to limit and/or eliminate advertising to children under 12

Select Public Sector Initiatives



Anti-Obesity Plan

Key Elements
- Increase # of USDA-accredited healthy schools
- More opportunities for physical activity
- Better availability of healthy foods in low-income areas

Assessment
- Commitment secured from school foodservice suppliers to cut fat and salt and offer more whole grains and fruit
- Doesn't address:
  - After-school eating behavior compliance
  - Supply-side calorie-reduction solutions
- High cost: $10 billion over 10 years



Calorie Labeling on Menus

Key Elements
- National legislation to note calories on restaurant menus
  - Applies to chains of 20 units or more

Assessment
- Evidence suggests potential reduction in calorie consumption for select outlets
  - Calorie reduction of 6% in Starbucks test
  - Little impact in fast food restaurants

California Initiatives

- Banned trans fats January 1, 2010
- Will post calorie counts on menus in 2011
- Considering a tax on soft drinks
- Los Angeles:
  - Moratorium on new fast food restaurants in certain districts
  - Reconfiguring vending machines in county facilities as they come up for renewal
    - More baked chips, low-fat cookies and crackers
    - No action yet on soft drinks



H.R. 4310

Key Elements

- Strip deductions for marketing/advertising to children for:
  - Fast food consumption
  - Food of "poor nutritional quality"
- Would result in 40% reduction of ad messages to children

Assessment

- Would raise government revenues
- Will face strong food and advertising industry resistance
- Not a "win-win" – will negatively impact bottom lines



Ways & Means Precedent

Key Elements

- Strip deductions for direct-to-consumer drug ads
- Would generate $37 billion over 5 years

Result

- Strong resistance from advertising federation quickly squelched the proposal



Soda Tax Proposal

Key Elements

- 10% tax would reduce sugared beverage consumption by 8-10%
- Will raise substantial government revenues

Assessment

- Strong industry resistance
  - Deleterious to business financial models
- Other academic studies suggest tax would negligibly impact obesity
- Regressive to consumers in tough economic climate
  - Need for taste precludes rapid shift to water

Bridging the Gap

Blueprint for Success

Criteria

1. Corporations must make profits
2. Corporations must be part of the solution
3. Bottom-up consumer efforts need allied support
4. Actions must be geared to lowering obesity rates not punishing specific products or categories
5. Keep It Simple

Initiative to Engage the Food Industry

❖ Advancing a plan with Senate and House



Incentive to reduce calories

Initiative to Engage the Food Industry

Goals

1. Lower the # of calories sold on a mass basis
   - Calories +29% over last 50 years; need to reverse
2. Leverage marketing prowess of food companies to help educate consumer about healthier eating

Initiative to Engage the Food Industry

❖ Plan Highlights



1. Must lower calories sold to keep tax deductions on advertising expenditures
   - Docked up to 50% if increase calories
   - Bonus if lower calories 10%
2. Must "tag" 25% of ads with healthy eating/ lifestyle message to retain full deductions
   - Bonus for airing PSAs

Initiative to Engage the Food Industry

❖ Definitions



1. Calories sold:
   - ❑ Restaurants: Calories per store
   - ❑ Packaged goods: Calories per serving
2. Tags:
   - ❑ Portion control or healthy lifestyle message (e.g.) "Eat Smart, Move More"

Initiative to Engage the Food Industry

Benefits

❖ **Bipartisan appeal**
- ❑ Structured to mitigate industry resistance
- ❑ Opportunity to raise $1 billion over 5 years

❖ **Non-punitive structure: *Shifts* rather than eliminates tax deductions**
- ❑ Corporations that meet criteria will not lose deductions
- ❑ Potential to earn additional tax deductions
- ❑ Provides maximum flexibility for corporations to meet criteria

❖ **Superior approach to punitive taxes**
- ❑ Focuses on the crux of the problem: excess calories from any source

❖ **Simple to implement and track**

Putting the Pieces Together

Calorie Reduction Incentive Plan

+

Eat Smart Move More NORTH CAROLINA

Full Engagement of key constituencies

Recap

- An engaged food industry is essential to enhancing child nutrition
- Regulatory initiatives must consider both corporate and public health goals
- Changing consumer behavior is challenging
  - Leverage the power of the Eat Smart, Move More program
- Lowering excess calories should be our #1 priority

General Assembly of North Carolina

Thank You

Hank@StuffedNation.com

www.StuffedNation.com

stuffed

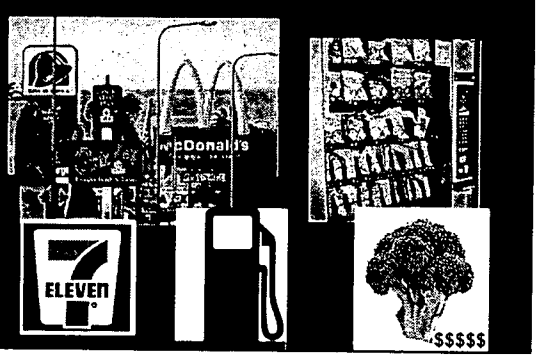
The Rudd Center

- Strategic science
- Research on
  - food marketing to youth
  - soft drink taxes
  - school and pre-school nutrition
  - menu labeling
  - weight bias

Optimal defaults

- Public health examples
  - Ban trans fat in restaurants (NYC)
  - Fluoride in drinking water
  - Airbags
  - No lead paint, gasoline
- Nutrition
  - Easiest to make healthy choices

Current nutrition default



"Don't eat anything your great-grandmother wouldn't recognize as food."

- ENRICHED FLOUR (WHEAT FLOUR, NIACIN, REDUCED IRON, THIAMIN MONONITRATE [VITAMIN B1], RIBOFLAVIN [VITAMIN B2], FOLIC ACID), SUGAR, CORN SYRUP, SOYBEAN AND PALM OIL (WITH TBHQ FOR FRESHNESS), DEXTROSE, HIGH FRUCTOSE CORN SYRUP, CORN SYRUP SOLIDS, CRACKER MEAL, CONTAINS TWO PERCENT OR LESS OF WHEY, CORNSTARCH, SALT, MILK CHOCOLATE (SUGAR, CHOCOLATE, COCOA BUTTER, MILK), COCOA PROCESSED WITH ALKALI, MODIFIED CORN STARCH, CREAM, HYDROGENATED PALM KERNEL OIL, LEAVENING (BAKING SODA, SODIUM ACID PYROPHOSPHATE, MONOCALCIUM PHOSPHATE), NATURAL AND ARTIFICIAL FLAVOR, GELATIN, DRIED EGG WHITES, SOY LECITHIN, COLOR ADDED, XANTHAN GUM, CARNAUBA WAX, VITAMIN A PALMITATE, DATEM, NIACINAMIDE, REDUCED IRON, RED #40, PYRIDOXINE HYDROCHLORIDE (VITAMIN B6), YELLOW #5, YELLOW #5 LAKE, RIBOFLAVIN (VITAMIN B2), THIAMIN HYDROCHLORIDE (VITAMIN B1), BLUE #1, FOLIC ACID.



Marketing to Children

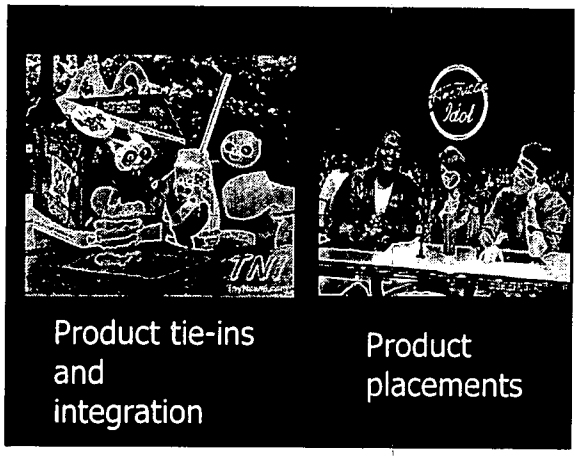
Research

- Massive:
  - 15 TV food ads /day
  - 5500 TV messages per year
- Not just TV
- 98% of ads promote products high in fat, sugar, and/or sodium

Research

- Industry spends >$1.6b/yr marketing to children and teens
- Relation between TV viewing/higher BMI
  - Specifically due to food ads
  - Children consume 45% more when exposed to food advertising

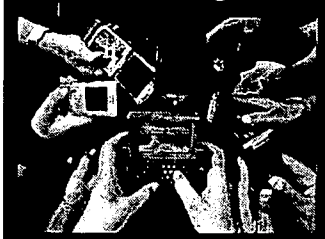
Not just TV ads anymore: The current default



Product tie-ins and integration

Product placements

Mobile marketing



Social media

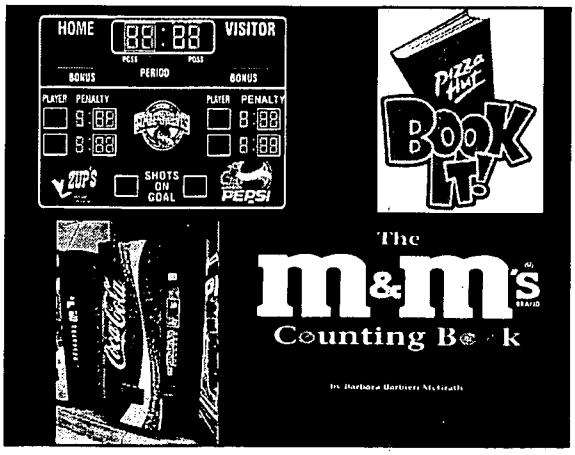


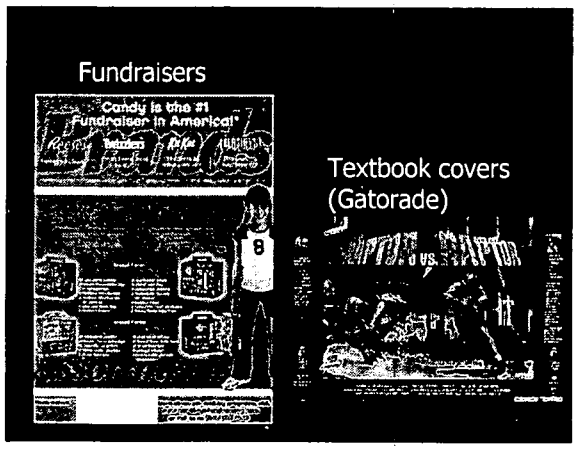
Internet advertising and advergames

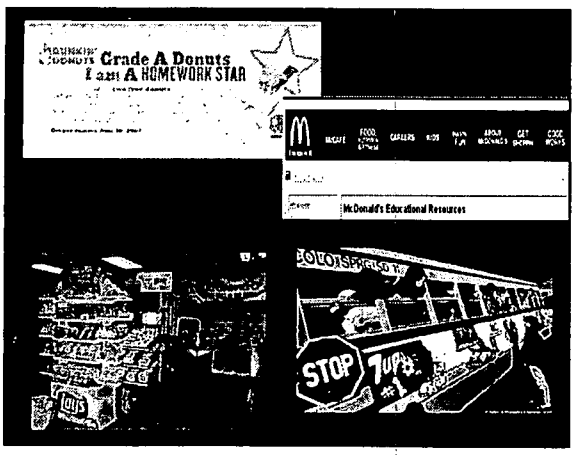


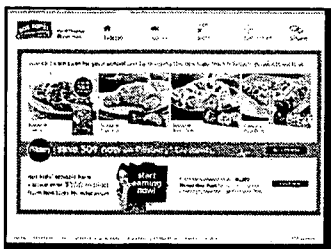
In-store marketing




HOME
VISITOR
BONUS
PERIOD
BONUS
PLAYER PENALTY
PLAYER PENALTY
SHOTS ON GOAL
PEPSI
Pizza Hut
BOOK IT!
The
M&M's
Counting Book


Fundraisers
Candy is the #1 Fundraiser in America!
Textbook covers (Gatorade)


Grade A Donuts I am A HOMEWORK STAR
McDonald's Educational Resources
STOP
7up



Box tops for education

Internet ads



Rudd Cereal Study

- Reduce harm associated with food marketing to youth
- Reduce exposure
- Product reformulation
- Government oversight
  - *ads*
  - *nutrition*
  - *health claims*

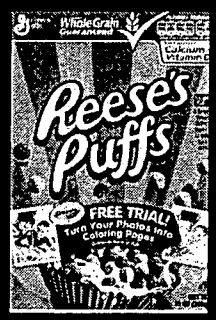


Key findings

- Least healthy are MOST heavily marketed to children
- 85% more sugar, 65% less fiber, 60% more sodium (vs. adults' cereals)
- Avg *preschooler* sees 642 cereal ads/yr on TV alone, almost all for cereals with worst nutrition rankings
- Research shows children *will* eat low-sugar cereals

Worst cereal: 41% sugar

- GM markets to children more than any other cereal company
- 6 of 10 least healthy cereals advertised to children made by GM



Policy

- Statewide wellness policy language
  - Ban ALL advertising on school campuses
  - Ban all food/bev ads
  - Ban ads for foods not allowed to be sold on campus
  - Ban sale of non-nutritious products (would eliminate much of the ads)
  - Exclusive contracts do not permit sales and ads (local policy)

Other States

- NC could be the leader!

Sugar-Sweetened Beverage Consumption and Taxes



Why the concern?

- Consumption is increasing
  - 1970-2000 per-person consumption of SSBs increased 70% from 7.8 to 13.2 oz
  - Soft drinks and other SSBs are the primary source of added sugars in Americans' diets
- Avg child = 172 cal/day
- Avg adult = 175 cal/day (NC: 49 gal/yr)

Why the concern?





SSBs are the primary source of added sugars in Americans' diets.

Links to health problems

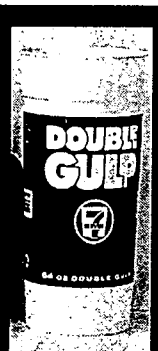
- Diet quality
- ***Weight gain/obesity***
- Type 2 diabetes
- Cardiovascular disease
- Dental caries
- Osteoporosis

Research

- Conflicts of interest
  - Industry funding increased likelihood of finding favorable to sponsor by 4- to 8-fold
  - Studies funded by food industry reported significantly smaller effects than did non-industry funded studies
- No credible evidence of benefit

A mechanism

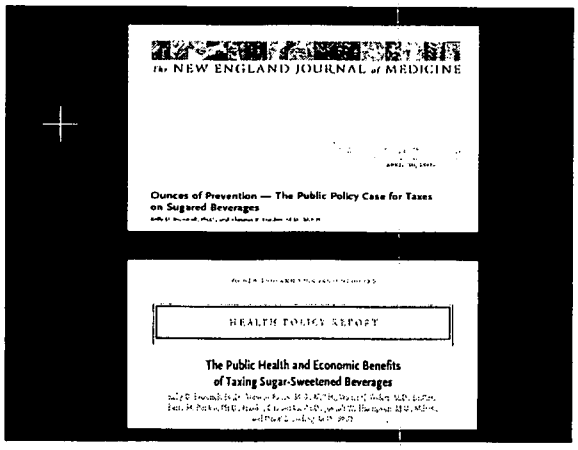
- Sugar in liquid form may be less filling than sugar in solid form
- We do not compensate for extra liquid calories by eating fewer calories from solid food



48 tsps sugar
~950 cal

Rudd research/reports

- Meta-analysis
  - clear assn w. increased cal intake/body weight; diabetes
- Price elasticity suggests beneficial impact
  - for every 10% increase in price, consumption decreases 8-10%



Calls for reducing added sugars and SSBs

- CDC
- USDA
- IOM
- American Academy Pediatrics
- American Medical Assn
- American Heart Assn
- World Health Organization

Taxes on SSBs



Proposal:

- Penny per ounce tax on any beverage with added caloric sweeteners

Goals:

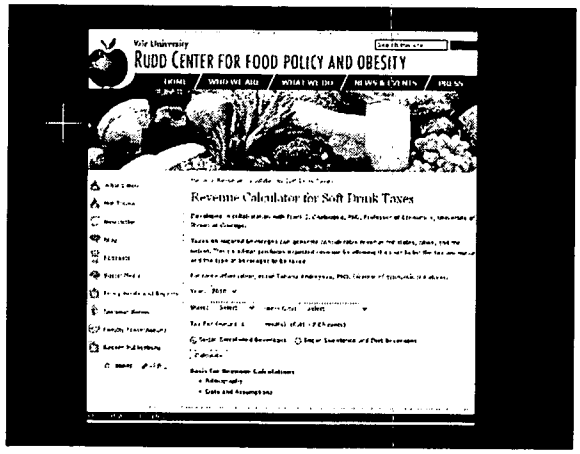
- Reduce consumption
- Raise money *for obesity prevention*

Effect

- 1 cent per oz = 10% reduction in calorie consumption or 20 kcal per person per day
- Reduction sufficient for weight loss

Industry Defense

Many things drive obesity	True
It won't solve obesity	True
Consumption is down, obesity is up	False
Sugar isn't so important	False
It's about physical activity	False
The science isn't clear	False
All calories are equal	False
People will lose jobs	False



In NC

- Penny per ounce excise would
  - decrease consumption by about 23% to 37.6 gallons (vs. 48.8)
- Revenue:
  - 2010-2012: $1,381,000,000
  - 2010-2015: $2,852,000,000

Policy Recommendations

- Excise at manufacturer/distributor level
- Penny per ounce
- Earmarked: "Child Obesity Trust Fund"

States/cities proposing

- Arizona
- California
- Colorado*
- Hawaii
- Massachusetts*
- Mississippi
- New Hampshire
- New Mexico
- New York
- Tennessee
- Virginia*

- Philadelphia

Improving School Nutrition

Current default

- Poor nutrition environment in schools
  - B'fast and lunch programs
  - Diets deteriorate after elementary school
- Competitive foods
  - Vending machines
  - A la carte lines
  - Class parties
  - After-school programs
  - Concession stands
  - Schoolstores

Research

- School-based food policies DO make a difference
  - Eat school lunch=better nutrition
  - Prohibit fast food in cafeteria=higher NSLP participation
  - Soft drink ads near cafeteria predict lower NSLP participation

Research

- School-based food policies DO make a difference
  - High school limits on junk foods: lower BMI
  - Too-early lunch period=larger a la carte sales

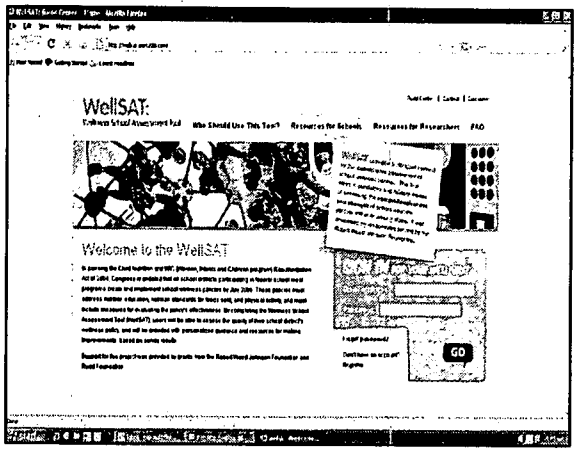
Rudd research addressing concerns

If ban junk foods:

- Revenue will fall
  - Not substantiated
  - Increased NSLP participation
- Kids will compensate
  - No compensatory increase in snack consumption at home if remove from schools
- □

Rudd research

- Wellness Policies
  - 96-item coding tool
  - higher strength scores assoc. w. better practices
  - strongest policies in poorest districts
- Prompt vs. make available: fruit
  - Prompt: 90% took, 70% consumed
  - Avail: 60% took, 40% consumed



Policies

- Implement new a la carte food standards in middle and high schools
- All school levels:
  - Ban all types SSBs
- Recess before lunch

Policies

- Wellness policies
  - –Evaluate state-wide
  - –Publicize results
  - –Permanent wellness committees

Policies

- Increase reimbursement rates for more fr/veg, whole grains
- Eliminate reduced-cost meal plan, enroll in free plan
- Train school food service personnel re: nutrition, cooking skills, obesity

Policies

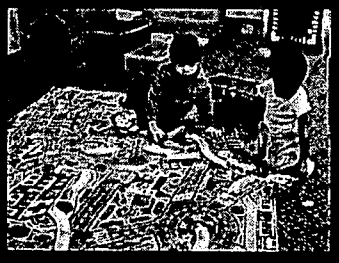
- Low- or non-fat milk only, NO chocolate
- Farm-to-school programs
- School gardens
- Updated cooking equipment

Beverage industry pledges

- Standards created by industry
  - Non-binding
- Evaluation by industry, not independent
- Existing contracts not amended
- Fell short in high schools
  - Sports drinks allowed
- Are reporting on compliance

Other States

- Stricter nutrition standards for USDA meals



Improving Pre-school nutrition

Pre-schools

- NC: 2640 CACFP centers
- 60% children under 5 avg 29 hours/week in childcare
- 41% spend ≥35 hrs/week

Rudd research

- Nutrition/physical activity environment, policies, practices, in CACFP preschools.

Preliminary findings:

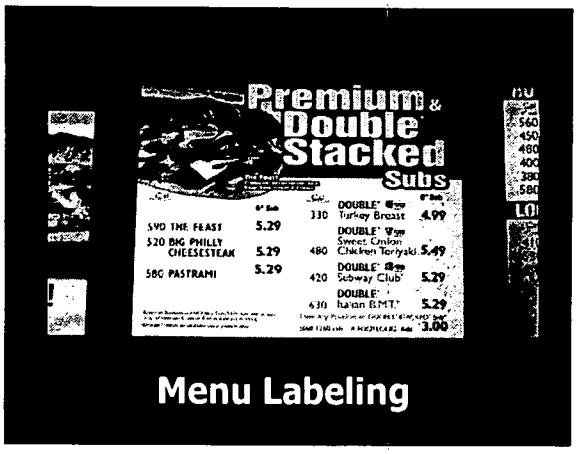
- Heavy consumption: processed, high-fat, and fried meats; full-fat cheeses
- Inadequate intake: fruits, vegs, whole grains

Policies

- Limit fruit juice consumption; not a substitute for whole fruit
- Only non- or low-fat dairy ages >2 yr
- 100% whole grains w. limited added sugar
- Lunch: must incl. vegetables
- Snacks: fruit or vegetables
- Lean meat only; no fried

Other States/cities

- California: pre-school nutrition standards bill
- Delaware: 5-2-1-almost none; better nutrition standards
- New York City: new standards


Premium & Double Stacked Subs
SUB OF THE MONTH
$5.00 FOOTLONG
$5.00 FOOTLONG

Research

- NYC study
  - 12,000 customers
  - Consumed average of 106 fewer calories than those who did not see or use information



Policy Recommendations

- Calories on menus, menu boards, drive-thrus
- Statement
- Other nutrition information on premises

NC menu labeling bill

- Develop plan to encourage restaurants to make information available

States/cities passed

- California
- Maine
- Massachusetts
- New Jersey
- Oregon
- Nashville
- 4 NY counties
- Montgomery Cty MD
- New York City
- Philadelphia
- Seattle/King Cty

Thank you!

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Perspective

APRIL 30, 2009

Ounces of Prevention — The Public Policy Case for Taxes on Sugared Beverages

Kelly D. Brownell, Ph.D., and Thomas R. Frieden, M.D., M.P.H.

> Sugar, rum, and tobacco are commodities which are nowhere necessaries of life, which are become objects of almost universal consumption, and which are therefore extremely proper subjects of taxation.
>
> Adam Smith, *The Wealth of Nations*, 1776

The obesity epidemic has inspired calls for public health measures to prevent diet-related diseases. One controversial idea is now the subject of public debate: food taxes.

Forty states already have small taxes on sugared beverages and snack foods, but in the past year, Maine and New York have proposed large taxes on sugared beverages, and similar discussions have begun in other states. The size of the taxes, their potential for generating revenue and reducing consumption, and vigorous opposition by the beverage industry have resulted in substantial controversy. Because excess consumption of unhealthful foods underlies many leading causes of death, food taxes at local, state, and national levels are likely to remain part of political and public health discourse.

Sugar-sweetened beverages (soda sweetened with sugar, corn syrup, or other caloric sweeteners and other carbonated and uncarbonated drinks, such as sports and energy drinks) may be the single largest driver of the obesity epidemic. A recent meta-analysis found that the intake of sugared beverages is associated with increased body weight, poor nutrition, and displacement of more healthful beverages; increasing consumption increases risk for obesity and diabetes; the strongest effects are seen in studies with the best methods (e.g., longitudinal and interventional vs. correlational studies); and interventional studies show that reduced intake of soft drinks improves health.[1] Studies that do not support a relationship between consumption of sugared beverages and health outcomes tend to be conducted by authors supported by the beverage industry.[2]

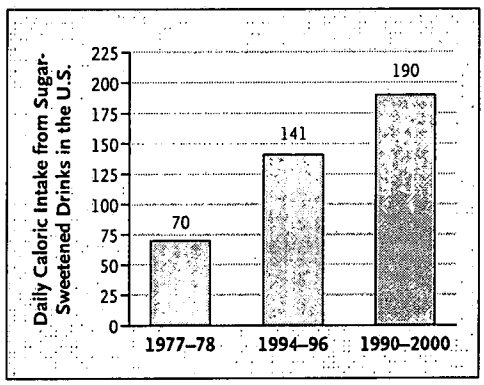
Sugared beverages are marketed extensively to children and adolescents, and in the mid-1990s, children's intake of sugared beverages surpassed that of milk. In the past decade, per capita intake of calories from sugar-sweetened beverages has increased by nearly 30% (see bar graph)[3]; beverages now account for 10 to 15% of the calories consumed by children and adolescents. For each extra can or glass of sugared beverage

consumed per day, the likelihood of a child's becoming obese increases by 60%.[4]

Taxes on tobacco products have been highly effective in reducing consumption, and data indicate that higher prices also reduce soda consumption. A review conducted by Yale University's Rudd Center for Food Policy and Obesity suggested that for every 10% increase in price, consumption decreases by 7.8%. An industry trade publication reported even larger reductions: as prices of carbonated soft drinks increased by 6.8%, sales dropped by 7.8%, and as Coca-Cola prices increased by 12%, sales dropped by 14.6%.[5] Such studies — and the economic principles that support their findings — suggest that a tax on sugared beverages would encourage consumers to switch to more healthful beverages, which would lead to reduced caloric intake and less weight gain.

The increasing affordability of soda — and the decreasing affordability of fresh fruits and vegetables (see line graph) — probably contributes to the rise in obesity in the United States. In 2008, a group of child and health care advocates in New York proposed a one-penny-per-ounce excise tax on sugared beverages, which would be expected to reduce consumption by 13% — about two servings per week per person. Even if one quarter of the calories consumed from sugared beverages are replaced by other food, the decrease in consumption would lead to an estimated reduction of 8000 calories per person per year — slightly more than 2 lb each year for the average person. Such a reduction in calorie consumption would be expected to substantially reduce the risk of obesity and diabetes and may also reduce the risk of heart disease and other conditions.

Some argue that government should not interfere in the market and that products and prices will change as consumers demand more healthful food, but several considerations support government action. The first is externality — costs to parties not directly involved in a transaction. The contribution of unhealthful diets to health care costs is already high and is increasing — an estimated $79 billion is spent annually for overweight and obesity alone — and approximately half of these costs are paid by Medicare and Medicaid, at taxpayers' expense. Diet-related diseases also cost society in terms of decreased work productivity, increased absenteeism, poorer school performance, and reduced fitness on the part of military recruits, among other negative effects.



Daily Caloric Intake from Sugar-Sweetened Drinks in the United States.

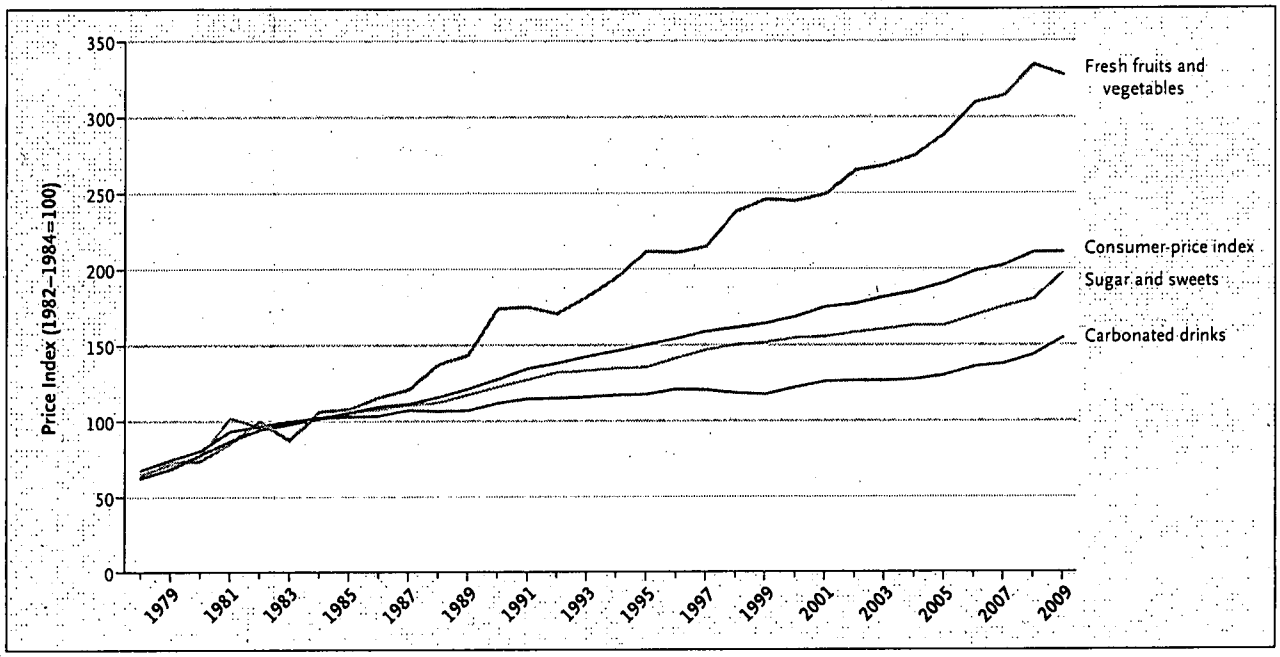
Data are from Nielsen and Popkin.[3]

The second consideration is information asymmetry between the parties to a transaction. In the case of sugared beverages, marketers commonly make health claims (e.g., that such beverages provide energy or vitamins) and use techniques that exploit the cognitive vulnerabilities of young children, who often cannot distinguish a television program from an advertisement.

A third consideration is revenue generation, which can further increase the societal benefits of a tax on soft drinks. A penny-per-ounce excise tax would raise an estimated $1.2 billion in New York State alone. In times of economic hardship, taxes that both generate this much revenue and promote health are better options than revenue initiatives that may have adverse effects.

Objections have certainly been raised: that such a tax would be regressive, that food taxes are not comparable to tobacco or alcohol taxes because people must eat to survive, that it is unfair to single out one type of food for taxation, and that the tax will not solve the obesity problem. But the poor are disproportionately affected by diet-related diseases and would derive the greatest benefit from reduced consumption; sugared beverages are not necessary for survival; Americans consume about 250 to 300 more calories daily today than they did several decades ago, and nearly half this increase is accounted for by consumption of sugared beverages; and though no single intervention will solve the obesity problem, that is hardly a reason to take no action.

The full impact of public policies becomes apparent only after they take effect. We can estimate changes in sugared-drink consumption that would be prompted by a tax, but accompanying changes in the consumption of other foods or beverages are more difficult to predict. One question



Relative Price Changes for Fresh Fruits and Vegetables, Sugars and Sweets, and Carbonated Drinks, 1978–2009.
Data are from the Bureau of Labor Statistics and represent the U.S. city averages for all urban consumers in January of each year.

is whether the proportions of calories consumed in liquid and solid foods would change. And shifts among beverages would have different effects depending on whether consumers substituted water, milk, diet drinks, or equivalent generic brands of sugared drinks.

Effects will also vary depending on whether the tax is designed to reduce consumption, generate revenue, or both; the size of the tax; whether the revenue is earmarked for programs related to nutrition and health; and where in the production and distribution chain the tax is applied. Given the heavy consumption of sugared beverages, even small taxes will generate substantial revenue, but only heftier taxes will significantly reduce consumption.

Sales taxes are the most common form of food tax, but because they are levied as a percentage of the retail price, they encourage the purchase of less-expensive brands or larger containers. Excise taxes structured as a fixed cost per ounce provide an incentive to buy less and hence would be much more effective in reducing consumption and improving health. In addition, manufacturers generally pass the cost of an excise tax along to their customers, including it in the price consumers see when they are making their selection, whereas sales taxes are seen only at the cash register.

Although a tax on sugared beverages would have health benefits regardless of how the revenue was used, the popularity of such a proposal increases greatly if revenues are used for programs to prevent childhood obesity, such as media campaigns, facilities and programs for physical activity, and healthier food in schools. Poll results show that support of a tax on sugared beverages ranges from 37 to 72%; a poll of New York residents found that 52% supported a "soda tax," but the number rose to 72% when respondents were told that the revenue would be used for obesity prevention. Perhaps the most defensible approach is to use revenue to subsidize the purchase of healthful foods. The public would then see a relationship between tax and benefit, and any regressive effects would be counteracted by the reduced costs of healthful food.

A penny-per-ounce excise tax could reduce consumption of sugared beverages by more than 10%. It is difficult to imagine producing behavior change of this magnitude through education alone, even if government devoted massive resources to the task. In contrast, a sales tax on sugared drinks would generate considerable revenue, and as with the tax on tobacco, it could become a key tool in efforts to improve health.

No potential conflict of interest relevant to this article was reported.

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HEALTH POLICY REPORT

The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages

Kelly D. Brownell, Ph.D., Thomas Farley, M.D., M.P.H., Walter C. Willett, M.D., Dr.P.H., Barry M. Popkin, Ph.D., Frank J. Chaloupka, Ph.D., Joseph W. Thompson, M.D., M.P.H., and David S. Ludwig, M.D., Ph.D.

The consumption of sugar-sweetened beverages has been linked to risks for obesity, diabetes, and heart disease[1-3]; therefore, a compelling case can be made for the need for reduced consumption of these beverages. Sugar-sweetened beverages are beverages that contain added, naturally derived caloric sweeteners such as sucrose (table sugar), high-fructose corn syrup, or fruit-juice concentrates, all of which have similar metabolic effects.

Taxation has been proposed as a means of reducing the intake of these beverages and thereby lowering health care costs, as well as a means of generating revenue that governments can use for health programs.[4-7] Currently, 33 states have sales taxes on soft drinks (mean tax rate, 5.2%), but the taxes are too small to affect consumption and the revenues are not earmarked for programs related to health. This article examines trends in the consumption of sugar-sweetened beverages, evidence linking these beverages to adverse health outcomes, and approaches to designing a tax system that could promote good nutrition and help the nation recover health care costs associated with the consumption of sugar-sweetened beverages.

CONSUMPTION TRENDS AND HEALTH OUTCOMES

In recent decades, intake of sugar-sweetened beverages has increased around the globe; for example, intake in Mexico doubled between 1999 and 2006 across all age groups.[8] Between 1977 and 2002, the per capita intake of caloric beverages doubled in the United States across all age groups[9] (Fig. 1). The most recent data (2005–2006) show that children and adults in the United States consume about 172 and 175 kcal daily, respectively, per capita from sugar-sweetened beverages.

The relationship between the consumption of sugar-sweetened beverages and body weight has been examined in many cross-sectional and longitudinal studies and has been summarized in systematic reviews.[1,2] A meta-analysis showed positive associations between the intake of sugar-sweetened beverages and body weight — associations that were stronger in longitudinal studies than in cross-sectional studies and in studies that were not funded by the beverage industry than in those that were.[2] A meta-analysis of studies involving children[10] — a meta-analysis that was supported by the beverage industry — was interpreted as showing that there was no evidence of an association between consumption of sugar-sweetened beverages and body weight, but it erroneously gave large weight to several small negative studies; when a more realistic weighting was used, the meta-analysis summary supported a positive association.[11] A prospective study involving middle-school students over the course of 2 academic years showed that the risk of becoming obese increased by 60% for every additional serving of sugar-sweetened beverages per day.[12] In an 8-year prospective study involving women, those who increased their consumption of sugar-sweetened beverages at year 4 and maintained this increase gained 8 kg, whereas those who decreased their intake of sugar-sweetened beverages at year 4 and maintained this decrease gained only 2.8 kg.[13]

Short-term clinical trials provide an experimental basis for understanding the way in which sugar-sweetened beverages may affect adiposity. Tordoff and Alleva[14] found that as compared with total energy intake and weight during a 3-week period in which no beverages were provided, total energy intake and body weight increased when subjects were given 530 kcal of sugar-sweetened beverages per day for 3 weeks but decreased when

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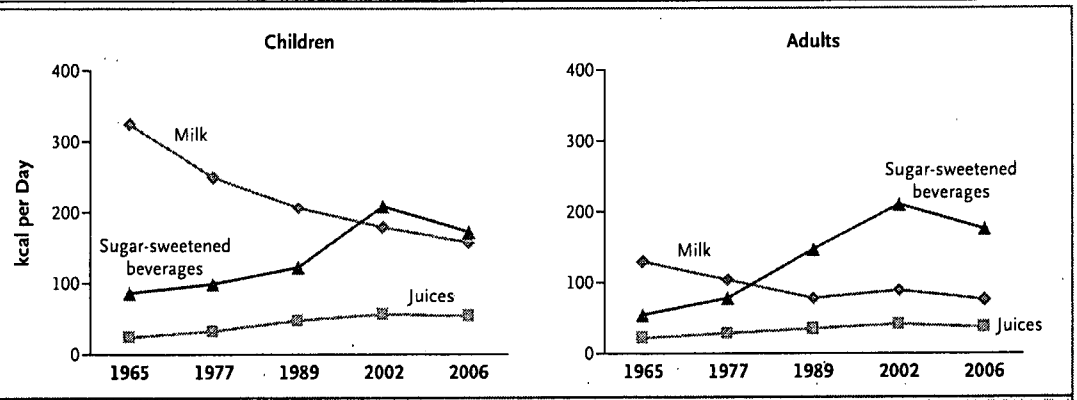


Figure 1. U.S. Trends in Per Capita Calories from Beverages.
Data are for U.S. children 2 to 18 years of age and adults 19 years of age or older. Data have been weighted to be nationally representative, with the use of methods that generate measures of each beverage that are comparable over time. Data for 1965–2002 are from Duffey and Popkin[9]; data for 2005–2006 have not been published previously.

subjects were given noncaloric sweetened beverages for the same length of time. Raben et al.[15] reported that obese subjects gained weight when they were given sucrose, primarily in the form of sugar-sweetened beverages, for 10 weeks, whereas they lost weight when they were given noncaloric sweeteners for the same length of time.

Four long-term, randomized, controlled trials examining the relationship between the consumption of sugar-sweetened beverages and body weight have been reported; the results showed the strongest effects among overweight persons. A school-based intervention to reduce the consumption of carbonated beverages was assessed among 644 students, 7 to 11 years of age, in the United Kingdom with the use of a cluster design.[16] After 1 year, the intervention group, as compared with the control group, had a nonsignificantly lower mean body-mass index (the weight in kilograms divided by the square of the height in meters) and a significant 7.7% lower incidence of obesity. In a study involving 1140 Brazilian schoolchildren, 9 to 12 years of age, that was designed to discourage the consumption of sugar-sweetened beverages, no overall effect on body-mass index was observed during the 9-month academic year.[17] Among students who were overweight at baseline, the body-mass index was nonsignificantly decreased in the intervention group as compared with the control group; the difference was significant among overweight girls. In another clinical trial, 103 high-school students in Boston were assigned to a control group or to an intervention group that received home delivery of noncaloric beverages for 25 weeks. The body-mass index was nonsignificantly reduced in the overall intervention group, but among students in the upper third of body-mass index at baseline, there was a significant decrease in the body-mass index in the intervention group, as compared with the control group (a decrease of 0.63 vs. an increase of 0.12).[18] The effects of replacing sugar-sweetened beverages with milk products were examined among 98 overweight Chilean children.[19] After 16 weeks, there was a nonsignificantly lower increase in the percentage of body fat in the intervention group than in the control group (0.36% and 0.78% increase, respectively), whereas there was a significantly greater increase in lean mass in the intervention group (0.92 vs. 0.62 kg).

Three prospective, observational studies — one involving nurses in the United States, one involving Finnish men and women, and one involving black women — each showed positive associations between the consumption of sugar-sweetened beverages and the risk of type 2 diabetes.[13,20,21] Among the 91,249 women in the Nurses' Health Study II who were followed for 8 years, the risk of diabetes among women who consumed one or more servings of sugar-sweetened beverages per day was nearly double the risk among women who consumed less than one serving of sugar-sweetened beverages per month[13]; about half the excess risk was accounted for by greater body weight. Among black women, excess weight accounted for most of the excess risk.

Among 88,520 women in the Nurses' Health

10.1056/NEJMhpr0905723 NEJM.ORG

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Study, the risk of coronary heart disease among women who consumed one serving of sugar-sweetened beverages per day, as compared with women who consumed less than one serving per month, was increased by 23%, and among those who consumed two servings or more per day, the risk was increased by 35%.[3] Increased body weight explained some, but not all, of this association.

MECHANISMS LINKING SUGAR-SWEETENED BEVERAGES WITH POOR HEALTH

A variety of behavioral and biologic mechanisms may be responsible for the associations between the consumption of sugar-sweetened beverages and adverse health outcomes, with some links (e.g., the link between intake of sugar-sweetened beverages and weight gain) better established than others. The well-documented adverse physiological and metabolic consequences of a high intake of refined carbohydrates such as sugar include the elevation of triglyceride levels and of blood pressure and the lowering of high-density lipoprotein cholesterol levels, which would be expected to increase the risk of coronary heart disease.[22] Because of the high glycemic load of sugar-sweetened beverages, consumption of these beverages would be expected to increase the risk of diabetes by causing insulin resistance and also through direct effects on pancreatic islet cells.[23] Observational research has shown that consumption of sugar-sweetened beverages, but not of noncalorically sweetened beverages, is associated with markers of insulin resistance.[24]

Intake of sugar-sweetened beverages may cause excessive weight gain owing in part to the apparently poor satiating properties of sugar in liquid form. Indeed, adjustment of caloric intake at subsequent meals for energy that had been consumed as a beverage is less complete than adjustment of intake for energy that had been consumed as a solid food.[25] For example, in a study involving 323 adults, in which 7-day food diaries were used, energy from beverages added to total energy intake instead of displacing other sources of calories.[26] The results of a study of school-age children were consistent with the data from adults and showed that children who drank 9 oz or more of sugar-sweetened beverages per day consumed nearly 200 kcal per day more than those who did not drink sugar-sweetened beverages.[27]

Short-term studies of the effect of beverage consumption on energy intake support this mechanism. Among 33 adults who were given identical test lunches on six occasions but were given beverages of different types (sugar-sweetened cola, noncaloric cola, or water) and amounts (12 oz [355 ml] or 18 oz [532 ml]),[28] the intake of solid food did not differ across conditions; the result was that there was significantly greater total energy consumption when the sugar-sweetened beverages were served.

Sugar-sweetened beverages may also affect body weight through other behavioral mechanisms. Whereas the intake of solid food is characteristically coupled to hunger, people may consume sugar-sweetened beverages in the absence of hunger, to satisfy thirst or for social reasons. Sugar-sweetened beverages may also have chronic adverse effects on taste preferences and food acceptance. Persons — especially children — who habitually consume sugar-sweetened beverages rather than water may find more satiating but less sweet foods (e.g., vegetables, legumes, and fruits) unappealing or unpalatable, with the result that their diet may be of poor quality.

ECONOMIC RATIONALE

Economists agree that government intervention in a market is warranted when there are "market failures" that result in less-than-optimal production and consumption.[29,30] Several market failures exist with respect to sugar-sweetened beverages. First, because many persons do not fully appreciate the links between consumption of these beverages and health consequences, they make consumption decisions with imperfect information. These decisions are likely to be further distorted by the extensive marketing campaigns that advertise the benefits of consumption. A second failure results from time-inconsistent preferences (i.e., decisions that provide short-term gratification but long-term harm). This problem is exacerbated in the case of children and adolescents, who place a higher value on present satisfaction while more heavily discounting future consequences. Finally, financial "externalities" exist in the market for sugar-sweetened beverages in that consumers do not bear the full costs of their consumption decisions. Because of the contribu-

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tion of the consumption of sugar-sweetened beverages to obesity, as well as the health consequences that are independent of weight, the consumption of sugar-sweetened beverages generates excess health care costs. Medical costs for overweight and obesity alone are estimated to be $147 billion — or 9.1% of U.S. health care expenditures — with half these costs paid for publicly through the Medicare and Medicaid programs.[31]

AN EFFECTIVE TAX POLICY AND PROJECTED EFFECTS

Key factors to consider in developing an effective policy include the definition of taxable beverages, the type of tax (sales tax or excise tax), and the tax rate. We propose an excise tax of 1 cent per ounce for beverages that have any added caloric sweetener. An alternative would be to tax beverages that exceed a threshold of grams of added caloric sweetener or of kilocalories per ounce. If this approach were used, we would recommend that the threshold be set at 1 g of sugar per ounce (30 ml) (32 kcal per 8 oz [237 ml]). Another option would be a tax assessed per gram of added sugar, but such an approach would be difficult to administer. The advantage of taxing beverages that have any added sugar is that this kind of tax is simpler to administer and it may promote the consumption of no-calorie beverages, most notably water; however, a threshold approach would also promote calorie reductions and would encourage manufacturers to reformulate products. A consumer who drinks a conventional soft drink (20 oz [591 ml]) every day and switches to a beverage below this threshold would consume approximately 174 fewer calories each day.

A specific excise tax (a tax levied on units such as volume or weight) per ounce or per gram of added sugar would be preferable to a sales tax or an ad valorem excise tax (a tax levied as a percentage of price) and would provide an incentive to reduce the amount of sugar per ounce of a sugar-sweetened beverage. Sales taxes added as a percentage of retail cost would have three disadvantages: they could simply encourage the purchase of lower-priced brands (thus resulting in no calorie reduction) or of large containers that cost less per ounce; consumers would become aware of the added tax only after making the decision to purchase the beverage; and the syrups that are used in fountain drinks, which are often served with multiple refills, would remain untaxed. A number of states currently exempt sugar-sweetened beverages from sales taxes along with food, presumably because food is a necessity. This practice should be eliminated, whether or not an excise tax is enacted.

Excise taxes could be levied on producers and wholesalers, and the cost would almost certainly be passed along to retailers, who would then incorporate it into the retail price; thus, consumers would become aware of the cost at the point of making a purchase decision. Taxes levied on producers and wholesalers would be much easier to collect and enforce than taxes levied on retailers because of the smaller number of businesses that would have to comply with the tax; in addition, the sugar used in syrups could be taxed — a major advantage because of the heavy sales of fountain drinks. Experience with tobacco and alcohol taxes suggests that specific excise taxes have a greater effect on consumption than do ad valorem excise taxes and can also generate more stable revenues because they are less dependent on industry pricing strategies.[32] In addition, tax laws should be written with provisions for the regular adjustment of specific excise taxes to keep pace with inflation, in order to prevent the effect of the taxes on both prices and revenues from eroding over time.

A tax of 1 cent per ounce of beverage would increase the cost of a 20-oz soft drink by 15 to 20%. The effect on consumption can be estimated through research on price elasticity (i.e., consumption shifts produced by price). The price elasticity for all soft drinks is in the range of −0.8 to 1.0.[33] (Elasticity of −0.8 suggests that for every 10% increase in price, there would be a decrease in consumption of 8%, whereas elasticity of 1.0 suggests that for every 10% increase in price, there would be a decrease in consumption of 10%.) Even greater price effects are expected from taxing only sugar-sweetened beverages, since some consumers will switch to diet beverages. With the use of a conservative estimate that consumers would substitute calories in other forms for 25% of the reduced calorie consumption, an excise tax of 1 cent per ounce would lead to a minimum reduction of 10% in calorie consumption from sweetened beverages, or 20 kcal per person per day, a reduction that is sufficient for weight loss and reduction in risk (unpublished

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data). The benefit would be larger among consumers who consume higher volumes, since these consumers are more likely to be overweight and appear to be more responsive to prices.[7] Higher taxes would have greater benefits.

A controversial issue is whether to tax beverages that are sweetened with noncaloric sweeteners. No adverse health effects of noncaloric sweeteners have been consistently demonstrated, but there are concerns that diet beverages may increase calorie consumption by justifying consumption of other caloric foods or by promoting a preference for sweet tastes.[34] At present, we do not propose taxing beverages with noncaloric sweeteners, but we recommend close tracking of studies to determine whether taxing might be justified in the future.

REVENUE-GENERATING POTENTIAL

The revenue generated from a tax on sugar-sweetened beverages would be considerable and could be used to help support childhood nutrition programs, obesity-prevention programs, or health care for the uninsured or to help meet general revenue needs. A national tax of 1 cent per ounce on sugar-sweetened beverages would raise $14.9 billion in the first year alone. Taxes at the state level would also generate considerable revenue — for example, $139 million in Arkansas, $183 million in Oregon, $221 million in Alabama, $928 million in Florida, $937 million in New York, $1.2 billion in Texas, and $1.8 billion in California. A tax calculator that is available online can generate revenue numbers for states and 25 major cities.[35]

OBJECTIONS, INDUSTRY REACTION, PUBLIC SUPPORT, AND FRAMING

One objection to a tax on sugar-sweetened beverages is that it would be regressive. This argument arose with respect to tobacco taxes but was challenged successfully by proponents of the taxes, who pointed out that the poor face a disproportionate burden of smoking-related illnesses, that nearly all smokers begin to smoke when they are teenagers, and that both groups are sensitive to price changes.[7] In addition, some of the tobacco revenue has been used for programs developed specifically for the poor and for youth. The poor are most affected by illnesses that are related to unhealthful diets, and brand loyalties for beverages tend to be set by the teenage years. In addition, sugar-sweetened beverages are not necessary for survival, and an alternative (i.e., water) is available at little or no cost; hence, a tax that shifted intake from sugar-sweetened beverages to water would benefit the poor both by improving health and by lowering expenditures on beverages. Designating revenues for programs promoting childhood nutrition, obesity prevention, or health care for the uninsured would preferentially help those most in need.

A second objection is that taxing sugar-sweetened beverages will not solve the obesity crisis and is a blunt instrument that affects even those who consume small amounts of such beverages. Seat-belt legislation and tobacco taxation do not eliminate traffic accidents and heart disease but are nevertheless sound policies. Similarly, obesity is unlikely to yield to any single policy intervention, so it is important to pursue multiple opportunities to obtain incremental gains. Reducing caloric intake by 1 to 2% per year would have a marked impact on health in all age groups, and the financial burden on those who consumed small amounts of sugar-sweetened beverages would be minimal.

Opposition to a tax by the beverage industry is to be expected, given the possible effect on sales; opposition has been seen in jurisdictions that have considered such taxes and can be predicted from the behavior of the tobacco industry under similar circumstances.[36] PepsiCo threatened to move its corporate headquarters out of New York when the state considered implementing an 18% sales tax on sugar-sweetened beverages.[37] The tobacco industry fought policy changes by creating front groups with names that suggested community involvement. The beverage industry has created Americans Against Food Taxes.[38] These reactions suggest that the beverage industry believes that a tax would have a substantial impact on consumption.

Public support for food and beverage taxes to address obesity has increased steadily. Questions about taxes in polls have been asked in various ways, and the results are therefore not directly comparable from year to year, but overall trends are clear. Support for food taxes rose from 33% in 2001 to 41% in 2003 and then to 54% in 2004.[39] A 2008 poll of New York State residents showed that 52% of respondents support a soda

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tax; 72% support such a tax if the revenue is used to support programs for the prevention of obesity in children and adults. The way in which the issue is framed is essential; support is highest when the tax is introduced in the context of promoting health and when the revenues are earmarked for programs promoting childhood nutrition or obesity prevention.

CONCLUSIONS

The federal government, a number of states and cities, and some countries (e.g., Mexico[8]) are considering levying taxes on sugar-sweetened beverages. The reasons to proceed are compelling. The science base linking the consumption of sugar-sweetened beverages to the risk of chronic diseases is clear. Escalating health care costs and the rising burden of diseases related to poor diet create an urgent need for solutions, thus justifying government's right to recoup costs.

As with any public health intervention, the precise effect of a tax cannot be known until it is implemented and studied, but research to date suggests that a tax on sugar-sweetened beverages would have strong positive effects on reducing consumption.[5,33] In addition, the tax has the potential to generate substantial revenue to prevent obesity and address other external costs resulting from the consumption of sugar-sweetened beverages, as well as to fund other health-related programs. Much as taxes on tobacco products are routine at both state and federal levels because they generate revenue and they confer a public health benefit with respect to smoking rates, we believe that taxes on beverages that help drive the obesity epidemic should and will become routine.

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RUDD REPORT

FALL 2009



SOFT DRINK TAXES

A Policy Brief

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RUDD CENTER
FOR FOOD POLICY
& OBESITY
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SOFT DRINK TAXES

Why Consider Them?

Sugar-sweetened beverages with little or no nutrition are staples of today's American diet. These beverages are inexpensive, in abundant supply, and appeal to our taste for sugar. They are heavily marketed, especially to children, often using celebrities, sports stars, and cartoon characters. More than for any category of foods, rigorous scientific studies have shown that consumption of soft drinks is associated with poor diet, increasing rates of obesity, and risk for diabetes. These links are strong for children.

Chronic diseases related to poor diet cost the country billions of health care dollars each year and are complex problems which must be addressed with multi-faceted strategies. Taxing certain classes of products to reduce consumption has been proposed as one means of improving the nation's nutrition, raising revenue for health programs, and recovering costs caused by consumption of calorie-dense, nutrient-poor foods.

Policy makers across the country who are concerned about nutrition are considering the implementation of soft drink taxes to complement other public health initiatives.

Thirty-three states now have sales taxes on soft drinks, but the taxes are too small to affect consumption, in many cases consumers do not know they exist, and revenues are not used for nutrition programs.[1]

What Would Taxes Accomplish?

Taxes on soft drinks can be conceived with two goals: raising revenue and changing consumption. They can:

- raise considerable funds to be earmarked for nutrition initiatives such as subsidies of healthy foods or programs in schools;
- raise the relative price of unhealthy beverages thereby discouraging their consumption;
- decrease sales of those beverages, and influence demand for healthier alternatives, which may encourage beverage manufacturers to reformulate their products;
- convey the message that government and policy makers are concerned about nutrition and the public's health.

REVENUE POTENTIAL

- A national tax of 1 cent per ounce on sugar-sweetened beverages would generate at least $14.9 billion in the first year alone.[2] Placing this in context, this is thirty times the amount the nation's largest funder of work on childhood obesity is spending in five years.
- A proposed sales tax of 18% on soft drinks in New York State was projected to bring in $400 million in the first year and close to $540 million thereafter.[3]

Issues Concerning Soft Drink Taxes and Results of Scientific Research

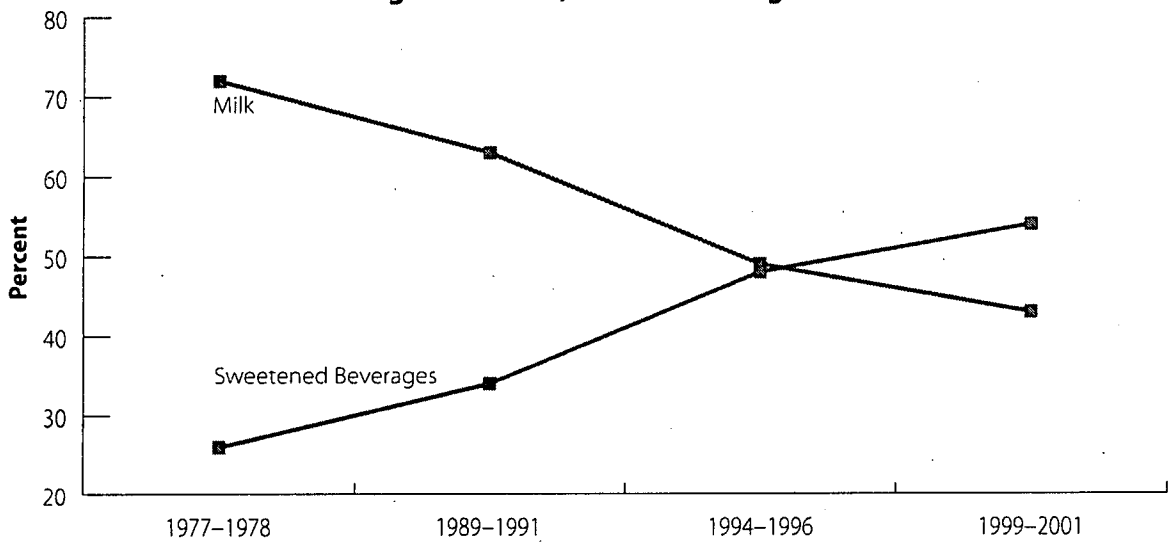
ISSUE: CONSUMPTION AND HEALTH EFFECTS

A substantial increase has occurred in the consumption of soft drinks since the 1970s, now averaging 50 gallons per person per year.

Consumption

- A 2004 study found that soft drinks are the single largest contributor of calorie intake in the United States.[4]
- U.S. per capita consumption of calories from sugar-sweetened beverages doubled between 1977-2002 across all age groups.[5]; children and adults consume about 172 and 175 calories daily, respectively, per capita from these beverages.[6] Further, traditional carbonated drinks are losing market share, while beverages like sports drinks, energy drinks, and sweetened waters and teas are showing significant growth in the marketplace.[7]
- The percentage of beverage calories from sweetened beverages consumed by 2-18 year olds has increased, while the percentage from milk has decreased. In the mid-1990s the intake of sugared beverages began surpassing that of milk.[8]

Percentage of Beverage Calories from Sweetened Beverages and Milk, for Children Ages 2–18



- Sugar-sweetened beverage consumption is highest among groups that are at greatest risk of obesity and type 2 diabetes.[9]
- Research suggests that people compensate less well for calories that come in beverages compared to calories in solid food; hence the large increase in calories from beverages is a matter of great concern.[10]

Effects on Health

- For children, each extra can or glass of sugar-sweetened beverage consumed per day increases their chance of becoming obese by 60%.[11]
- A 2009 California study found that adults who drink one or more sodas per day are 27% more likely to be overweight or obese than those who do not drink soda.[12]
- A 2009 study found a reduction of sugar-sweetened beverage intake was significantly associated with weight change. [13]
- Women who regularly consume sugar-sweetened beverages have a higher risk of coronary heart disease.[14]
- Systematic reviews of evidence conclude that greater consumption of sugar-sweetened beverages is associated with increased calorie intake, weight gain, diabetes, and obesity.[15] Papers not showing this effect are generally funded by the beverage or sugar industries.

ISSUE: PRICE

Price changes affect purchases and consumption.

Effect on Purchase and Consumption

- Based on the best estimates to date of the responsiveness of demand for soft drinks to changes in price,[16] a 10% tax could result in about an 8% reduction in consumption. The effects could be higher for heavy users of soft drinks.[17]
- Based on November 2008 price increase and volume sales information on Coca Cola and Pepsi sales in the U.S.,[18] demand for soda is "elastic" (-1.15) meaning that a 10% tax would reduce consumption by 11.5%.
- Price interventions can be effective in curtailing at-home soft drink consumption, and promoting milk consumption.[19]
- Experiments show that decreasing the cost of healthy foods relative to that of less-healthy foods is effective in promoting the purchase of healthy items.[20]

ISSUE: TAXING

Taxing alcohol and cigarettes has proven to be highly successful in reducing consumption. Major health benefits have been realized from tobacco taxes.

- Numerous economic studies conclude that every 10% increase in the real price of cigarettes reduces consumption by:
  - 3 to 5% overall;
  - 3.5% among young adult smokers;
  - 6 to 7% among children.[21]
- Major health benefits have been realized from tobacco taxes.

- A 2009 systematic review of 112 studies of alcohol taxes on price effects establishes that increasing prices of alcohol is an effective means to reduce drinking.[22]

ISSUE: PUBLIC SUPPORT

Will the public support soft drink taxes?

- Taxes whose revenues are designated to promote the health of key groups (such as children and underserved populations) are most likely to receive public support.[23]
- Public support varies significantly depending on how the poll questions are phrased.
  - A December 2008 poll of New Yorkers found modest support (31%) for an "obesity" or "fat" tax.[24]
  - In contrast, another December 2008 poll found that 52% of New Yorkers supported a "soft drink" tax. That number rose to 72% when respondents were informed that the revenue raised would be earmarked for obesity prevention among children and adults.[25]
- A 2008 study found that New York State residents would be willing to pay $690.6 million per year if it meant a 50% reduction in childhood obesity. When applied to the entire U.S., the number increases to $10.6 billion.[26]
- Support has increased over time: a 2003 national survey found that 41% percent supported a special tax on "junk food."[27]

Policy Recommendations

TAX CONSIDERATIONS

- Excise tax (fee per ounce)
  - *Advantages*
    - consumers see the increased price at the point of purchase;
    - can be imposed at the bottler, distributor, wholesaler, or importer level, making it easier to collect;
    - does not change if industry reduces prices;
    - will include the syrup used in fountain drinks;
    - generates more stable and predictable revenues;
    - avoids the problem of encouraging consumers to buy larger containers.
  - *Special note*
    - Taxes should be indexed to inflation to avoid erosion of the impact as prices rise.
- Sales tax (percentage of product's price).
  - *Advantage*
    - rises with inflation.
  - *Disadvantages*
    - may encourage consumers to buy larger containers because the cost per ounce is lower, so the tax per ounce would be lower as well;
    - retailers, especially small ones without computerized cash registers, may be inconvenienced by having to charge taxes on some beverages and not others. This may motivate them to become spokespersons for opposition or repeal.

In states where sales taxes are lower for groceries than for other goods, soft drinks should be taxed just like other consumer goods and not given a special lower rate reserved for food necessities.[28]

- Exempting diet beverages from taxes
  - *Advantage*
    - may encourage consumers to switch to diet or "light" beverages. This may be beneficial in combating weight gain, although there is inconclusive evidence about the role that artificial sweeteners play in obesity prevention[29] or overall health.
  - *Disadvantage*
    - generates less revenue.

PUBLIC HEALTH MESSAGE

- Make the public health message explicit to increase public support for a tax: the purpose is to fund nutrition programs and obesity prevention, to reduce consumption of unhealthy products, and to recoup costs for diet-related diseases now covered by public funds.
- Note that the tax is not just directed at obesity. Poor nutrition affects the health of everyone, overweight or not. In addition, children can develop habits and brand loyalties well in advance of becoming overweight.

USE OF THE REVENUE

- It is important, for reasons of public support and public health, to designate revenue produced by a tax for programs related to health and nutrition, obesity prevention, etc. Programs benefitting underserved populations are especially important.

  Such initiatives could include:
  - subsidies of fresh fruits and vegetables and other healthy foods:
    - in schools and communities;
    - for food stamp recipients, which can offset concerns that the tax is regressive.
  - school initiatives:
    - incentive programs to improve all foods sold on school grounds;
    - funding for schools to meet national physical education time standards;
    - farm-to-school grants;
    - fully subsidize breakfast and lunch for low-income students;
    - safe routes to schools;
  - statewide, comprehensive obesity prevention programs;
  - improvements to the built environment for increased physical activity;
  - incentives to attract supermarkets to low income neighborhoods;
  - social marketing campaigns to counteract the marketing strategies used by food industries to advertise soft drinks and snacks to children.

OTHER CONSIDERATIONS

- Define "soft drinks" as any beverage with added sugar or other caloric sweeteners such as high fructose corn syrup, including soda, sports drinks, sweetened teas, vitamin waters, fruit drinks, and energy drinks.
- Create a "disfavored" tax status for soft drinks, making it higher than general food taxes.

OTHER RESOURCES

- The Rudd Center for Food Policy and Obesity. www.yaleruddcenter.org.
- Center for Science in the Public Interest. http://www.cspinet.org/liquidcandy/index.html.
- Chaloupka, F.J., Powell, L.M., & Chriqui, J.F. *Sugar-sweetened beverage taxes and public health.* A research brief published by the Robert Wood Johnson Foundation's Health Eating Research and Bridging the Gap Programs, July 2009. www.healthyeatingresearch.org.
- ImpacTEEN. A policy research partnership for healthier youth behavior. *State snack and soda sales tax data, and state soda non-sales tax data.*. www.impacteen.org/obesitystatedata.htm.
- Institute of Medicine (IOM). 2009. *Local government actions to prevent childhood obesity.* Washington, DC: The National Academies Press. www.iom.edu.
- The Brookings Institution. *Bending the curve: Effective steps to address long-term health care spending growth.* www.brookings.edu.
- The Urban Institute. *Reducing obesity: Policy strategies from the tobacco wars.* http://www.urban.org/publications/411926.html.

The Rudd Center for Food Policy and Obesity at Yale University is directed by **Kelly D. Brownell, PhD**, and seeks to improve the world's diet, prevent obesity, and reduce weight stigma by establishing creative connections between science and public policy.

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ARGUMENTS FOR AND AGAINST SOFT DRINK TAXES

Opponents say:	Proponents say:
Soft drink taxes are regressive. They will disproportionately hurt the poor and minorities who spend a larger proportion of their income on food.	■ **Obesity is a regressive disease. That is, it disproportionately affects poor and minority populations.** ■ **Soft drink taxes have the potential to be most beneficial to low income people, who:** ▫ may currently consume more soft drinks; ▫ may be more sensitive to higher prices and therefore stand to benefit most from reducing consumption. This is especially true if the revenues are used for programs that will benefit the poor. ■ While everyone must eat, sugared beverages are not a necessary part of the diet and generally deliver many calories with little or no nutrition. ■ A no-cost alternative is readily available—water. ■ It is generally agreed that while it is good public policy for the tax system as a whole to be progressive, it would not be good policy to expect that every single sales tax should be progressive.[30]
The government should stay out of private behavior. It should not try to regulate what people eat or drink.	■ The government is deeply involved in what we eat, from farm subsidies to setting nutritional standards for school meals. Major government interventions have been successful in improving and protecting the public's health. Examples include smoking restrictions and tobacco taxes, air bags in autos, fluoridated water, and vaccinations. ■ Agriculture subsidies that support the production of high fructose corn syrup, and USDA policies on what can be sold in schools are examples of policies that may be counter-productive. ■ Some states and cities have lower sales taxes on food than other products by virtue of food being a necessity. Policies could define sugared beverages as non-necessities so they would not qualify for lower rates.
Soft drink taxes can't be compared to cigarette and alcohol taxes. The use of tobacco and alcohol can have adverse consequences (called "negative externalities") for non-users such as second hand smoke and drunk driving accidents. This is not true for soft drink consumption.	**Sugared beverage intake also results in externalities.** Because of the relationship of soft drink intake to negative health outcomes in both children and adults, health care costs rise. Obesity-related medical expenditures are estimated to be $147 billion per year. Half of these costs are paid for with taxpayer dollars through Medicaid and Medicare.[31]
People who consume too many soft drinks know they risk becoming overweight. Everyone else shouldn't have to bear the burden of their bad decisions.	**Consumers, especially young ones, may not know the risks involved in over-consumption of soft drinks or calories. For example:** ■ People may not be aware that a 20-ounce bottle of Coca Cola has more than 15 teaspoons of sugar and 240 calories. ■ Most people cannot estimate the number of calories when they eat out. Even experienced nutritionists underestimate the numbers. ■ Overweight and obese children are more likely to become obese adults and suffer from related chronic diseases. The public may also not be aware that in 2006 manufacturers spent about $1.62 billion to market soft drinks, snacks, and other unhealthy foods, just to children and adolescents and just in the U.S. Approximately $870 million of that was spent on advertising to children under 12.[32]
It's wrong to blame soft drinks for obesity because sales of "regular" soft drinks have decreased but obesity rates are still rising.	**Sales of traditional carbonated sodas may be down, but sales of other sugared beverages have increased; hence the recommendation that all sugar-sweetened beverages be taxed.**

FOOTNOTES

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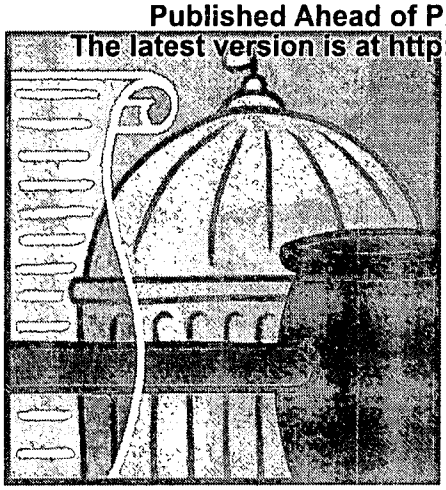
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Addressing Complex Problems

The Impact of Food Prices on Consumption: A Systematic Review of Research on the Price Elasticity of Demand for Food

Tatiana Andreyeva, PhD, Michael W. Long, MPH, and Kelly D. Brownell, PhD

In light of proposals to improve diets by shifting food prices, it is important to understand how price changes affect demand for various foods.

We reviewed 160 studies on the price elasticity of demand for major food categories to assess mean elasticities by food category and variations in estimates by study design. Price elasticities for foods and nonalcoholic beverages ranged from 0.27 to 0.81 (absolute values), with food away from home, soft drinks, juice, and meats being most responsive to price changes (0.7–0.8). As an example, a 10% increase in soft drink prices should reduce consumption by 8% to 10%.

Studies estimating price effects on substitutions from unhealthy to healthy food and price responsiveness among at-risk populations are particularly needed. (*Am J Public Health.* Published online ahead of print December 17, 2009: e1–e7. doi:10.2105/AJPH.2008.151415)

THE INCREASING BURDEN OF diet-related chronic diseases has prompted policymakers and researchers to explore broad-based approaches to improving diets.[1,2] One way to address the issue is to change the relative prices of selected foods through carefully designed tax or subsidy policies. The potential of price changes to improve food choices is evident from growing research on how relative food prices affect dietary quality and obesity, particularly among young people, lower income populations, and those most at risk for obesity.[3] Experience from tobacco tax regulation further underscores the power of price changes to influence purchasing behavior and, ultimately, public health.[4]

Experimental research in both laboratory and intervention settings shows that lowering the price of healthier foods and raising the price of less healthy alternatives shift purchases toward healthier food options.[5–8] Although these studies demonstrate price effects in specific, isolated settings or on 1 or 2 individual product changes, to our knowledge, the expected effects of broader food price changes have not been systematically reviewed. Such information would be helpful in designing policies that change the relative food and beverage prices paid by all or many consumers.

Relatively small-scale, cost-neutral approaches to improving nutrition in vulnerable populations include the 2009 changes in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) food packages; whole grains, fruits and vegetables, and soy-based milk alternatives were added to these packages, indirectly subsidizing healthy foods for WIC participants.[9] Another larger scale approach is to change prices directly through taxing products such as sugar-sweetened beverages[1,10] or subsidizing healthier foods (e.g., a refund on the costs of fruits and vegetables to Supplemental Nutrition Assistance Program participants).[11] Some states already tax soft drinks and snacks at higher rates than other foods, but thus far taxes have been small and designed to generate revenue rather than influence consumption.[12]

We sought to estimate the effects of price changes on consumer demand for major commodity foods included in the Dietary Guidelines for Americans food categories.[13] We identified all published US studies of food price elasticity of demand (the expected proportional change in product demand for a given percentage change in price) and combined their estimates into average estimated price elasticities for 16 major food and beverage groups. Our goal was to provide a comprehensive summary of research on food demand and consumption behavior in the United States over the past 7 decades, with particular attention to differences in price effects across income levels.

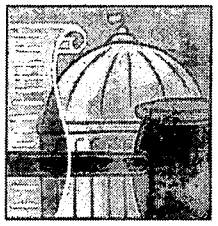
One timely estimate that can be gained from our review is how altering the prices of soft drinks can alter their consumption, information that is of critical need for policymakers considering soft drink taxes. We compared the sensitivity of estimates across different analytic approaches to modeling food demand. We identify important gaps in the food demand analysis literature and suggest avenues for future research.

METHODS

We reviewed all US-based studies on the price elasticity of demand for major food categories to determine mean price elasticities by category and assess variations in estimates by study design.

Definition of Terms

The price elasticity of demand is a dimensionless construct



referring to the percentage change in purchased quantity or demand with a 1% change in price. It is determined by a multitude of factors: availability of substitutes, household income, consumer preferences, expected duration of price change, and the product's share of a household's income.[14] When the relative change in purchased quantity is below the relative change in price, demand is inelastic (numerically, the absolute value of price elasticity is below 1.0). In contrast, changes in demand that exceed the relative price change reflect elastic demand (the absolute value of price elasticity is above 1.0). For example, when a commodity's purchased quantity falls by 5% owing to a 10% increase in price, the price elasticity of demand is −0.5, reflecting inelastic demand. If the same price increase reduces the commodity's purchased quantity by 15%, demand for the product is elastic (−1.5).

Our review of food price elasticities focused on the effects of price changes on primary demand (also called commodity or category demand), which is consumer demand for a category or group of products measured by quantity purchased. By contrast, brand demand reflects purchases of an individual brand or products. In the case of policy decisions such as those involving taxation or subsidies, parameters of primary demand for a category of products (e.g., soft drinks) are necessary to predict the magnitude of policy-induced changes in consumer demand.

We distinguish between uncompensated and income-compensated price elasticity of demand, with the latter assuming that consumers are compensated for price changes through income changes (i.e., compensated models estimate only substitution between products without including any effects on a consumer's overall budget resulting from price changes). We consider both price demand elasticity and cross-price elasticity of demand for a product. Whereas price elasticity reflects changes in the purchased quantity of a commodity with changes in that commodity's price, cross-price elasticity reflects changes in demand for a particular commodity when prices of other products change. The construct of cross-price elasticities is important from a policy perspective in that relative shifts in prices through taxation or subsidies can affect demand for other products not regulated by policies.

Selection of Studies

Our review included US-based studies estimating the price elasticity of demand for food and nonalcoholic beverages. We reviewed original research articles published in English between 1938 and September 2007. Two independent searches were conducted with the search terms "food and price elasticity," "price elasticity," "demand elasticity," "food demand," and "price elasticities," as well as combinations of these terms with "food," "meat," "beverages," and "dairy." We used a number of databases and search engines to retrieve articles for review, including PubMed, EconLit, JSTOR, and Google Scholar. The reference lists of all retrieved articles were reviewed to identify relevant papers.

In addition to studies published in peer-reviewed journals, our search included working papers, dissertations, and US Department of Agriculture (USDA) technical reports. We retrieved these documents to capture all expert work, particularly USDA studies that appear only in government reports. Tests confirmed the sensitivity of our results to the exclusion of studies from non-peer-reviewed sources. Commentaries, editorials, essays, and consensus statements were excluded. We limited our review to US data because of the possibility of cross-country variations in market, product, and consumer characteristics introducing bias into our interpretations of food price effects in US studies. We included studies focusing on specific population groups or geographic regions to capture all variance in the US data.

Data Extraction and Analysis Variables

Data were independently extracted by one reviewer (T.A. or M.L.) and checked for consistency by the other reviewer. Variables assessed were food product, demand estimation model, data characteristics (study design, time, and source), estimates of price elasticity for all foods and nonalcoholic beverages, estimates of cross-price elasticity for major substitutes or complementary foods, demand elasticity for average and low-income households (if available), statistical significance of elasticity estimates, and publication source and year. Synthesizing data on income elasticity of food demand (food demand responsiveness to income changes) was beyond the scope of our review. We did not use price elasticities for specific types of fruits or vegetables in estimating average fruit and vegetable elasticities because, as a result of the availability of substitutes, demand for specific foods such as apples is more elastic than that for an aggregate group that includes all fruits.

We used the following procedure to extract elasticity estimates. When estimates from multiple periods were reported, we selected the most recent data. In studies providing estimates of both compensated and uncompensated demand elasticity, we used uncompensated elasticity because most of the reviewed studies included only uncompensated demand estimates. We rounded final estimates to the second digit and calculated these estimates as absolute values. In studies with estimates from multiple models, we took mean values. We were interested in estimating the elasticity of fruit prices separately from that of vegetable prices. However, many studies included only one estimate for fruits and vegetables combined, and in these instances we had to assume the same elasticity of demand for fruits and vegetables. If a study estimated demand parameters for both low-income consumers and all consumers, we included estimates for the 2 groups.

Methodological Variation of Studies

Our goal was not to review methodological details of food demand system estimation, which are available in other reviews,[15–17] but rather to distill from the existing



literature food demand parameters that can be useful to the public health community. In doing so, we accounted for variations in methods and data, which affect individual parameters and may have implications for synthesized average estimates. We segmented studies into 3 mutually exclusive categories based on type of data in estimation: time series, household surveys, and retail scanner data.

Time series data were represented by monthly, quarterly, or annual data on food prices, consumption, and expenditures over time (derived from the USDA and the US Department of Commerce). Survey data were taken from cross-sectional national household surveys (e.g., Nationwide Food Consumption Survey, National Food Stamp Program Survey). More recent studies have often involved retail scanner data from commercial providers (e.g., ACNielsen) that track supermarket transactions. We excluded estimates from laboratory experiments, which could change real-world price sensitivity among customers. We also considered the type of demand system estimation model used.

Consumer demand is a function of multiple factors in addition to prices, including product quality, advertising, preferences, and other demand shift variables. Several studies included advertising in their model or provided quality-adjusted and unadjusted elasticity estimates, which we combined because we had insufficient power to consider them separately. We included a decade of data collection, using the median time point for data over multiple decades.

We pooled estimates of price elasticities across studies by food category (if at least 10 studies were available) and computed ranges and means (along with their 95% confidence intervals) for 16 food and beverage categories: beef, cereal, cheese, dairy products, eggs, fats and oils, fish, food away from home (including fast food and restaurant meals), fruit, juice, milk, pork, poultry, soft drinks, sugars and sweets, and vegetables. We had limited statistical power to synthesize estimates for other foods of interest, including fresh fruits and vegetables, fast food, snacks, and candy.

RESULTS

In the sections to follow, we describe the existing US-based studies involving food demand analyses, provide summary estimates of price elasticities for major food categories, and consider variation in estimates across studies.

Description of Available Literature

We identified 464 relevant citations in our literature search. After all selected articles had been retrieved and reviewed, 184 studies with data on food price elasticity remained. We excluded 5 international studies, 4 review articles, 3 studies involving experimental data, and 12 studies with brand-level food price elasticities, leaving 160 studies in our review (a list of these 160 studies is available on request).

Time series data were used in most studies (99 studies, or 62%), followed by household survey data (34 studies, or 21%) and scanner data (27 studies, or 17%). Only 38 studies were published before 1970. Despite increasing interest in the topic, only 9 studies estimated food price elasticities specifically for low-income groups, with 3 studies examining a broad range of foods.[18–20] Consumer demand for meat, particularly beef and pork, has received substantially greater attention than demand for any other food. Of the 160 studies, 31% provided price elasticity estimates for beef; 29% for pork; 14% for poultry; and 10% for fish. Fewer studies provided estimates for milk (15%), cereal (12%), cheese (12%), and fruits or vegetables (11%). For example, we identified only 6 estimates for fresh fruits and vegetables as a combined category (not including studies focusing on individual vegetables or fruits). Other foods were considered in less than 10% of all reviewed studies.

Price Elasticity Estimates

Mean price elasticity estimates for the 16 food and beverage groups considered, along with their 95% confidence intervals and ranges, are presented in Table 1. Overall, our results are consistent with customary characterizations of the demand response to food prices as inelastic; all mean price elasticity estimates were below 1.0 and ranged from 0.27 to 0.81 (all elasticity estimates here and throughout the text are absolute values). Estimates were relatively less inelastic for soft drinks (0.79), juice (0.76), meats (0.68–0.75), fruit (0.70), and cereals (0.60) and most inelastic for eggs (0.27), sugars and sweets (0.34), cheese (0.44), and fats and oils (0.48). Food away from home was most responsive to changes in prices among other categories (0.81) and more elastic than demand for food at home (0.59; however, the latter value is based on 7 studies).

Milk was the most studied category aside from meat (26 estimates). Thirteen studies provided elasticity estimates for specific milk fat levels. Mean elasticities for skim, 1%, and whole milk ranged from 0.75 to 0.79, whereas the mean elasticity for 2% milk was 1.22.[21–33] Understanding differences in price elasticity for different types of milk and cross-price elasticity for milk with varying fat content is important in food policy analyses that examine approaches to reducing saturated fat consumption (as recommended in the Dietary Guidelines for Americans).

Because milk is among the 3 leading sources of saturated fat in the American diet, substitution away from whole milk toward milk with lower fat content is one promising avenue for dietary change.[13] We identified 5 studies that evaluated cross-price elasticities for milk with varying fat content.[22,26,27,30,32] For a 10% increase in the price of whole milk, increases in purchased quantities ranged between 0.6% and 5% for low-fat or reduced-fat milk and between 0.1% and 2.9% for skim milk. Thus, consumers are more likely to switch to reduced or low-fat milk than skim milk when the price of whole milk increases.

Only a small number of studies evaluated the effects of income level on demand elasticity, and thus we were not able to identify consistent differences in estimated price elasticities between

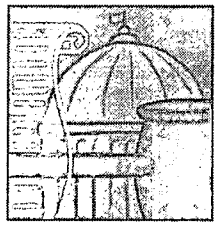


TABLE 1—US Price Elasticity Estimates, by Food and Beverage Category, from 1938–2007

Food and Beverage Category[a]	Absolute Value of Mean Price Elasticity Estimate (95% CI)	Range	No. of Estimates
Food away from home	0.81 (0.56, 1.07)	0.23–1.76	13
Soft drinks	0.79 (0.33, 1.24)	0.13–3.18	14
Juice	0.76 (0.55, 0.98)	0.33–1.77	14
Beef	0.75 (0.67, 0.83)	0.29–1.42	51
Pork	0.72 (0.66, 0.78)	0.17–1.23	49
Fruit	0.70 (0.41, 0.98)	0.16–3.02	20
Poultry	0.68 (0.44, 0.92)	0.16–2.72	23
Dairy	0.65 (0.46, 0.84)	0.19–1.16	13
Cereals	0.60 (0.43, 0.77)	0.07–1.67	24
Milk	0.59 (0.40, 0.79)	0.02–1.68	26
Vegetables	0.58 (0.44, 0.71)	0.21–1.11	20
Fish	0.50 (0.30, 0.69)	0.05–1.41	18
Fats/oils	0.48 (0.29, 0.66)	0.14–1.00	13
Cheese	0.44 (0.25, 0.63)	0.01–1.95	20
Sweets/sugars	0.34 (0.14, 0.53)	0.05–1.00	13
Eggs	0.27 (0.08, 0.45)	0.06–1.28	14

Note. Values were calculated based on the 160 studies reviewed. Absolute values of elasticity estimates are reported. The price elasticity of demand measures the percentage change in purchased quantity or demand with a 1% change in price.
[a]Including restaurant meals and fast food.

low-income consumers and consumers as a whole. Of the 9 studies reporting price elasticity estimates for low-income populations, 7 presented data for both low-income and all consumers. One study focusing on milk demand showed that demand was more price elastic in low-income populations (1.2 versus 0.66), and a study on fast food depicted a large difference as well (2.09 versus 0.51).[34,35] However, 3 studies including estimates for a broader group of foods reported essentially no difference, with average elasticities of 0.62 for low-income populations and 0.64 for consumers as a whole.[18,20,36]

Of particular importance to policymakers, the available estimates of food price elasticity offer little guidance on a number of key food categories included in the Dietary Guidelines for Americans. Many of the studies reviewed focused on aggregate food categories, with little (if any) consideration for disentangling healthier and less healthy options within categories. Specifically, in the case of many key foods in the Dietary Guidelines for Americans, we did not identify any studies that estimated price elasticities, including cross-price elasticities, to predict within-category shifts between healthier and less healthy alternatives. These foods included whole grain products as well as substitutions between brown and white rice, baked and regular chips, lean and regular types of meat, and reduced-fat and regular cheese.

Although the public health community is attempting to increase people's intake of whole grains, existing research offers no data to predict price-induced shifts in purchases of whole grain products. We found no estimates of how quantities of whole wheat bread purchased would react to changes in the price of refined flour bread. Only 1 study estimated price elasticities for diet and regular soft drinks,[28] and the authors did not offer cross-price elasticities (although a number of brand-level studies have examined substitutions between specific brands of diet and regular soft drinks). One study estimated price elasticities for snack food and candy, and 2 studies offered estimates for fast food.[28,37,38] Despite an increasing focus on nutrient density, we did not identify any studies with elasticity estimates for specific nutrients such as saturated fat.

Sensitivity of Estimates Across Studies

For virtually all estimated demand functions, there is evidence of persistence in food purchasing behavior. For beef, the most commonly analyzed food in our review, we found little variation in elasticity estimates across study designs. Type of demand model, data, peer review status (i.e., peer review versus no peer review), study size (multiple versus single categories of foods), and time of data analysis were not significantly related to the estimates in beef analyses (either jointly in F tests or individually in *t*-test comparisons). Similarly, the estimated parameters for pork, cheese, and vegetables did not vary significantly according to study methodology. There was some variation in how type of demand system model and data affected estimates in studies on milk, fruit, and fish. However, because of the smaller number of data points (e.g., 18 for fish and 26 for milk versus 51 for beef), these findings must be interpreted with caution.

Given the heightened interest of legislators in the soft drink category and the importance of estimating price elasticity of demand for soft drinks to forecast tax effects, we calculated alternate elasticity estimates based on different assumptions or definitions of soft drinks as a product. The mean price elasticity for the soft drink category (0.79, absolute value) was based on 14 estimates in which definitions of the category varied; category definitions included soft drinks, carbonated soft drinks, juice and soft drinks, soda, soda and fruit ades, nonalcoholic beverages, other beverages (all nonalcoholic beverages excluding milk and juices), and, in 1 study, beverages (the exclusion of this final study had essentially no effect on the mean estimate, increasing it from 0.79 to 0.82).

In a more conservative approach to defining the category of soft drinks, we included 7 studies with estimates for soft drinks, carbonated soft drinks, soda, and soda or fruit ades, with a mean



price elasticity of 1.00. Further restricting the definition of soft drinks limited the number of available studies for review. Only 2 estimates were available for carbonated soft drinks (1.08)[39] and soda (0.58),[40] along with 1 study with a combined estimate for soda and fruit ades (1.10)[41] and 1 study with separate regular soft drink (1.05) and low-calorie soft drinks (1.26) estimates.[28] Excluding working papers and the single dissertation resulted in a mean price elasticity of demand for soft drinks of 0.93.

DISCUSSION

Considerable data are available on price elasticities of demand for certain foods. We found mean price elasticity estimates ranging from 0.27 to 0.81 (absolute values), with the highest price elasticities for food away from home, soft drinks, juice, meats, and fruit and the most inelastic demand for eggs. Higher elasticity estimates suggest greater changes in population purchases as prices shift. From a public health perspective, more elastic demand for food is encouraging if change in demand is a priority (e.g., decreased intake of sugar-sweetened beverages and increased consumption of fruits and vegetables). Such data help bridge the public health and economics communities and begin to establish a vision of where price changes might have the greatest impact on consumer food choices, nutrition, and health.

Although economists have published extensively on the effects of price changes on commodity- and brand-level demand for foods and beverages, substantial gaps in the research base exist. These gaps must be filled to gain a more complete understanding of the public health impact of policies that realign food prices. The studies we reviewed did not assess the effects of price changes on substitutions from unhealthy to healthy food choices for many of the key categories (e.g., whole grains) in the Dietary Guidelines for Americans, which are targets in public health campaigns. There is some evidence to suggest that low-income populations may be more sensitive to price changes than the overall population.[3] Still, current data on the role of income are rather limited, and assessments of differences in responsiveness to food prices according to age, education, culture, or ethnicity are not available.

The effects of cigarette taxes on smoking prevalence demonstrate the significant potential of tax policies to modify purchasing behavior.[4] The public health benefit of even moderate price increases for unhealthy foods can be compared with the demand effect of moderate changes in the price of cigarettes. For example, a negligible change in the price of cigarettes (0.03% of weekly earnings) reduced smoking prevalence by 0.3% among Australian adults.[42] In contrast, the World Health Organization concluded that large tax increases have been the most effective policy for reducing tobacco use.[43] In addition, studies of cigarette taxation suggest that young people may be more responsive to price changes and taxes than the adult population.[44] This is an important consideration in evaluating the potential effects of food tax or subsidy policies on children's food purchases and childhood obesity.

Food Policy Implications

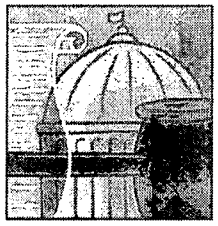
As a result of their negative effects on nutrition and their current taxation status, soft drinks offer a possible target for public health tax policies.[1,45] On average, sugar-sweetened beverages contribute 301 kcal (1260 kJ) per day per capita (13% of total daily energy values) to the diets of American adolescents.[46] Assuming no substitution of soft drinks with other caloric beverages and no change in other factors affecting purchasing behavior, our estimates of the price elasticity of soft drinks suggest that a 10% tax on soft drinks could lead to an 8% to 10% reduction in purchases of these beverages.

Small changes add up. One USDA study that estimated potential weight loss from various tax rates on salty snacks under a range of price elasticities predicted that a 10% price increase from a national sales tax could reduce body weight between 0.2 and 0.99 lb (0.1–0.5 kg) per year while generating approximately $1 billion in tax revenue.[47] State governments already target sales taxes at soft drinks and selected snack foods. As of January 2009, 33 states taxed the sale of soft drinks at an average rate of 5.2%.[48] Of importance to policymakers, recent surveys show that the public is willing to pay increased taxes if the funds generated are used to address childhood obesity.[49,50]

Although the potential public health benefits of price changes in specific food categories can be estimated, it is essential to assess changes in consumer behavior as price changes occur. For example, in the event of higher prices resulting from increased taxes, consumers could increase their caloric consumption from fruit juice to compensate for their reduction in soft drink intake, or, more positively, they might generalize the healthy changes they make to other categories of foods. It is also important to consider how governments use revenues generated by changes in economic policies such as taxes. For instance, regressive food taxes could be offset by using revenues to lower the costs of healthy foods, particularly for low-income population groups.

Such policies are under consideration. The Food, Conservation and Energy Act of 2008 (known as the "Farm Bill") authorized a $20 million pilot study examining the use of price incentives to promote consumption of fruits, vegetables, and other healthy foods among food stamp recipients.[11] On the basis of our mean price elasticities of 0.70 for fruits and 0.58 for vegetables, a 10% reduction in the price of these foods would increase purchases on average by 7.0% and 5.8%, respectively.

As such, changes in prices alone would probably not increase consumption of fruits and vegetables to the levels recommended in the Dietary Guidelines for Americans. However, price changes combined with public education campaigns and other regulations affecting the



food environment in institutional and home settings may have a multiplicative effect that could significantly improve diets, particularly among at-risk population groups. Although demand for food is relatively inelastic, the power of small price changes, especially applied to foods most responsive to such changes, should not be underestimated given that their effects accumulate across a population.

Our review had limitations. For example, we used combined estimates of price elasticity for fruits and vegetables (which were the only available estimates in many studies), and thus we may have underestimated the separate price elasticities of demand for fruits and vegetables. In addition, none of the studies included in our review were published after September 2007 (when we completed the review). Finally, our synthesis of estimates was a simplified calculation of means rather than a meta-analysis, which could not be conducted given the lack of elasticity estimate standard errors in the literature.

Conclusions

Economic shocks such as falling income in a recession or dramatic increases in energy or food prices can lead to changes in purchasing behavior that are not necessarily predicted by elasticity estimates calculated with data collected under normal market conditions. It is important to understand the effects of such economic circumstances on diet quality, particularly in low-income groups. The fear is that increasing food prices or falling incomes in a recession create pressure to purchase the foods lowest in cost, which makes processed, calorie-dense foods more attractive. Given the relative consensus in the economic community about the magnitude of food price elasticities and the observed gaps in research related to substitutions between healthy and unhealthy foods, future research should focus on predicting the impact of specific public health policies aimed at improving diets and reducing the burden of chronic disease. ■

About the Authors

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Contributors

T. Andreyeva and M. W. Long conducted the literature review and extracted, synthesized, and analyzed data. T. Andreyeva and K. D. Brownell originated the study. T. Andreyeva led the data interpretation and the writing of the article. All of the authors helped to conceptualize ideas and interpret findings and contributed to the writing and revision process.

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Human Participant Protection

No protocol approval was needed for this study.

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STATE OF NORTH CAROLINA
NORTH CAROLINA
GENERAL ASSEMBLY
STATE LEGISLATIVE
BUILDING
RALEIGH, NORTH CAROLINA
27601

April 1, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R. Purcell
Chairman, Representative Douglas Y. Yongue

SUBJECT: **Meeting Notice for Monday, April 19, 2010 at 11:00 am**

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY:	**Monday**	**TIME:**	**11:00 am**
DATE:	**April 19, 2010**		
LOCATION:	**Room 643 LOB**		

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend.

Posted:

cc:	Committee	X
	Record	
	Interested Parties	X

MINUTES

JOINT LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY

Monday, April 19, 2010
11:00 a.m.
Room 643, Legislative Office Building

The Joint Legislative Task Force on Childhood Obesity met Monday, April 19, 2010 at 11:00 a.m. in Room 643 of the Legislative Office Building. Co-Chair Representative Doug Yongue, presided. ***(SEE ATTACHMENT: Members and Guests Present.)***

Co-Chair Yongue said the work the Task Force has started was a dream come true for him; something he had been working to see for four or five years. He praised the staff for the work done in drawing together the various components demonstrated to the Task Force.

On motion of Representative Insko and second by Representative Brown the draft minutes for the February 15th meeting were approved. Then on motion of Representative Brown and second by Representative Insko the draft minutes for the February 23rd meeting were approved.

Co-Chair Yongue reiterated the charge given to the Task Force:

- Consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity.
- Encourage healthy eating and increased physical activity

The methods called for early childhood intervention, child care facilities, before and after school programs, physical education and activity, in school emphasis on higher childhood nutrition standards and nutrition education, more access for children for physical activity and any other means the group might find appropriate.

The Task Force took a comprehensive approach to the problem at hand. Over sixty five per cent of adult North Carolinians are overweight or obese. In the 10-17 age group thirty two per cent are overweight or obese. As Co-Chair Yongue noted there is no one way to solve the problem. Over the course of five Task Force meetings, 36 different presenters provided insight into a variety of parts of the problem of childhood obesity:

1. Focus on the epidemic-gather data
2. Access to nutritious foods in the community
3. Children's access to nutritious food pre-school through high school
4. Physical activity, food industry involvement etc.

Lee Dixon of the Fiscal Research Staff began the discussion of the draft Report to be presented to the May, 2010 Session: ***(SEE ATTACHMENT: Task Force on Childhood Obesity Draft)***

Recommendation 1: Expand the Supplemental Nutrition Assistance Program (SNAP) education. This is accompanied by a legislative proposal for DHHS to expand scope and draw down additional federal funds. There would be a three-year expansion plan with a feasibility study for SNAP-Ed to be under NCSU and/or NC A&T State University.

Representative Insko asked that the bill language include the reference to "soliciting SNAP-Ed proposals" as in the recommendation. Representative Grady asked why NCSU and NC A&T were involved in the bill. Mr. Dixon said that sixteen other states had their SNAP-Ed programs tied to their land grant colleges, such as the ones in this proposal. Representative Grady asked if these schools were considered to be more competent to administer the programs and if the Chancellors of the two schools had been consulted. Mr. Dixon said there had been discussion about the program, but not specifically with the Chancellors or their representatives. Representative Grady said he didn't want to vote for something that the schools knew nothing about. Representative Weiss said she appreciated Representative Grady's position, but since the language in the recommendation was "to study the feasibility" of such a transfer the matter would be discussed with all concerned. Co-Chair Yongue said the language could be changed in committee.

Representative Insko moved and Representative Brown seconded the motion to accept the recommendation, and it accompanying draft bill

Recommendation 2 Expand Capacity of Farmers Markets to Accept Electronic Bank Transfer Cards. This is also accompanied by a legislative proposal directing DHHS to solicit vendors to assist in expanding the EBT use.

This mechanism is used in other states. The bill says that $200,000 will be used from existing funds to facilitate the program. Representative Insko supported the idea with the proviso that this proposed legislation would be discussed in Committee with DHHS. Based on that, she moved acceptance and Senator Preston seconded. The recommendation and its accompanying draft bill were approved.

Recommendation 3 Improve Preschool Nutrition Standards. The accompanying legislation directs the Division of Child Development in DHHS to develop the standards.

The new rules would ban sugar-sweetened beverages in locations regulated by the Division. The facilities would serve reduced fat milk for children over two and limit juice intake to between four and six ounces each day for children over a year old. The facilities are encouraged to provide weather- permitting- out- door- play each day. Representative Weiss asked that "best practices" recommendations on physical activity be addressed. The suggestion was noted. Representative Weiss also asked that exceptions be considered in the rule-making for electrolytic drinks children might be required to drink.

(At the Direction of the Co-Chair and with no objection, Recommendation 3 was displaced to allow additional language to be added.)

Recommendation 4 State Matching Funds for the USDA School Meal Program. The draft bill directs the use of funds for food and food preparation costs alone.

Currently, the state receives $7.2 million in federal funds for the meal program, of that $5.2 million is being used by Child Nutrition Directors for administrative uses at the local level. The recommendation requires the entire amount be spent for food and food preparation. Using the entire amount in the way recommended would allow the state to draw additional funds from the federal meal program. (This additional money would allow the elimination of reduced price meals. **Recommendation 5**) The exact amount of the additional draw down of funds is not known, but any excess would also be used for meals. Representative Hughes asked the number of Child Nutrition Directors in the state. Dr. Lynn Harvey of the Department of Public Instruction said there are 115-one for each LEA. Representative Insko moved, Representative Brown seconded and the recommendation and draft bill were approved.

Recommendation 5 Reduced Price Meals. The bill appropriates $5.2 million as mentioned above to eliminate those meals. The accompanying bill seeks the appropriation.

The Task Force legislation should provide free lunches for additional children. Representative Insko moved, Representative Brown seconded, and the recommendation and draft bill were approved.

Recommendation 6 Creates Statewide Nutrition Standards. The bill draft actually updates the standards for food and beverages in public elementary, middle and high schools. *(A fiscal note on the bill is Appendix 1 in the report draft.)*

The Task Force heard testimony that the State Board of Education adopted standards as directed by law in 2006, but the time for implementation had been extended. This recommendation calls for a schedule for the implementation:

1. Elementary schools 2011-2012
2. Middle schools 2012-2013
3. High schools 2013-2014

The recommendation recognizes several organizations which have created standards to be used as guidelines and the recommendation can also track federal guidelines from the USDA when and if a new child nutrition program passes Congress. The North Carolina standards will be reviewed every three years by the State Board of Education. The standards also apply to a la carte items. Further a website will be created so that the guidelines can be monitored. The fiscal note recognizes the 5-year phasing of the

standards and a 5 cents per meal subsidy over a 2-year period would assist in the transition. Representative Insko said candy that schools sell for fund raising should be included, also school-operated snack bars. Senator Preston mentioned candy-covered popcorn. Representative Insko said she felt this was a very important part of the recommendation. Representative Weiss said the website should be used primarily as an educational tool for nutrition and the standards. Representative Insko said she did not want to eliminate birthday parties in schools.

At the direction of the Co-Chair and with no objections from the Commission Recommendation 6 was displaced while additional language was developed to accommodate the additional points raised

Recommendation 7 Indirect costs-Child Nutrition Program. The recommendation and its accompanying draft bill would have the General Assembly's Program Evaluation Division include a study of indirect costs in the nutrition programs, in the Divisions 2010 work plan.

The Task Force heard testimony that indirect costs—heat, lights, etc—of up to 5% of the revenue generated by the local nutrition may be paid to the school districts regardless of the operating balance of the child nutrition program. These costs are considered part of the cost of doing business, but may not have a relationship to the particular function or activity. The Program Evaluation Division will report to the Task Force on Childhood Obesity. Representative Weiss asked if there was some way to evaluate the capacity of the cafeterias to provide healthy meals. Mr. Dixon suggested to Representative Weiss that issue would be covered in another recommendation. At the request of Representative Grady, Co-Chair Yongue asked that members of the Commission be provided copies of information tracking the indirect cost figures.

(At the direction of the Co-Chair and with no objections from the members, Recommendation 7 was temporarily displaced.)

Recommendation 8 Farm to School The recommendation and its draft bill creates a new Farm to School position in the Department of Agriculture and outlines the duties of the new position.

The information which came to the Task Force praised the program where it is in play. The program allows locally grown fresh fruits and vegetables to be purchased by the schools. The program has been operating since 1977 and currently serves 77 schools. The position would seek to expand the program and make it more effective. The Department of Agriculture would provide an annual report on the Farm to Schools program to various legislative committees. Co-Chair Yongue said he felt expanding the program would help particularly in low-wealth counties. Representative Grady asked if the Program was currently handled as a part time position in the Department. Mr. Dixon said the program is handled now as part of the duties of one person. In further response, Mr. Dixon said staff would find out what percentage of the time the current employee spends on the

program. Representative Weiss said she was impressed with the possibilities of the program expanding and being more viable. She moved to approve and Representative Brown seconded the motion. The recommendation and its bill were approved.

Recommendation 9 Healthy School Cafeteria Program. The recommendation provides a plan to seek private money for cafeteria equipment that can prepare healthier meals.

The Task Force presentations noted that school cafeterias do not have such items as steamers to prepare healthier meals. If the Task Force is re-authorized, it will seek money from private sources such as the Golden Leaf Foundation, N. C. Health and Wellness Trust Fund etc. for $12 million to be used over a four year period to retrofit school cafeterias so healthier meals can be provided. There is no legislation for this beyond the re-authorization of the Task Force. A similar effort was used in Mississippi. Representative Grady said he was in favor of the proposal, but it made minimal impact if there was not enough money to buy the food. Mr. Dixon said the 5 cent state supplement along with a 7 cent per meal subsidy from Congress would help with food money. The Representative re-stated his disappointment about no recommendation about indirect costs and overhead and said the more money that is given, the more is taken away. Upon motion of Senator Preston and second by Representative Hughes, the recommendation was approved.

Recommendation 10 Physical Education and Activity in Schools This would require legislative action to mandate the use of evidence based fitness testing for all students K-8 by the 2011-2012 school year.

The Department of Public Instruction has a working relationship with the North Carolina Alliance for Athletics, Health, Physical Education, Recreation and Dance to provide an in-school obesity prevention program to the target years with $3.5 million in Foundation money. The money runs out in 2012. 65 LEAs and 6 charter schools are participating. This recommendation requires evidence of results. Representative Insko moved and Representative Brown seconded the motion which was approved.

Recommendation 11 Screen and Reduce BMI Levels in Children This would require DHHS to find ways to implement BMI screening for certain children and reduce BMI levels for all children. There is accompanying legislation.

There was extensive information provided the Task Force regarding the extent of obesity within all age brackets. Part of this information focused on the large number of North Carolina children who are obese and the evidence that such obesity is a precursor to more serious health conditions. The recommendation seeks to head off increases in the trend toward obesity. Representative Insko was concerned the screening could have a shaming effect on students and that the students need help with their conditions. Community Care of North Carolina will implement the program and measure results of results in BMI. Senator Preston noted that the State Health Plan will begin its weight reduction program

within two years. On motion of Representative Hughes and second by Senator Davis, the recommendation and draft bill were approved.

Recommendation 12 Encourage Children to Walk to School and Collaboration for Healthy Environments.

Sidewalks promote children walking to school and adults walking in general was part of the evidence provided to the Task Force. Evidence also showed that North Carolina cities and towns could obtain federal funds through the Safe Routes to School program to help in the effort. Collaboration between DOT and DHHS was urged to allow creation of healthy environments in the state. There is no seperate legislation involved. On motion of Representative Brown and second by Senator Davis and a positive vote the recommendation was approved.

Recommendation 13 Support for Restaurant Menu Labeling.

The problem of making nutritious food choices while dining out was presented in several ways to the Task Force. Information about the effects of federal legislation on menu labeling was also provided. The Task Force supports such labeling and no additional legislation is involved. Representative Insko moved and Co-Chair Senator Purcell seconded and the motion to approve passed.

Recommendation 14 Continue the Task Force on Childhood Obesity

The Task Force believes there is much more work to be done beyond the current termination point: May 1, 2010 or upon filing a final report. Therefore the recommendation and its draft bill would carry the Task Force forward until May 1, 2012.

Representative Weiss praised the work of the Task Force and the information presented and agreed that the work should continue. Representative Insko said she hoped there would be some way to track the progress of prevention efforts. Co-Chair Yongue referred to the efforts of the Task Force as a "prize" for him. Senator Davis moved and Representative Hughes seconded the motion to approve the recommendation, which passed.

The Task Force returned to consideration of **Recommendation 3**, Pre-school Nutrition and Physical Activity.

The draft bill was amended to include the development of physical activity standards along with the nutrition standards. Further, there was additional wording included to require DHHS to examine progress and report to the Task Force and other legislative entities, and the short title was adjusted to reflect better the changes. Representative Brown moved and Senator Davis seconded the motion to approve which carried.

Then **Recommendation 6**, Nutrition Standards was considered again.

At the request of Representative Insko, the language was added to amend to cover any items such as candy etc sold or offered on campus during the instructional day. The intent was to cover schools snack bars, the selling of candy as fund-raisers etc. This would not affect birthday parties. Representative Insko noted that the phrase "or offered to" could be deleted. However, it was determined that more specific language could be added to cover such celebrations. Representative Insko and Senator Davis seconded the motion to adopt, which passed.

Then **Recommendation 7**, which had been displaced, was brought back, moved for approval by Representative Insko and seconded by Representative Brown. That motion passed.

At the suggestion of Representative Weiss, with support of Representative Insko and both Co-Chairs, staff was asked to develop a recommendation to be made to the State Personnel Commission to seek a policy in support of state employees who are breast-feeding their infants. Representative Weiss made such a motion. The motion passed.

Co-Chair Representative Yongue told the Task Force of recent a visit he had made to the Southeast Regional Hospital which is taking the anti-obesity efforts to the staff of the hospital. He said the CEO told him that the cafeteria was changing prices on food items so that healthier foods cost less than the junk food items.

Co-Chair Senator Purcell praised the quality of the presenters and the information that was brought to the Task Force. He also praised the staff for their work. He said the work should have a positive impact on the health of the people of North Carolina.

The meeting adjourned at 12:32 p.m.

Representative Doug Yongue, Co-Chair
Presiding

Katie Stanley, Commission Clerk

Senator William Purcell, Co-Chair

Minutes by Ted Harrison

VISITOR REGISTRATION SHEET

Task Force on Juvenile Obesity — 4/19/10

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
A-White	DHHS/DPH/HDSP
Rebecca Reeve	DHHS/NC Healthy Schools
Betsy Weber	American Heart Assn.
JUDY MARTINO	NCAAHPERD
Nathan Acosta	NCAAHPERD
Ron Morrow	NCAAHPERD
Nick Dean	NCAAHPERD
Paula Hudson Collins	SBE/DPI
Laurie Stradley	Be Active NC
Laura Aiken	WakeMed
Kaye Webb	The Links, Inc.

VISITOR REGISTRATION SHEET

Task force on Juvenile Obesity — 4/19/10

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Gardner	NC Dept. of Public Inst.
Margaret Stacy	Covenant w/NC's Children
Alice Lewis	DHHS - DPH
LYNN HARVEY	DPI - Child Nutr Svcs
Janet Johnson	DPI - Child Nutr. Svcs
Alissa Willett	NCACC
Kari Leonard	NCACC
John Dervin	Gov's Office
Jamie Cousins	DHHS - DPH
Ben Matthews	NCDPI
Dean Simpson	DHHS

NAME	AGENT
Peg O'Connell	NCAHI (AH 4 Health)

VISITOR REGISTRATION SHEET

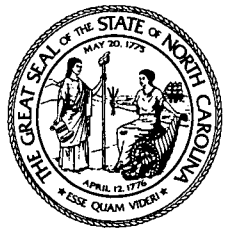
Task Force on Juvenile Obesity — 4/19/10

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cindy Marion	School Nutrition Assoc
Cynthia Sevier	School Nutrition Assoc.
Wendy Kelly	Policy Group
Gene Causby	S+S NC
W. Dan Gill	Personal Interest
Amy McConkey	NC Beverage Assn
Brock Gunnells	" "
Hardy Ellen	NC Retail
Susan Harrison	WCPSS
Brad A. Salmon	Campbell Law
Tony S. J	Campbell Law

Name	Organization
Pam Seamans	NC Alliance for Health
Greg Griggs	NC Academy of Family Physicians
Jimmy Newkirk	NC Div. of Public Health
Kristie Thompson	Eat Smart Move More NC
Cathy Thomas	NC Division of Public Health
Carolyn Dunn	NC Cooperative Extension
ALICE AMMERMAN	UNC- CHAPEL HILL NUTRITION DEPT
Leanne Winner	NCSBA
Maria Spaulding	DHHS
Joanne Stevens	school nursing



Legislative Task Force on Childhood Obesity (2009)

SENATE APPOINTMENTS	Telephone / Office
• Sen. William Purcell, MD (Co-Chair)	733-5953 / 625 LOB
• Sen. Charlie Dannelly	733-5955 / 2010 LB
• Sen. Donald Davis	733-5621 / 525 LOB
• Sen. Jean Preston	733-5706 / 1121 LB
• Sen. Jerry W. Tillman	733-5870 / 628 LOB
• Sen. Michael Walters	733-5651 / 2108 LB

HOUSE APPOINTMENTS	
• Rep. Douglas Yongue, (Co-Chair)	733-5821 / 2207 LB
• Rep. Larry Brown	733-5607 / 609 LOB
• Rep. Bob England, MD	733-5749 / 303 LOB
• Rep. Robert Grady	715-9644 / 302 LOB
• Rep. Sandra Spaulding Hughes	733-5754 / 537 LOB
• Rep. Jennifer Weiss	715-3010 / 532 LOB
• Rep. Verla Insko (Advisory Member)	733-7208 / 307 B1 LOB

Task Force on Childhood Obesity
AGENDA
Monday, April 19, 2010
11:00 am
Room 643, Legislative Office Building

I. Introduction
Senator Purcell, Co-Chair
Representative Yongue, Co-Chair

II. Final Report and Recommendations

NORTH CAROLINA GENERAL ASSEMBLY

TASK FORCE ON CHILDHOOD OBESITY

REPORT TO THE 2010
REGULAR SESSION
OF THE 2009
GENERAL ASSEMBLY

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STATE OF NORTH CAROLINA

TASK FORCE ON CHILDHOOD OBESITY

April 19, 2010

TO THE MEMBERS OF THE 2010 REGULAR SESSION OF THE 2009 GENERAL ASSEMBLY:

Attached for your consideration is the report to the 2010 Regular Session of the 2009 General Assembly. This report was prepared by the Task Force on Childhood Obesity pursuant to Session Law 2009-574, Part XLIX of the 2009 General Assembly.

Respectfully submitted,

Senator William Purcell
Cochair

Representative Douglas Yongue
Cochair

TASK FORCE MEMBERSHIP

Legislative Task Force on Childhood Obesity

SENATE APPOINTMENTS	Telephone / Office
• Sen. William Purcell, MD (Co-Chair)	733-5953 / 625 LOB
• Sen. Charlie Dannelly	733-5955 / 2010 LB
• Sen. Donald Davis	733-5621 / 525 LOB
• Sen. Jean Preston	733-5706 / 1121 LB
• Sen. Jerry W. Tillman	733-5870 / 628 LOB
• Sen. Michael Walters	733-5651 / 2108 LB
• Sen. Bob Atwater (Advisory Member)	715-3036 / 312A LOB

HOUSE APPOINTMENTS	
• Rep. Douglas Yongue, (Co-Chair)	733-5821 / 2207 LB
• Rep. Larry Brown	733-5607 / 609 LOB
• Rep. Bob England, MD	733-5749 / 303 LOB
• Rep. Robert Grady	715-9644 / 302 LOB
• Rep. Sandra Spaulding Hughes	733-5754 / 537 LOB
• Rep. Jennifer Weiss	715-3010 / 532 LOB
• Rep. Verla Insko (Advisory Member)	733-7208 / 307 B1 LOB

AUTHORIZING LEGISLATION

S.L. 2009-574, Part XLIX

SECTION 49.1. There is created the Legislative Task Force on Childhood Obesity.

SECTION 49.2. The Task Force shall consist of 12 members as follows:

(1) Six members of the House of Representatives.

(2) Six members of the Senate.

SECTION 49.3. The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Vacancies on the Task Force shall be filled by the same appointing authority that made the initial appointment. A quorum of the Task Force shall be a majority of its members.

SECTION 49.4. The Task Force shall include, but should not be limited to, study of issues relating to childhood obesity. In the course of the study, the Task Force shall consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity and encouraging healthy eating and increased physical activity among children through:

(1) Early childhood intervention;

(2) Childcare facilities;

(3) Before and after-school programs;

(4) Physical education and physical activity in schools;

(5) Higher nutrition standards in schools;

(6) Comprehensive nutrition education in schools;

(7) Increased access to recreational activities for children;

(8) Community initiatives and public awareness; and

(9) Other means.

SECTION 49.5. The Task Force shall encourage input from public nonprofit organizations, promoting healthy lifestyles for children, addressing the problems related to childhood obesity, encouraging healthy eating, and increasing physical activity among children.

SECTION 49.6. Members of the Task Force shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Task Force, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Task Force may meet at anytime upon the joint call of the cochairs. The Task Force may meet in the Legislative Building or the Legislative Office Building.

With approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Task Force in its work. The House of Representatives' and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Task Force, and the expenses relating to the clerical employees shall be borne by the Task Force. The Task Force may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02. If the Task Force hires a consultant, the consultant shall not be a State employee or a person currently under contract with the State to provide services.

All State departments and agencies and local governments and their subdivisions shall furnish the Task Force with any information in their possession or available to them.

SECTION 49.7. The Task Force shall submit a final report of the results of its study and its recommendations to the 2010 Regular Session of the 2009 General Assembly. The Task Force shall terminate on May 1, 2010, or upon the filing of its final report, whichever occurs first.

TASK FORCE PROCEEDINGS

The Task Force on Childhood Obesity met 6 times from January 26, 2010 until April 19, 2010.

January 26, 2010

Childhood Obesity Epidemic: Impact on Schools
June Atkinson, State Superintendent

Childhood Obesity Epidemic: Impact on the Health System
Maria Spaulding, Deputy Secretary, DHHS

Childhood Obesity Epidemic: Impact on the Health of Children
Jeffrey Engel, NC State Health Director

Childhood Obesity Epidemic: Impact on the State's Economy
David Chenoweth, Worksite Health Promotion Director
Department of Health Education and Promotion, ECU

NC Obesity Prevention Funders Alliance
Jennifer MacDougall, Blue Cross Blue Shield of NC Foundation
Meka Sales, Duke Endowment

February 2, 2010

Alice Ammerman, Ph.D. Director, Center for Health Promotion and Disease Prevention
University of North Carolina

Sue Foerester, Chief, Network for a Healthy California – Webinar

Nancy Creamer, Ph.D. Professor, Department of Horticultural Science
North Carolina State University

Daniel Rodriguez, Director, Carolina Transportation Program, University of North Carolina

Carolyn Dunn, Professor and Nutrition Specialist, North Carolina State University

Jimmy Newkirk, Manager, Physical Activity and Nutrition Branch, Division of Public Health

Emily Jackson, Appalachian Sustainable Food Project

Gary Gay, Director, Food Distribution Division, Department of Agriculture

February 11, 2010

Dr. Sara Benjamin, Assistant Professor, Department of Community and Family Medicine
Duke University Medical Center

Jessica Donze Black, National Director, Healthy Schools Program
Alliance for a Healthier Generation

Dr. Lynn Hoggard Harvey, Section Chief, Child Nutrition Services
Division of School Support, NC Department of Public Instruction

Philip Price, Chief Financial Officer, NC Department of Public Instruction

Alice Lenihan, Director, Nutrition Services, NC Department of Health and Human Services

Margaret Samuels, Executive Director, Orange County Partnership for Young Children

Cindy Marion, Director, Child Nutrition Services, Stokes County
Co-Chair, Public Policy Committee, School Nutrition Association of NC

Cynthia Sevier, Director, Child Nutrition Services, Guilford County
Co-Chair, Public Policy Committee, School Nutrition Association of NC

Deborah Carpenter, Director, Child Nutrition Services, Hoke County
President, School Nutrition Association of NC

February 15, 2010

Paula Card-Higginson, Deputy Director, Center on Childhood Obesity
Robert Wood Johnson Foundation

Philip Bors, MPH, Project Officer, Active Living By Design & Healthy Kids
Healthy Communities, NC Institute for Public Health

Dr. Kelly Evenson, PhD, Research Associate Professor
Gillings School of Global Public Health, University of North Carolina

Dr. Elizabeth Tilson, MD, MPH, Medical Director
Community Care of Wake and Johnston Counties

David Gardner, Section Chief, Healthy Schools, NC Department of Public Instruction

Tim Hardison, Program Director
Moving Adolescents with Technology to Choose Health (MATCH)

Dr. Suzanne Lazorick, MD, Brody School of Medicine, East Carolina University

Col. Kevin Shwedo, Deputy Commanding Officer
United States Army, Basic Combat Training Center, Center of Excellence

February 23, 2010

Kelly Johnston, Vice President - Government Affairs, Campbell's Soup Company

Butch Gunnells, President, North Carolina Beverage Association

Susan Havala Hobbs, Clinical Associate Professor
Director, Doctoral Program in Health Leadership, UNC School of Public Health

Hank Cardello, Chair, Global Obesity Business Forum, UNC Chapel Hill

Roberta Friedman, Director of Policy, Rudd Center, Yale University

SUMMARY OF TASK FORCE PROCEEDINGS

The Task Force heard from the individuals listed below during the specified meeting dates.

January 26, 2010

- June Atkinson, North Carolina Superintendent of Public Instruction, gave an overview of the impact of childhood obesity on North Carolina's local school administrative units (LEAs) and provided information on the Department of Public Instruction's (DPI) efforts to address the issues of childhood obesity.
- Paula Collins, Chief Health Officer, DPI, and Lynn Harvey, Director of Child Nutrition, DPI, presented information about the Child Nutrition Program, including the funding of this program, the nutrition standards that the State Board of Education has developed, and the State's Healthy Active Children policy. Collins and Harvey also provided information about the many efforts underway in North Carolina for obesity prevention and reduction of obesity related diseases.
- Maria Spaulding, Deputy Secretary, Department of Health and Human Services (DHHS), gave an overview of the impact of obesity on North Carolina's health care system and provided information on DHHS's efforts to address the issues of obesity. Spaulding spoke about the direct medical costs for obesity and the cost to employers, as well as highlighting various DHHS efforts to reduce and prevent obesity including Eat Smart, Move More NC and interagency collaboration.
- Dr. Jeffrey Engel, MD, State Health Director, North Carolina Division of Public Health, spoke to the Task Force about the impact of obesity on the health of children and adults in North Carolina. Dr. Engel presented data that showed a growing nationwide trend in obesity beginning in 1985 and indicated that no state has experienced a decrease in obesity for 16 years. In North Carolina 65.7% of adults are overweight or obese, above the national average, and 32.8% of North Carolina children ages 10-17 were overweight or obese in 2008. Dr. Engel provided information on the adverse health consequences due to obesity such as diabetes, heart disease, high blood pressure, and kidney disease and failure.
- David Chenoweth, PhD, Worksite Health Promotion Director, Department of Health Education and Promotion, East Carolina University and President, Chenowith & Associates, Inc., presented information about the economic cost and implications of childhood obesity for North Carolina. He presented data from *Tipping the Scales: How obesity and unhealthy lifestyles have become a weighty problem for the North Carolina economy,* a 2008 report from BeActive North Carolina, Inc. The data indicated that physical inactivity, excess weight, type II diabetes, and low fruit and vegetable intake cost North Carolina billions of dollars per year.
- Jennifer MacDougall, Blue Cross Blue Shield of North Carolina Foundation, and Meka Sales, Duke Endowment, gave an overview of the North Carolina Obesity

Prevention Funders Alliance. The Alliance works to improve the health of children and their families by addressing the obesity epidemic.

February 2, 2010

- Dr. Alice Ammerman, Director of the Center for Health Promotion and Disease Prevention, UNC-Chapel Hill, spoke about a community based approach to dealing with childhood obesity. Dr. Ammerman reviewed a socio-ecological model of community change and suggested policy approaches that could be successful during difficult economic conditions, including protecting successful existing programs, using "stealth help" to change policies to promote healthier, more active lifestyles, leveraging available federal money for nutrition programs, and raising funds through excise taxes on soft drinks.

- Dr. Nancy Creamer, Professor, Department of Horticulture Science, NCSU, spoke about cultivating thriving communities and sustainable farms, and the work of the Center for Environmental Farm Systems. Dr. Creamer stated that the Center, which seeks to promote environmentally friendly farms that will provide economic opportunities for both rural and urban North Carolina, will release an action plan in March, part of which is geared toward obesity. Dr. Creamer also spoke about Farm to School programs across the country, as well as increasing locally grown food access through community gardens, urban farms, farmers markets, supermarkets and corner stores.

- Sue Foerester, Chief of the Network for a Healthy California, spoke by teleconference from California regarding information about that state's SNAP-Ed (Supplemental Nutrition Assistance Program Education) program. She was joined in the teleconference by fellow staff members Roseanne Stephenson, Chief of Operations, Valerie Quinn, head of Regional Operations, and Alicia Ghirardelli. Ms. Foerester identified the target population and Ms. Stephenson explained the funding sources for the program. Ms. Quinn spoke about the regional approach used by the program to reach partners for collaboration.

- Dr. Daniel Rodriguez, Director of the Carolina Transportation Program, UNC-CH, spoke about linking the built environment and health, and the importance of physical activity to reduce the problems of obesity. Dr. Rodriguez presented information on trends showing declines in physical activity and suggested that changes in local infrastructure, such as off-road trails, greenways, bikeways, and sidewalks could increase physical activities such as walking and cycling. Dr. Rodriguez concluded with policy recommendations for state and local entities to create an environment that encourages physical activity.

- Dr. Carolyn Dunn, Chair, Eat Smart, Move More Leadership Team, and Professor and Nutrition Specialist, NCSU, spoke about the work of Eat Smart, Move More North Carolina. Dr. Dunn spoke about factors which have contributed to the rise in childhood obesity and the need to create a series of policies involving nutrition and physical activity rather than seek a silver bullet approach. Dr. Dunn recommended the Centers for Disease Control community strategies and measures concerning obesity as an evidence base for obesity prevention measures.

- Jimmy Newkirk, Physical Activity and Nutrition Branch, NC Division of Public Health, provided information on the Eat Smart, Move More Community Grants awarded over the last decade. Mr. Newkirk also spoke about the grants awarded for the Childhood Obesity Prevention Demonstration Projects in 2008-2009 and the outcomes from those grants.

- Emily Jackson, Program Director – Growing Minds, Appalachian Sustainable Food Project and National Farm to School Network, provided information about the mission of both the Appalachian Sustainable Food Project and National Farm to School Network. Ms. Jackson spoke about the advantages of buying locally grown food and importance of exposure of children to the process of growing food. Ms. Jackson recommended steps for the Task Force to encourage Farm to School Programs and locally grown foods.

- Gary Gay, Director, Food Distribution Division, NC Department of Agriculture, gave the background and aims of the Farm to School Program in North Carolina, and provided information about the program's operation and participation by local school nutrition programs.

February 11, 2010

- Dr. Sara Benjamin, Department of Community and Family Medicine and Global Health Institute, Duke University Medical Center, discussed issues surrounding diet and physical activity of children in child care. Dr. Benjamin shared 10 model child care policies for healthy eating and 10 for physical activity, and provided information on the Nutrition and Physical Activity Self Assessment for Children Project which aims to increase consumption of fruits and vegetables and physical activity.

- Jessica Donze Black, National Director, Healthy Schools Program, Alliance for a Healthier Generation, presented information on the Healthy Schools Program that operates in 30 states including North Carolina. Ms. Black pointed out that research indicates good nutrition is linked to improved student behavior, lower absenteeism and reduced tardiness; eating breakfast at school is linked to greater test scores and math grades; and physical fitness levels predict better math performance and lower anxiety and stress levels. Ms. Black also presented information on the percentage of schools restricting the sale of less nutritious foods.

- Dr. Lynn Hoggard Harvey, Section Chief, Child Nutrition Services, Division of School Support, NC Department of Public Instruction, presented information on school nutrition programs. North Carolina has the 8th largest program in the nation, serves 1.8 million meals each day, and is available to all students. The Child Nutrition program is governed by federal regulations, 50% of NC students qualify for free or reduced price meals, and NC has the fifth fattest student body in the nation. From 1990-2003, the a la carte program experienced growth due to the profits made by the school and the increased appetite/demand for the items offered. Dr. Harvey pointed out that NC piloted the "Healthful School Food Choices Pilot Program" and found that food and production costs were higher, schools were not adequately equipped, districts lost 15 times the amount that was appropriated for the pilot in less than 5 months due to decreased a la carte sales, and that the anticipated

cost of implementing nutrition standards in elementary schools is $20 million each year. Additional information provided by Dr. Harvey included the following: federal reimbursement does not cover the cost of preparing/serving the meal; there is a diminished profit margin for more healthful foods; breakfast and lunch participation decrease from elementary to high school; local board approved meal charge policies deny meals to students who do not have money in some NC school districts; and foods and beverages that are sold in competition with the Child Nutrition program erode the nutritional, operational, and financial integrity of the school meal program. Dr. Harvey offered six suggestions to solve the problems faced by the child nutrition program including: increased focus on the program, increased focus on offering affordable and nutritious meals, adequate funding, and requiring that food and beverage offerings be based on student health and well-being and not on profits.

- Philip Price, Chief Financial Officer, NC Department of Public Instruction, presented information on indirect costs which represent the expenses of doing business that are necessary for the general operation of the organization and not readily identified with a particular funding source or activity. Mr. Price described indirect cost rates, how they are determined, and the two types: restricted and nonrestricted. Indirect costs go to the Department of Public Instruction and local education agencies. For FY 2007-2008, collected indirect costs from the child nutrition program were $31,416,316.99 and for FY 2008-09, they were $27,763,310.16.

- Alice Lenihan, Director, Nutrition Services, NC Department of Health and Human Services, presented information on the origins and influences on childhood obesity, the Federal Nutrition Assistance Program, and opportunities for improvement. She pointed out that opportunities for improvement include breastfeeding promotion and protection, improving nutrition in schools and child care, and local wellness plans.

- Margaret Samuels, Executive Director, Orange County Partnership for Young Children, provided information on efforts to combat obesity which included community gardens and physical activity programs.

- The following three individuals spoke on behalf of the School Nutrition Association of NC: Cindy Marion, Director, Child Nutrition Services, Stokes County, Cynthia Sevier, Director, Child Nutrition Services, Guilford County, and Deborah Carpenter, Director Child Nutrition Services, Hoke County. Revenues generated by Child Nutrition Programs are divided as follows: 45.5% labor and benefits, 43.6% food and supplies, 6% direct costs, 5% indirect costs. Currently 68 of 115 Child Nutrition Programs operate in the red financially.

- Paula Card-Higginson, Deputy Director of the Robert Wood Johnson Foundation, Center to Prevent Childhood Obesity, spoke about national trends in childhood obesity and presented information about specific state efforts to address childhood obesity. Ms. Card-Higginson provided information about legislation in Arkansas, the 2003 Child and Adolescent Obesity Initiative, and its impacts. Ms. Card-Higginson also spoke about the goals of the Robert Wood Johnson Foundation for reducing childhood obesity, and policy priorities at the federal, state, and local levels.

- Philip Bors, Project Officer, Active Living by Design & Healthy Kids, Healthy Communities, NC Institute for Public Health, and Dr. Kelly Evenson, Research Associate Professor, NC Institute for Public Health, spoke about physical activity and the built environment. They recommended increasing safe opportunities for active travel through means such as creating more walkable destinations, safer routes to and from schools, and safer routes in the community for walking and biking. They also recommended creating and maintaining parks, open spaces, mountain trails and greenways, and increasing safe opportunities for play and physical activity through shared uses of schools after hours and on weekends.

- Dr. Elizabeth Tilson, Medical Director, Community Care of Wake and Johnston Counties, provided information on Community Care of North Carolina (CCNC), its primary goals, and key program areas. Dr. Tilson spoke about the CCNC Childhood Obesity Initiatives that four networks have participated in since 2008. Dr. Tilson discussed the goals and results of the Initiatives, including clinical tools, co-located nutritionists, community links, case management, and fostering advocacy with other groups.

- David Gardner, Section Chief, Healthy Schools, NC Department of Public Instruction, spoke about the NC Healthy Schools program. Mr. Gardner discussed the Healthful Living Standard Course of Study for all grades, and provided specific information about the course of study for Physical Education and Health Education in elementary, middle, and high schools. Mr. Gardner spoke about the Healthy Active Children Policy of the State Board of Education and presented highlights from the report on implementation of that policy. Mr. Gardner also spoke about data collection, including the In-School Prevention of Disease (IsPod) program.

- Mr. Tim Hardison, Program Director, Moving Adolescents with Technology to Choose Health (MATCH), and Dr. Suzanne Lazorick, Brody School of Medicine, East Carolina University, spoke about the MATCH program, a seventh grade cross-curricular wellness instruction pilot. Mr. Hardison explained that MATCH was a behavior modification program which used incentive-based rewards based on personal goals, and was aligned with the NC Standard Course of Study and other national standards. Dr. Lazorick discussed the program evaluation and outcomes, and initial finding that the program appeared effective for obesity prevention and intervention with overweight students.

- Col. Kevin Shwedo, Deputy Commanding Officer, U.S. Army, Basic Combat Center, Center of Excellence, spoke about the impact of the increase in overweight/obesity rates and lack of fitness on military service. Col. Shwedo

discussed how this problem has created issues for military service by shrinking the pool of qualified individuals, reducing abilities to perform required tasks, increasing health care costs, causing more injuries, creating a higher risk of attaining related diseases, and increasing attrition. He spoke about specific Army strategies to address issues of fitness and obesity.

February 23, 2010

- Kelly Johnston, Vice President for Governmental Affairs for the Campbell Soup Company, reported on the progress and developments of the Children's Food and Beverage Advertising Initiative (CFBAI), a group of 16 food manufacturers that have joined together to support the efforts of parents and schools in solving childhood obesity by shifting the mix of food products advertised primarily to children 12 and under to more nutrient dense products with fewer calories and lower fats, sodium and sugars. Mr. Johnston reported on the transition to science-based nutrition standards that guide CFBAI participants on what food products to advertise and provided information and specific examples about the reformulation, creation or enhancement of at least 130 food products. Next, he reviewed CFBAI's future goals, including stronger advertising commitments from members, expansion of the nutrition standards for child-directed advertising to more venues such as digital and mobile media, a review of relevant authoritative nutrition science developments, and a redefinition of "child-directed" advertising. Mr. Johnston concluded by discussing the $4.1 million awarded by the Centers for Disease Control to New Jersey from 2008-2013 for its "Shaping NJ" initiative which is focused on policy and environmental changes to make the healthy choice the easy choice.

- Butch Gunnells, President of the North Carolina Beverage Association (NCBA), reported on the beverage industry's efforts to improve the beverage mix in public schools, reduce total calorie content in school beverages, and control beverage advertising directed at children. He noted NCBA's voluntary efforts to change school vending machine beverages and its unprecedented support of legislation passed in 2005 establishing statewide standards for vending machine beverages and snack foods sold in public schools. Then he reviewed the specific elementary, middle, and high school beverage standards and guidelines, which have successfully reduced the total amount of calories in school beverages and reduced the shipments of full calorie soft drinks to high schools. Mr. Gunnells reported that the results of a three-year audit of agreements between local education agencies and bottlers to implement these guidelines is due in March and should show substantial compliance. He concluded by emphasizing the "Let's Move" Campaign initiated by First Lady Michelle Obama and the NCBA's involvement in implementing the "Clear on Calories" initiative regarding product labels and vending and fountain machine displays.

- Suzanne Hobbs, Clinical Associate Professor and Director of the Doctoral Program in Program Leadership at UNC-Chapel Hill, who is also a registered dietician and columnist for the News & Observer, spoke from the perspective of a consumer advocate. Her presentation focused on the Institute of Medicine's recommendations for improving school lunches and she encouraged North Carolina to implement the

recommendations now rather than waiting for the federal government to adopt them in the form of regulations over the next three to five years. The recommendations include an increase in fruits and vegetables, substituting whole grains for half grains, requiring low or no fat milk and trans fat-free products, limiting sodium, and establishing a maximum calorie target. Next, she reviewed a national school food report card chart for 2007 which graded North Carolina a "D." Her suggestions for improving the State's report card focused on improved wellness policies, nutritional standards for foods available in schools and school fundraisers, mandatory menu labeling in restaurants, stronger marketing policies to limit junk-food advertising in school settings, and increases in soft drink taxes to generate revenues to fund programs addressing childhood obesity.

- Hank Cardello, Chair of the Global Obesity Business Forum at UNC-Chapel Hill, reviewed the work of the Task Force on Childhood Obesity and its examination of how the competing interests of the food and beverage industry, health advocates, and consumers is derailing the effort to solve the problem of obesity. He discussed the difficulty in changing consumer behavior and reviewed some industry initiatives to change consumer behavior and improve healthful eating, such as: portion-controlled packaging, special restaurant products for children's meals, reduced-sugar cereal initiatives, modifications to school vending machine programs, and limited advertising to children under age 12. Mr. Cardello also presented several public sector initiatives regarding healthy schools, increased physical activity, better availability of healthy foods in low-income areas, and legislation to mandate menu labeling, ban trans fats, and impose a soda tax. He emphasized that the overall focus must be on getting the industry, health advocates, and consumers to become invested in reducing calories.

- Roberta Friedman, Director of Public Policy for the Rudd Center for Food Policy and Obesity, Yale University, presented the Task Force with research done by the Center and others to make healthy eating and good nutrition the default, easy choice for school-aged children by implementing the following 5 policy recommendations: (1) Ban all advertising on school campuses; (2) ban all food and beverage ads; (3) ban ads for products not allowed for sale on campus; (4) ban sales of non-nutritional products; and (5) require exclusive contracts to disallow sales and ads. Ms. Friedman expressed the Center's support of a tax on all beverages with sugar based sweeteners, and not just soft drinks, in order to reduce consumption and generate tax revenues for obesity prevention. She also noted that the Center agrees with other research suggesting that schools are not healthy environments, and recommended that North Carolina pursue menu labeling to make caloric information available at drive thru lanes and other nutrition information available on restaurant premises, along with an anchor statement about the recommended daily caloric intake for an average adult.

FINDINGS AND RECOMMENDATIONS

Recommendation 1: Expand and Enhance Supplemental Nutrition Assistance Program (SNAP) Education

The Task Force finds, as presented by Alice Ammerman, UNC Center for Health Promotion and Disease Prevention, that one way to increase support for obesity programs is by leveraging federal money in such programs as SNAP, the new name for the federal Food Stamp Program.

The Task Force also finds, as presented by Susan Foerster, Network for a Healthy California, that a SNAP-Ed program based on the following objectives has been successful in California: maximize impact by maintaining a strong infrastructure, grow the movement through regional collaboratives, and reach consumers through regionally delivered social marketing.

The Task Force recommends that the Department of Health and Human Services (DHHS) immediately seek the technical assistance available from the United States Department of Agriculture (USDA) and other states to make North Carolina's SNAP-Ed program the model for the South.

The Task Force recommends that the General Assembly enact legislation to direct the Department of Health and Human Services to do all of the following:

- Expand the definition and use of in-kind resources to draw down additional federal funds to expand the SNAP-Ed program in North Carolina;
- Develop a three-year plan to expand and enhance the SNAP-Ed program;
- Solicit SNAP-Ed proposals beginning in October 2010 for submission and funding of new local and state programs in April 2011. The proposals should be solicited from across the State and should emphasize social marketing techniques;
- Study the feasibility of placing the responsibility for the SNAP-Ed program at North Carolina State University and/or North Carolina A&T State University, the land grant institutions; and
- Report to the Legislative Task Force on Childhood Obesity by September 1, 2011.

(Legislative Proposal I)

Recommendation 2: Expand the Capacity of Farmers Markets to Accept Electronic Bank Transfer (EBT) Cards

The Task Force finds, as presented by both Susan Foerster, Network for a Healthy California, and Emily Jackson, Appalachian Sustainable Food Project, that an effective way to provide access to healthy, fresh, and affordable foods is to enable farmers markets to process Electronic Bank Transfer (EBT) cards.

The Task Force finds, as presented by Nancy Creamer, NCSU Department of Horticultural Science, that 12 counties in North Carolina are equipped to process EBT cards at farmers markets.

The Task Force recommends that the General Assembly enact legislation to direct the Department of Health and Human Services to seek proposals from qualified vendors to facilitate North Carolina's farmers markets ability to accept EBT cards.
(Legislative Proposal II)

Recommendation 3: Preschool Nutrition and Physical Activity
The Task Force finds, as presented by Sara Benjamin, Duke University Medical Center's Department of Community and Family Medicine, that nearly three-fourths of children ages two to six years are in some form of child care. There is evidence to suggest that child care attendance does contribute to childhood obesity.

The Task Force recommends that the General Assembly enact legislation to direct the Division of Child Development to work with the Child Care Commission to include in the Child Care Rules all of the following:

- Sugar sweetened beverages shall not be served at Child Care Centers or Homes regulated by the Division of Child Development;
- Reduced fat milk (skim or 1%) shall be served to children older than two years of age at Child Care Centers or Homes regulated by the Division of Child Development; and
- Juice shall be limited to a total of four to six ounces per day for children over one year of age at Child Care Centers or Homes regulated by the Division of Child Development.

(Legislative Proposal III)

The Task Force finds, as presented by Alice Lenihan, NC Department of Health and Human Services, that the United States Department of Agriculture's Child and Adult Care Food Program (CACFP) provides meals and snacks to children and adults. The CACFP requirements are food based, not nutrient based, and are not required to meet Dietary Guidelines for Americans or to be updated regularly.

The Task Force strongly encourages the Division of Child Development and the Division of Public Health to work together to ensure that the regulations governing Child Care and the regulations governing CACFP are not in conflict and support the goal of significantly enhancing the nutrition standards governing facilities serving children.

Recommendation 4: State Matching Funds for United States Department of Agriculture (USDA) Reimbursable School Meal Program
The Task Force finds, as presented by Philip Price, NC Department of Public Instruction, that the amount of the State match to draw down federal funds is $7.2 million dollars. Currently, $5.2 million of this amount is used to fund Child Nutrition Directors at the local level.

The Task Force recommends that the entire $7.2 million be spent on food and food preparation costs in the Child Nutrition Program rather than for Child Nutrition Directors.
(Legislative Proposal IV)

Recommendation 5: Reduced Price Meals

The Task Force finds, as presented by Cindy Marion, Cynthia Sevier, and Deborah Carpenter, School Nutrition Association of North Carolina, that eliminating the reduced price meal category for school lunches would make free lunches available to a substantial number of additional children.

The Task Force recommends that the General Assembly appropriate $5.2 million to eliminate reduced-price meals.

(Legislative Proposal V)

Recommendation 6: Statewide Nutrition Standards

The Task Force finds, as presented by Dr. Lynn Harvey, Section Chief, Child Nutrition Services, NC Department of Public Instruction, that the State Board of Education adopted minimum nutrition standards as directed by law in 2006 for school meals, a la carte foods and beverages, and items served in the After School Snack Program, based on the federal Dietary Guidelines for Americans, but that time for implementation of these standards in schools has been extended.

The Task Force finds, as presented by Dr. Harvey, that the Healthful School Food Choices Pilot Program conducted during the 2004-2005 school year demonstrated that there were higher food and production costs for schools implementing higher nutrition standards.

The Task Force further finds that Dr. Harvey explained that competitive foods, foods that are sold or offered to students in competition with the Child Nutrition Program, erode the nutritional, operational, and financial integrity of the school meals program.

The Task Force recommends that the General Assembly enact legislation to require the following:

1. The State Board of Education shall review and revise current minimum nutrition standards to meet recognized national standards, such as those adopted by the Alliance for Healthier Generation and the National Academy of Sciences Institute of Medicine, for elementary, middle and high schools.
2. The revised minimum nutrition standards shall be implemented in elementary schools by 2011-2012, in middle schools by 2012-2013, and in high schools by 2013-2014.
3. Every three years, the State Board of Education shall review and update as necessary the minimum nutrition standards to align with nationally recognized standards. The State Board of Education shall also review and update standards as needed to align with changes to federal law or the Dietary Guidelines for Americans.
4. The minimum nutrition standards for school meals, a la carte foods and beverages, and items served in the After School Snack Program shall also be applied to competitive foods.
5. A public website shall be created for concerned parents, students, teachers, and citizens to report possible inconsistencies in the implementation of the statewide nutrition guidelines.

(Legislative Proposal VI)

The Task Force recommends that funding to enable implementation of the minimum nutrition standards be provided beginning in 2011 to child nutrition programs in the form of a five cent per meal supplement over the first two years of implementation for elementary, middle and high schools, respectively, to offset higher costs of implementation and potential short-term decreases in revenue.
(See Appendix I)

The Task Force recommends that an evaluation be conducted by the Program Evaluation Division of the North Carolina General Assembly at the conclusion of the 2012-13 school year regarding the implementation of the statewide standards in elementary schools and the use of the 5-cent supplement to purchase foods that meet the standard, and similar evaluations of implementation at the middle school level in 2013-2014, and the high school level in 2014-2015.

The Task Force encourages organizations concerned with healthy eating in North Carolina, such as Eat Smart Move More NC, the NC Health and Wellness Trust Fund, NC Prevention Partners, NC Alliance on Obesity, Healthy Carolinians, and local Parent-Teacher Associations and Wellness Committees, to incorporate into their ongoing social marketing campaigns activities to inform citizens across the state of the new statewide minimum child nutrition standards.

Recommendation 7: Indirect Cost—School Nutrition Programs
The Task Force finds, as presented by Cindy Marion, Deborah Carpenter, and Cynthia Sevier, with the School Nutrition Association of NC, that indirect costs of up to five percent (5%) of revenue generated by local child nutrition programs may be paid to school districts, and that these costs may be assessed regardless of the operation balance held by local child nutrition programs. As explained by Phillip Price, Associate State Superintendent for Financial and Business Services with the NC Department of Public Instruction (DPI), indirect costs are expenses of doing business that are not readily identified with a particular grant, contract, project function or activity, but are necessary for the general operation of the organization and the conduct of activities it performs. Mr. Price explained that DPI has been delegated the authority to approve indirect cost rates for local school administrative units (LEAs) based on a federally approved formula.

The Task Force finds that the School Nutrition Association of NC has requested that a statewide policy be adopted requiring that indirect costs cannot be assessed by an LEA from a child nutrition program until that program has achieved and sustained a three months operation balance. The Task Force finds that additional study of this issue is needed.

The Task Force recommends that the General Assembly enact legislation directing the Program Evaluation Division to include in their annual work plan for 2010 a study of the operation of the Child Nutrition Program, specifically the guidelines for assessing indirect cost rates for local child nutrition programs in LEAs and the financial impact for LEAs and child nutrition programs of a policy requiring that indirect costs cannot be assessed by an LEA from a child nutrition program until that program has achieved and sustained a three months operation balance. The Program Evaluation Division shall report to the Task Force on Childhood Obesity on the results of its findings.
(Legislative Proposal VII)

Recommendation 8: Farm to School Programs

The Task Force finds, as presented by Emily Jackson with the Appalachian Sustainable Agriculture Project, that the Farm to School program plays a critical role in providing healthy fruits and vegetables to schools and serving as a market for locally grown produce. The Task Force also finds, as presented by Gary Gay, Director of Food Distribution with the NC Department of Agriculture, that the NC Farm to School program, which began in 1997, currently serves 75 school districts.

The Task Force recommends that the General Assembly enact legislation to establish a dedicated Farm to School position in the NC Department of Agriculture. The duties of this position shall include the following:

- Increase the educational components of the NC Farm to School program.
- Develop and maintain a list of farmers interested in selling to school systems.
- Encourage more school systems to participate in the NC Farm to School program.
- Expand the current efforts of participating school systems in the NC Farm to School program.
- Provide technical assistance to farmers on participation in the NC Farm to School program.
- Seek opportunities to standardize the small purchase threshold for Child Nutrition to facilitate school systems to buy from local farmers.
- Work with NC DPI to create NC Farm to School curriculum materials and/or revise existing materials to correlate with the NC Standard Course of Study.
- Collaborate with the NC Child Nutrition Program, NC Division of Public Health, and other groups working in the area of child nutrition.

(Legislative Proposal VIII)

The Task Force recommends that the General Assembly enact legislation requiring the NC Department of Agriculture to report annually on the NC Farm to Schools program, including information on participation rates, amount and types of produce purchased, education, and expansion efforts. The report shall be made to the Task Force on Childhood Obesity, the Joint Legislative Education Oversight Committee, the Joint Legislative Health Care Oversight Committee, the Chair of the House Committee on Agriculture, and the Chair of the Senate Committee on Agriculture, Environment and Natural Resources.

(Legislative Proposal VIII)

Recommendation 9: Healthy School Cafeteria Program

The Task Force finds, as presented by Dr. Lynn Harvey, Section Chief, Child Nutrition Services, NC Department of Public Instruction, that the Healthful School Food Choices Pilot Program conducted during the 2004-2005 school year demonstrated that inadequate equipment and decreased a la carte sales were difficulties faced by participating school nutrition programs, resulting in financial losses to those programs.

The Task Force also finds, as presented by Cindy Marion, Deborah Carpenter, and Cynthia Sevier, with the School Nutrition Association of NC, that Child Nutrition Directors report

difficulties in meeting nutrition standards due to out of date equipment and pressures to increase a la carte sales to provide funding for the child nutrition programs.

If reauthorized, the Task Force will seek to meet with the Directors of the Golden Leaf Foundation, NC Health and Wellness Trust Fund, and the philanthropic foundations of the North Carolina Obesity Prevention Funders Alliance to recommend the establishment of a Healthy School Cafeteria Program, modeled after the successful efforts of the Bowers Foundation in Mississippi. The Program would establish a four-year effort to devote $3.0 million each year ($12 million total) to retrofitting school cafeterias and enriching nutrition personnel to process, cook, and serve healthy foods. Efforts would include Nutrition Integrity Grants, for new and replacement equipment, and Five-Star Food Grants, to train school nutrition personnel to present fresh fruit and vegetables in a manner that invites kids to select and eat.

Recommendation 10: Physical Education and Activity in Schools

The Task Force finds, as presented by Dr. June Atkinson, Superintendent of NC Public Schools, that current research demonstrates a parallel between healthy students and academic performance, and the need to encourage increased activity in students.

The Task Force finds, as presented by Dr. June Atkinson, Superintendent of NC Public Schools, that NC DPI has a current partnership with the North Carolina Alliance for Athletics, Health, Physical Education, Recreation, and Dance (NCAAHPERD) to provide the In-School Prevention of Obesity and Disease (IsPOD) program. This program, which targets students in grades K-8 has received $3.5 million in funding from the Kate B. Reynolds Charitable Trust for a four-year funding cycle ending in 2012. 65 LEAs and six charter schools have participated in IsPOD training, including conducting FITNESSGRAM testing which measures muscular strength, muscular endurance, flexibility, cardio-vascular endurance, and body mass index (BMI).

The Task Force recommends that the General Assembly enact legislation to mandate the use of evidence-based fitness testing for students statewide in all K through 8 schools by the 2011-2012 school year.
(Legislative Proposal IX)

Recommendation 11: Explore BMI Screening for at-risk Medicaid and Health Choice Children and Collaborate to Decrease BMI Levels in Children and Youth

During the meeting on January 26, 2010, the Task Force heard presentations on the epidemic of childhood obesity. The Task Force heard from: State Superintendent June Atkinson on the epidemic's impact on schools; Deputy Secretary Maria Spaulding, Department of Health and Human Services on the impact of obesity on the health system; Dr. Jeffrey Engel, NC State Health Director, on the epidemic's impact on children; and Dr. David Chenoweth, Department of Health Education and Promotion, East Carolina University, on the impact on the State's economy.

Dr. Engel pointed out that 65.7% of North Carolina adults are overweight or obese, 56% are not meeting the physical activity recommendation, and 78% are not meeting the fruits or

vegetables recommendation. Dr. Engle reported that in 2008, 32.8% of NC children ages 10-17 were overweight or obese. A body mass index (BMI) chart for NC children ages 10-17 depicted the following: 15% obese, 18% overweight, 61% healthy weight, and 6% underweight. Dr. Engel pointed out that 53% of the premature deaths among North Carolinians are preventable. Adverse consequences due to obesity include the following chronic diseases: diabetes, heart disease, kidney disease and failure, cancer, asthma, and arthritis.

On February 15, the Task Force heard a presentation by Dr. Elizabeth Tilson, Medical Director, Community Care of Wake and Johnston Counties. Dr. Tilson presented an overview of Community Care of NC (CCNC); childhood obesity as it affects CCNC's role in managing health care costs; clinical issues for CCNC physicians; and the CCNC Childhood Obesity Initiative. Community Care of North Carolina (CCNC) consists of regional networks organized and operated by physicians, hospitals, health departments, and departments of social services with a goal of providing positively impacting health care quality, cost, and access for Medicaid recipients. The North Carolina Office of Rural Health and Community Care administers the CCNC program. Support for Community Care is provided through the Office of the Secretary and Division of Medical Assistance in the Department of Health and Human Services; the North Carolina Foundation for Advanced Health Programs; and grant funding from various sources. CCNC represents 14 networks and more than 3500 primary care physicians. As of February 2010, there were more than 985,000 Medicaid enrollees. Dr. Tilson discussed childhood obesity as it affects CNC's role in improving quality and decreasing Medicaid costs. She pointed out the higher prevalence of childhood obesity in lower socio-economic populations and the concurrent co-morbidities and future co-morbidities. Dr. Tilson shared the following information regarding a grant funded program to address childhood obesity: participating networks, program elements, year 1 goals and results, year two goals, clinical tools, and piloting a co-located nutritionist in a primary care practice.

The Task Force desires to reverse North Carolina's trend toward obesity by focusing on identifying and addressing the issue with our children and youth. The Task Force also realizes that chronic diseases resulting from obesity are costly to the State when treated under State supported program like Medicaid.

The Task Force recommends that the General Assembly direct the Department of Health and Human Services (DHHS) to explore the possibility of requiring Community Care of North Carolina (CCNC) to implement body mass index (BMI) screening for children participating in Medicaid or the Health Choice for Children Program, who are at risk of becoming obese and developing diabetes or other chronic diseases; and to require CCNC networks to collaborate with local health departments, county departments of social services, Eat Smart Move More Coalitions, and local education agencies on ways to decrease BMI levels in children and youth. The plans developed by DHHS must include establishing performance goals within each CCNC network which will include: 1) Care management for children at-risk; and 2) annual BMI testing to identify the percentage of children who have a BMI test and the percentage of children who have a decrease in the BMI. The Department of Health and Human Services must ensure the privacy and integrity of information collected. Additionally, in the development of a plan to collect BMI, DHHS should explore data collection through programs like Fitnessgram, a fitness assessment and reporting

program for youth that includes health-related physical fitness tests to assess aerobic capacity; muscular strength, muscular endurance, and flexibility; and body composition. **(Legislative Proposal X)**

Recommendation 12: Encourage Children to Walk to School and Encourage Collaboration to Develop Healthy Environments

On February 2, the Task Force heard a presentation by Dr. Daniel Rodriguez, Associate Professor, University of North Carolina – Chapel Hill, on linking the built environment and health. The presentation pointed out the connection between investments in local infrastructure and the increase in physical activity. Dr. Rodriguez pointed out that in a review of 16 studies, having sidewalks resulted in a 20% increase in the likelihood that people would be more physically active. Additionally, Dr. Rodriguez gave a breakdown of the $15 million in federal funding NC has received for the Safe Routes To School program. During the presentation on February 15, 2010, Paula Card-Higginson, Deputy Director, Robert Wood Johnson Foundation Center to Prevent Childhood Obesity, suggested that federal policy opportunities in the transportation area may be one way to address childhood obesity. She also mentioned the Institute of Medicine and Centers for Disease Control recommended strategies to increase physical activity by improving safety and security of streets and park use, especially in higher-crime neighborhoods.

Also during the above meeting, the Task Force heard a presentation with information from Philip Bors and Kelly Evenson on, "Preventing Childhood Obesity: Physical Activity Effective Policies and Built Environment Strategies." Information was shared with the Task Force on what was happening in other states. According to the presentation, in 2007, 60% of North Carolina adults reported they would increase their physical activity if their community had more accessible sidewalks or trails for walking or bicycling (63% Eastern NC, 59% Piedmont, 53% Western NC). The presenter highlighted the following six goals:

- More walkable destinations,
- Safer routes in the community,
- Create and maintain trails and greenways,
- Safer routes to/from school,
- Create and maintain parks and open space,
- Shared use of schools after hours/weekends.

For the goal of safer routes to/from school, the presenter outlined federal funding North Carolina has received for Safe Routes to School. Also highlighted were NC's Complete Streets Policy and pedestrian and bicycle plans to promote safer routes in the community. The Complete Streets Policy requires Department of Transportation planners and designers to consider and incorporate multimodal alternatives in the design and improvement of all appropriate transportation projects within a growth area of a town or city unless exceptional circumstances exist.

The Task Force supports the activities that have already taken place in NC to encourage development and use of safe routes as a means to increase physical activity.

The Task Force recommends the Department of Transportation continue development of the Safe Routes to Schools program, continue to pursue federal funding opportunities, and

to make efficient and effective use of this funding to ensure sufficient mechanisms are in place to encourage children to walk to school.

The Task Force supports the Complete Streets efforts of the Department of Transportation and recommends collaboration between the Department of Transportation and the Department of Health and Human Services to create healthy environments in North Carolina.

Recommendation 13: Support for Restaurant Menu Labeling

The meeting on February 2 focused on "Active Living and Nutritious Food in the Community." The Task Force heard from numerous presenters who discussed how difficult it is to make informed food choices when restaurants don't have nutrition information available on the various menu choices. On February 23, the Task Force heard from the food industry and from individuals that discussed food industry packaging and the impact this has on obesity. These presentations also highlighted the availability of nutrition information for food and beverages. The Task Force acknowledges the difficulty in making nutritious food selection when nutrition information is not available and expresses support for restaurant menu labeling.

On April 19, Lee Dixon, Task Force staff, provided an overview of changes due to enactment of the following federal Acts: Patient Protection and Affordable Care Act (HR 3590) and Health Care and Education Affordability Act of 2010 (HR 4872). Mr. Dixon discussed the impact of these Acts on menu labeling.

The Task Force expresses support for restaurant menu labeling.

Recommendation 14: Continue the Task Force on Childhood Obesity

S.L. 2009-574, Part XLIX, created the Legislative Task Force on Childhood Obesity and provided that the Task Force would terminate on May 1, 2010, or upon the filing of its final report, whichever occurs first. The Task Force believes that there is still much work to be done to address the issue of childhood obesity in North Carolina.

The Task Force recommends the General Assembly enact legislation to continue the Task Force on Childhood Obesity.
(Legislative Proposal XI)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S **D**

BILL DRAFT 2009-MGz-92 [v.10] (04/12)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 4:54:06 PM

Short Title:	Expand SNAP-Ed Program.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF SOCIAL SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXAMINE WAYS TO EXPAND AND ENHANCE THE SUPPLEMENTAL NUTRITION ASSISTANCE EDUCATION PROGRAM IN NORTH CAROLINA, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Social Services, shall examine and recommend ways to expand and enhance the Supplemental Nutrition Assistance Education (SNAP-Ed) Program in this State. The recommendations shall include all of the following:

(1) An expanded definition and use of in-kind resources in order to draw down additional federal funds to expand the SNAP-Ed Program in North Carolina.

(2) A three-year plan to expand and enhance the SNAP-Ed Program.

(3) A determination as to the feasibility of placing the responsibility for the SNAP-Ed Program at North Carolina State University or North Carolina A&T State University, or both.

Not later than September 1, 2011, the Department shall report its findings and recommendations on the directives outlined in subdivisions (1) through (3) of this section to the Legislative Task Force on Childhood Obesity, if reestablished for the 2011-2012 Session, to the Public Health Study Commission, and to the Fiscal Research Division.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-101 [v.6] (04/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 4:37:58 PM

Short Title:	Electronic Funds Transfers/Farmers Markets.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ISSUE A REQUEST FOR PROPOSALS TO FACILITATE ACCEPTANCE OF PAYMENTS BY ELECTRONIC FUNDS TRANSFER AT LOCAL FARMERS MARKETS, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. Of the funds appropriated to the Department of Health and Human Services, Division of Social Services, for the 2010-2011 fiscal year, the sum of two hundred thousand dollars ($200,000) shall be used by the Department to issue a request for proposals from qualified vendors to facilitate the ability of local farmers markets to accept payments by electronic funds transfer.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-96 [v.5] (04/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 4:55:14 PM

Short Title:	Improve Child Care Nutrition Standards.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE CHILD CARE COMMISSION, IN CONSULTATION WITH THE DIVISION OF CHILD DEVELOPMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO DEVELOP IMPROVED NUTRITION STANDARDS FOR CHILD CARE FACILITIES, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91(2) reads as rewritten:

"(2) Health-Related Activities. – The Commission shall adopt rules for child care facilities to ensure that all children receive nutritious food and beverages according to their developmental needs. ~~After consultation with the State Health Director,~~ The Commission shall consult with the Division of Child Development of the Department of Health and Human Services to develop nutrition standards ~~shall~~ to provide for requirements appropriate for children of different ages. The nutrition standards shall include all of the following:

a. A prohibition against serving sugar sweetened beverages to children of any age.

b. A requirement to serve reduced fat milk to children older than two years of age.

c. A prohibition against serving more than four to six ounces of juice per day to children over one year of age.

Each child care facility shall have a rest period for each child in care after lunch or at some other appropriate time and arrange for each child in care to be out-of-doors each day if weather conditions permit."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

BILL DRAFT 2009-MGz-97 [v.9] (04/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 4:40:46 PM

Short Title:	National School Lunch Program/Funds.	(Public)
Sponsors:	Representative Yongue.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF PUBLIC INSTRUCTION TO USE A SPECIFIED AMOUNT OF CHILD NUTRITION PROGRAM FUNDS AS REQUIRED STATE MATCHING FUNDS FOR MEALS UNDER THE NATIONAL SCHOOL LUNCH PROGRAM, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. Of the funds appropriated to the Department of Public Instruction for the Child Nutrition Program for the 2010-2011 fiscal year, the sum of five million two hundred thousand dollars ($5,200,000) shall be used as State matching funds necessary to draw down federal funds for school meals under the United States Department of Agriculture National School Lunch Program. These funds shall be used only for food and food preparation costs in the Child Nutrition Program.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

BILL DRAFT 2009-MGz-98 [v.3] (04/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/13/2010 2:54:22 PM

Short Title:	Eliminate Reduced Price School Meals/Funds.	(Public)
Sponsors:	Representative Yongue.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF PUBLIC INSTRUCTION TO ELIMINATE THE COST OF REDUCED PRICE LUNCHES FOR SCHOOL CHILDREN WHO QUALIFY FOR REDUCED PRICE MEALS, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Public Instruction the sum of five million two hundred thousand dollars ($5,200,000) for the Child Nutrition Program for the 2010-2011 fiscal year. These funds shall be used to eliminate the cost of reduced price school lunches for children who qualify for reduced price meals.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-102 [v.3] (04/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 4:26:40 PM

Short Title:	Update Statewide Nutrition Standards.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO UPDATE STATEWIDE NUTRITION STANDARDS FOR FOOD AND BEVERAGES AVAILABLE IN PUBLIC ELEMENTARY, MIDDLE AND HIGH SCHOOLS, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-264.3 reads as rewritten:

"**§ 115C-264.3. Child Nutrition Program standards.**

(a) The State Board of Education, in direct consultation with a cross section of local directors of child nutrition services, shall establish statewide nutrition standards that meet recognized national standards adopted by the Alliance for a Healthier Generation or the National Academy of Sciences, Institute of Medicine by December 2010. The statewide nutrition standards apply to all of the following:

(1) School meals.

(2) A la carte foods and beverages.

(3) Items served in the After School Snack Program administered by the Department of Public Instruction and child nutrition programs of local school administrative units.

(4) All food and beverage items sold or offered to students outside child nutrition programs of local school administrative units.

The statewide nutrition standards shall be implemented in elementary schools by the end of the 2011-2012 school year, in middle schools by the end of the 2012-2013 school year, and in high schools by the end of the 2013-2014 school year.~~for school meals, a la carte foods and beverages, and items served in the After School Snack Program administered by the Department of Public Instruction and child nutrition programs of local school administrative units. The nutrition standards will promote gradual changes to increase fruits and vegetables, increase whole grain products, and~~

~~decrease foods high in total fat, trans fat, saturated fat, and sugar. The nutrition standards adopted by the State Board of Education shall be implemented initially in elementary schools. All elementary schools shall achieve a basic level by the end of the 2009-2010 school year, followed by middle schools and then high schools.~~

(b) Beginning with the 2013-2014 school year, and every three years thereafter, the State Board of Education shall review and, as necessary, update statewide nutrition standards to align with nationally recognized nutrition standards. The State Board of Education shall also update nutrition standards as frequently as necessary to align with changes to federal law or the Dietary Guidelines for Americans published by the United States Departments of Health and Human Services and Agriculture.

(c) The State Board of Education shall make available free of charge to the general public on its Internet Web site a system for reporting possible inconsistencies in the implementation of statewide nutrition standards."

SECTION 2. This act is effective when it becomes law.

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-99 [v.3] (04/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 11:11:29 AM

Short Title:	Study Child Nutrition Program.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY INDIRECT COSTS UNDER CHILD NUTRITION PROGRAMS, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Joint Legislative Program Evaluation Oversight Committee shall include in the 2010 Work Plan for the Program Evaluation Division of the General Assembly a study of the operation of the Child Nutrition Program. The Division shall examine (i) the guidelines for assessing indirect costs to local child nutrition programs in local school administrative units and (ii) the financial impact upon local child nutrition programs and local school administrative units of a policy prohibiting the assessment of indirect costs to a child nutrition program until that program has achieved and sustained a three-month operating balance.

SECTION 1.(b) The Program Evaluation Division shall submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee, to the Legislative Task Force on Childhood Obesity, if reestablished for the 2011-2012 Session, and to the Fiscal Research Division at a date to be determined by the Joint Legislative Program Evaluation Oversight Committee.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

BILL DRAFT 2009-LNz-194 [v.5] (04/15)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/16/2010 10:44:01 AM

Short Title:	Farm to School Program/Funds.	(Public)
Sponsors:	Representative Yongue.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN EMPLOYEE POSITION IN THE DEPARTMENT OF AGRICULTURE DEDICATED TO ADMINISTRATION AND OPERATION OF THE FARM TO SCHOOL PROGRAM AND TO REQUIRE THE DEPARTMENT TO REPORT ANNUALLY ON THE PROGRAM, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is appropriated from the General Fund to the North Carolina Department of Agriculture the sum of sixty-five thousand dollars ($65,000) for the 2010-2011 fiscal year. These funds shall be used to establish a position in the Department dedicated to the administration and operation of the Farm to School Program. Duties of the position shall include:

(1) Increasing the educational components of the Farm to School Program.
(2) Developing and maintaining a list of farmers interested in selling farm products to school systems in this State.
(3) Encouraging more school systems to participate in the Farm to School Program.
(4) Expanding the current efforts of participating school systems in the Farm to School Program.
(5) Providing technical assistance to farmers on participation in the Farm to School Program.
(6) Seeking opportunities to standardize the small purchase threshold for child nutrition programs to facilitate the purchase by school systems of farm products from local farmers.
(7) Working with the Department of Public Instruction to create Farm to School Program curriculum materials or to revise existing materials to correlate with the North Carolina Standard Course of Study.

(8) Collaborating with the Child Nutrition Program, the Department of Health and Human Services, Division of Health Services, and other groups working in the area of child nutrition.

SECTION 1.(b) The Department of Agriculture shall report annually on the Farm to School Program, including information on participation rates, amount and types of produce purchased, education and expansion efforts. The Department shall report to the Task Force on Childhood Obesity, the Joint Legislative Education Oversight Committee, the Joint Legislative Health Care Oversight Committee, the Chair of the House Committee on Agriculture, and the Chair of the Senate Committee on Agriculture, Environment, and Natural resources.

SECTION 2. This act becomes effective July 1, 2010.

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

BILL DRAFT 2009-LNz-195 [v.4] (04/15)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/16/2010 10:38:06 AM

Short Title:	Physical Education and Activity in Schools.	(Public)
Sponsors:	Representative Yongue.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PUBLIC SCHOOLS TO USE EVIDENCE-BASED FITNESS TESTING FOR STUDENTS STATEWIDE IN GRADES K THROUGH 8, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 8 of Chapter 115C of the General Statues is amended by adding the following new section to read:

"**§ 115C-81.5. Fitness testing.**

The State Board of Education shall require the use of evidence-based fitness testing for students statewide in grades K through 8."

SECTION 2. This act is effective when it becomes law. Implementation of the testing required in Section 1 of this act shall begin with the 2010-2011 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

BILL DRAFT 2009-MGz-94 [v.6] (4/12)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2010 4:29:46 PM

Short Title:	Screen And Reduce BMI Levels In Children.	(Public)
Sponsors:	Representative Yongue.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPLORE WAYS TO IMPLEMENT BODY MASS INDEX SCREENING FOR CERTAIN CHILDREN WHO ARE AT RISK OF BECOMING OBESE AND TO REDUCE BODY MASS INDEX LEVELS FOR ALL CHILDREN, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall explore the feasibility of requiring Community Care of North Carolina (CCNC) to implement body mass index (BMI) screening for children at risk of becoming obese and developing diabetes or other chronic diseases, who are receiving Medicaid or participating in the North Carolina Health Choice for Children Program.

SECTION 1.(b) As part of its exploration into the feasibility of requiring BMI screening pursuant to subsection (a) of this section, the Department shall work towards the development of each of the following items:

(1) Establishing performance goals within each CCNC network that includes each of the following components:
   a. Care management for children who are at risk of becoming obese and developing diabetes or other chronic diseases.
   b. Annual BMI screening to identify the percentage of children who have a BMI test and the percentage of children who have a decrease in BMI levels.

(2) Developing a uniform protocol across the CCNC network to ensure the integrity and confidentiality of information collected through BMI screening.

(3) Implementing reliable methods of collecting data utilizing fitness assessment and reporting programs for youth that include

health-related physical fitness tests to assess aerobic capacity; muscular strength, muscular endurance, and flexibility; and body composition.

SECTION 2. The Department shall require CCNC networks to collaborate with local health departments, county departments of social services, Eat Smart, Move More coalitions, and local education agencies on ways to reduce BMI levels in all children.

SECTION 3. Not later than September 1, 2011, the Department shall report its findings and recommendations to the Legislative Task Force on Childhood Obesity, if reestablished for the 2011-2012 Session, to the Public Health Commission, and to the Fiscal Research Division.

SECTION 4. This act is effective when it becomes law.

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

BILL DRAFT 2009-MGz-95 [v.8] (4/12)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/16/2010 11:46:14 AM

Short Title:	Legislative Task Force On Childhood Obesity.	(Public)
Sponsors:	Representative Yongue.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REESTABLISH THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Task Force on Childhood Obesity, as created in Part XLIX of S.L. 2009-574, is reestablished for the 2011-2012 Session.

SECTION 2. The Task Force may make an interim report of the results of its study and recommendations to the 2011 General Assembly, and shall submit a final report of the results of its study and recommendations to the 2011 General Assembly, Regular Session 2012. The Task Force shall terminate on May 1, 2012, or upon the filing of its final report, whichever occurs first.

SECTION 3. This act is effective when it becomes law.

APPENDIX I

FISCAL ANALYSIS FOR RECOMMENDATION #6

Task Force staff conducted additional research on the information provided by several of the presenters concerning the financial viability of providing healthy school meals. The staff learned that there is a substantial amount of studies and research indicating that serving healthy food can be revenue neutral, even profitable. These studies conclude that to make a successful financial transition to serving healthy foods a temporary subsidy for school nutrition programs needs to be in place as they transition to the total menu of healthy foods.

Recommendation 6 calls for the Board of Education to implement revised nutrition standards for schools beginning with the 2011-2012 school year—SFY 2011-12. The standards would be phased in for Elementary, Middle and High Schools over a 5-year period. During this phase-in, it is the recommendation of the Task Force that the General Assembly appropriate a 5-cent a meal subsidy to Elementary, Middle, and High Schools for a 2-year period. This two-year subsidy would allow the schools to make the transition to a healthy menu of school meals, as has been done successfully in other schools.

Neither the Task Force nor the current session of the General Assembly can bind the 2011 or any other session of the General Assembly to any legislative or budgetary action. However, the following is fiscal analysis of the resources that would be necessary to provide the temporary two-year 5-cent subsidy.

Number of Meals Served in North Carolina Public Schools	
Reimbursable Breakfast Meals	63,318,720
Reimbursable Lunch Meals	163,298,191
A la carte Meals	112,345,071
Total number of meals served	338,961,982

Projected Annual Cost of 5-cent Supplement by Grade Level			
Number of Meals Served by Grade Level		**Apply 5-cent Supplement @ Meal**	**Annual Cost of 5-cent Supplement**
Elementary—K – 5 (47.5%)	161,006,941	$0.05	$8,050,347
Middle—6 – 8 (22.8%)	77,283,332	$0.05	$3,864,167
High—9 – 12 (29.7%)	110,671,709	$0.05	$5,033,585
Total	338,961,982		

Projected Annual Cost by Fiscal Year				
	SFY 2011-12	SFY 2012-13	SFY 2013-14	SFY 2014-15
Elementary School	$ 8,050,347	$ 8,050,347		
Middle School		$ 3,864,167	$ 3,864,167	
High School			$ 5,033,585	$ 5,033,585
TOTAL	$ 8,050,347	$ 11,914,514	$ 8,897,752	$ 5,033,585

STATE OF NORTH CAROLINA
NORTH CAROLINA
GENERAL ASSEMBLY

November 10, 2010

MEMORANDUM

TO: Members of the Legislative Task Force on Childhood Obesity

FROM: Chairman, Senator William R Purcell
Chairman, Representative Douglas Y Yongue

SUBJECT: **Meeting of Task Force on Childhood Obesity**

There will be a meeting of the: Legislative Task Force on Childhood Obesity

DAY:	**Thursday**	**TIME:**	**10:00 am -12:00 pm**
DATE:	**November 18, 2010**		
LOCATION:	**Room 415, Legislative Office Building**		

Agenda: To plan and discuss the future work of the Task Force on Childhood Obesity

Committee members, please advise Katie Stanley, Committee Assistant, at 919.733.5821, or e-mail yonguela@ncleg.net if you are unable to attend.

Posted:
cc: Committee X
Record ____
Interested Parties X

MINUTES

Legislative Task Force on Childhood Obesity
Thursday, November 18, 2010
10:00 a.m.
Room 415, Legislative Office Building

The Task Force on Childhood Obesity met Thursday, November 18, 2010 in Room 415 of the Legislative Office Building. Co-Chair Representative Doug Yongue presided. The Commission has two new advisory members: Senator Josh Stein and Representative Ray Rapp. The focus of the meeting was to begin planning the next objectives for the Commission.

The members discussed a recent meeting concerning juvenile obesity efforts in North Carolina, Mississippi, Kentucky and Louisiana. The meeting, "Promoting Healthy Lifestyles and Reducing Childhood Obesity", was sponsored by the National Conference of State Legislatures and was held in Raleigh. Co-Chairs Yongue and Purcell presented the Commission's 2009-2010 report and recommendations. Along with the Co-Chairs, Representatives Rapp and Insko and Senator Tillman attended portions of the meetings. Senator Purcell said the meeting showed that North Carolina was further ahead than any other state in passing legislation to reduce childhood obesity. North Carolina passed five bills this year dealing with reducing childhood obesity. (NOTE ATTACHMENT BELOW)

The Commission's term has been extended until 2012. The panel may report findings and recommendations to the 2011 Session of the General Assembly, but there must be a final report to the 2012 Session. With this in mind, the Commission discussed the need for an additional planning meeting before the end of 2010. The consensus was that there should be such a meeting and members will be polled to determine date and time. In consideration of recent election results, Senator Dannelly said that information should be given to all Commission members to inform them that their legislative obligation does not end until December 31st.

Ms. Theresa Matula, Research Division, provided the Task Force with the results of the recommended legislation sponsored in the 2010 legislation session. Of the eleven measures introduced, five bills passed. *(ATTACHMENT: Task Force on Childhood Obesity-Status of Recommendations.)*

Co-Chair Yongue spoke to a familiar theme: that obesity is not as prevalent in many other countries as it is in the United States.

Representative Weiss asked for an update on the Farm to School program within the Department of Agriculture. Lee Dixon of the Research Staff said a position was established in the 2010 Session and that a person had been hired as coordinator. Mr. Dixon also said he had spoken with Dan Gerlach, Executive Director of the Golden Leaf Foundation, about funding for the Farms to Schools program. Mr. Gerlach said that Golden Leaf and the Blue Cross Blue Shield Foundation would discuss the possibility of a joint venture in the future. Mr. Dixon agreed to follow up with Mr. Gerlach.

Representative Brown suggested that the Task Force work to develop a blueprint to be used to encourage healthy communities. Co-Chairman Yongue said that was the sort of issue that the Commission should consider as new initiatives are planned.

Representative Weiss said the Sustainable Community Task Force was reporting its findings to another legislative committee. She proposed that the Childhood Obesity Task Force could find a way to work with the Sustainable Community Task Force.

Representative Hughes talked about a computer program that was developed by a Wilmington Company which would allow parents to monitor what their children eat at school. The program costs $10/per child. There was no other know information about the program. Committee staff was directed to further research the software program.

The meeting adjourned at 10:40 a.m.

Representative Doug Yongue, Co-Chair
Presiding.

Katie Stanley, Clerk

Minutes by Ted Harrison

VISITOR REGISTRATION SHEET

Leg. Task Force on Childhood Obesity — Nov. 18, 2010, 10:00 am

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Korinne Chiu	UNCG 301 S Greene St. Greensboro NC 27402
Veronica B. Wilson	NC Division of Social Ser. 325N Salisbury St.
GEORGE SUDDATH	NR BEV
Butch Gunnells	NC Bev
Matt Gross	NC Partnership for Children
Matt Farrell	NCSBA
John Bowdish	AstraZeneca
Christine Mason	ACS
Betsy Vetter	AHA
Kathrine Joyce	NCASA
DOUG HERON	WILLIAMS MULLEN

Task Force on Childhood Obesity
Status of Recommendations

S 1151 **S.L. 2010-160**	H 1775 Ref. to Education, if fav. Health	Supplemental Nutrition Assistance Program
S 1288 Ref. to Appropriations	H 1776 Ref. to Health	Electronic Funds Transfer/Farmers Market
S 1287 Ref. to Health	H 1726 **S.L. 2010-117**	Improve Child Care Nutrition/Activity Standards
S 1339 Ref. to Appropriations	H 1917 Ref. to Appropriations	National School Lunch Program/Funds
S 1285 Ref. to Appropriations	H 1774 Ref. to Education, if fav. App.	Eliminate Reduced Price School Meals/Funds
S 1289 Ref. to Health	H 1756 Ref. to Health, if fav. Education	Update Statewide Nutrition Standards
S 1152 **S.L. 2010-115**	H 1777 Fav. in Ed, Re-Ref to Health	Study Child Nutrition Programs
S 1284 Ref. to Appropriations	H 1832 Ref. to Appropriations	Farm to School Program Funds
S1296 Ref. to Education	H 1757 **S.L. 2010-161**	Physical Education and Activity in Schools/ Fitness Testing and Activity in Schools
S 1286 Fav to Com Sub in S. Health, Passed 2nd and 3rd in Senate, Ref to H. Health, Fav in H. Health, Ref. to H. Rules	H 1904 Ref to Health, if Fav. to Rules	Screen and Reduce BMI
S 1153, Ref to S. Health, Fav to Com Sub S. Health, Passed 2nd and 3rd Reading in Senate, Ref to H. Rules	H 1827 Fav to Com. Sub. In Ed, Re-Ref to Rules **S.L. 2010-152** Part XXVI	Legislative Task Force on Childhood Obesity

SECTION 25.1. Section 2 of S.L. 2009-281 reads as rewritten:

"**SECTION 2.** The General Statutes Commission shall study and recommend to the ~~2010~~2011 Regular Session of the ~~2009~~2011 General Assembly ways to ensure that the General Statutes properly and uniformly refer to federal or state military organizations. These may include a single term that will include all organizations that compose the reserve components of the armed forces. The recommendations may include a process to be authorized by the General Assembly whereby changes that do not change the law can be made administratively by the Attorney General."

SECTION 25.2. Section 1 of S.L. 2009-273 reads as rewritten:

"**SECTION 1.** The General Statutes Commission shall study and recommend ~~to the 2010 Regular Session of the 2009 General Assembly and the 2011 Regular Session of the General Assembly~~ ways to make the General Statutes and the North Carolina Constitution gender neutral. These may include recommending legislative changes needed to make the General Statutes and the Constitution gender neutral and a process to be authorized by the General Assembly whereby changes that do not change the law can be made administratively by the Attorney General to make the General Statutes gender neutral."

PART XXVI. REESTABLISH LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (S.B. 1153 – Purcell; H.B. 1827 – Yongue, Brown, Hughes, Insko)

SECTION 26. Part XLIX of S.L. 2009-574 reads as rewritten:

"**PART XLIX. LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (Yongue)**

"**SECTION 49.1.** There is created the Legislative Task Force on Childhood Obesity.

"**SECTION 49.2.** The Task Force shall consist of 12 members as follows:

(1) Six members of the House of Representatives.

(2) Six members of the Senate.

"**SECTION 49.3.** The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Terms of the initial members begin on appointment and continue until the convening of the 2011 Session of the General Assembly. Subsequent appointments begin during the 2011 Session of the General Assembly and continue until the Task Force terminates. Vacancies on the Task Force shall be filled by the same appointing authority that made the initial appointment. A quorum of the Task Force shall be a majority of its members.

"**SECTION 49.4.** The Task Force shall include, but should not be limited to, study of issues relating to childhood obesity. In the course of the study, the Task Force shall consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity and encouraging healthy eating and increased physical activity among children through:

(1) Early childhood intervention;

(2) Childcare facilities;

(3) Before and after-school programs;

(4) Physical education and physical activity in schools;

(5) Higher nutrition standards in schools;

(6) Comprehensive nutrition education in schools;

(7) Increased access to recreational activities for children;

(8) Community initiatives and public awareness; and

(9) Other means.

"**SECTION 49.5.** The Task Force shall encourage input from public nonprofit organizations, promoting healthy lifestyles for children, addressing the problems related to childhood obesity, encouraging healthy eating, and increasing physical activity among children.

"**SECTION 49.6.** Members of the Task Force shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Task Force, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Task Force may meet at anytime upon the joint call of the cochairs. The Task Force may meet in the Legislative Building or the Legislative Office Building.

With approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Task Force in its work. The House of Representatives' and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Task Force, and the expenses relating to the clerical employees shall be borne by the Task Force. The Task Force may contract for professional, clerical, or consultant services as

provided by G.S. 120-32.02. If the Task Force hires a consultant, the consultant shall not be a State employee or a person currently under contract with the State to provide services.

All State departments and agencies and local governments and their subdivisions shall furnish the Task Force with any information in their possession or available to them.

"**SECTION 49.7.** The Task Force shall submit a ~~final~~ report of the results of its study and its recommendations to the 2010 Regular Session of the 2009 General Assembly. The Task Force may make a report of the results of its study and recommendations to the 2011 General Assembly and shall submit a report to the 2012 Regular Session of the 2011 General Assembly. The Task Force shall terminate ~~on May 1, 2010, or upon the filing of its final report, whichever occurs first.~~ upon the convening of the 2012 Regular Session of the 2011 General Assembly."

PART XXVII. JOINT LEGISLATIVE STUDY COMMITTEE ON THE CONSOLIDATION OF EARLY CHILDHOOD EDUCATION AND CARE (S.B. 1116 – Blue, Purcell, Swindell; H.B. 1781 – Rapp, Glazier, Insko)

SECTION 27.1. Committee Established. – There is created the Joint Legislative Study Committee on the Consolidation of Early Childhood Education and Care. The Committee shall consist of 18 members to be appointed as follows:

(1) Five members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Five members of the Senate appointed by the President Pro Tempore of the Senate.

(3) Seven ex-officio nonvoting members as follows:
   a. The Secretary of the Department of Health and Human Services.
   b. The Chairman of the State Board of Education.
   c. The President of the North Carolina Partnership for Children, Inc.
   d. The Executive Director of the Office of Early Learning at the Department of Public Instruction.
   e. The Director of the Head Start State Collaboration Office at the Office of Early Learning at the Department of Public Instruction.
   f. The President of the Child Care Services Association.
   g. The Executive Director of the North Carolina Licensed Child Care Association.

(4) A developmental pediatrician appointed by the Governor as a nonvoting member.

The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Vacancies on the Committee shall be filled by the same appointing authority making the initial appointment.

The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Committee may meet at any time upon the joint call of the cochairs. The Committee may meet in the Legislative Building or the Legislative Office Building. The Committee may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02.

The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. The House of Representatives and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Committee, and the expenses relating to the clerical employees shall be borne by the Committee. Members of the Committee shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 27.2. Duties. – The Committee shall continue the work of the Task Force on the Consolidation of Early Childhood Education and Care created under S.L. 2009-451 by continuing to work toward the development of an integrated system of early childhood education and care. To that end, the Committee may consult with and receive reports from the appropriate State departments, agencies, and board representatives on issues related to early childhood education and care and consider any other issues the Committee deems relevant.

SECTION 27.3. Report. – The Commission may make a final report, including any proposed legislation, to the 2011 General Assembly upon its convening. The Commission shall

SECTION 25.1. Section 2 of S.L. 2009-281 reads as rewritten:

"**SECTION 2.** The General Statutes Commission shall study and recommend to the ~~2010~~2011 Regular Session of the ~~2009~~2011 General Assembly ways to ensure that the General Statutes properly and uniformly refer to federal or state military organizations. These may include a single term that will include all organizations that compose the reserve components of the armed forces. The recommendations may include a process to be authorized by the General Assembly whereby changes that do not change the law can be made administratively by the Attorney General."

SECTION 25.2. Section 1 of S.L. 2009-273 reads as rewritten:

"**SECTION 1.** The General Statutes Commission shall study and recommend ~~to the 2010 Regular Session of the 2009 General Assembly and the 2011 Regular Session of the General Assembly~~ ways to make the General Statutes and the North Carolina Constitution gender neutral. These may include recommending legislative changes needed to make the General Statutes and the Constitution gender neutral and a process to be authorized by the General Assembly whereby changes that do not change the law can be made administratively by the Attorney General to make the General Statutes gender neutral."

PART XXVI. REESTABLISH LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (S.B. 1153 – Purcell; H.B. 1827 – Yongue, Brown, Hughes, Insko)

SECTION 26. Part XLIX of S.L. 2009-574 reads as rewritten:

"**PART XLIX. LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (Yongue)**

"**SECTION 49.1.** There is created the Legislative Task Force on Childhood Obesity.

"**SECTION 49.2.** The Task Force shall consist of 12 members as follows:

(1) Six members of the House of Representatives.

(2) Six members of the Senate.

"**SECTION 49.3.** The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Terms of the initial members begin on appointment and continue until the convening of the 2011 Session of the General Assembly. Subsequent appointments begin during the 2011 Session of the General Assembly and continue until the Task Force terminates. Vacancies on the Task Force shall be filled by the same appointing authority that made the initial appointment. A quorum of the Task Force shall be a majority of its members.

"**SECTION 49.4.** The Task Force shall include, but should not be limited to, study of issues relating to childhood obesity. In the course of the study, the Task Force shall consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity and encouraging healthy eating and increased physical activity among children through:

(1) Early childhood intervention;

(2) Childcare facilities;

(3) Before and after-school programs;

(4) Physical education and physical activity in schools;

(5) Higher nutrition standards in schools;

(6) Comprehensive nutrition education in schools;

(7) Increased access to recreational activities for children;

(8) Community initiatives and public awareness; and

(9) Other means.

"**SECTION 49.5.** The Task Force shall encourage input from public nonprofit organizations, promoting healthy lifestyles for children, addressing the problems related to childhood obesity, encouraging healthy eating, and increasing physical activity among children.

"**SECTION 49.6.** Members of the Task Force shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Task Force, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Task Force may meet at anytime upon the joint call of the cochairs. The Task Force may meet in the Legislative Building or the Legislative Office Building.

With approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Task Force in its work. The House of Representatives' and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Task Force, and the expenses relating to the clerical employees shall be borne by the Task Force. The Task Force may contract for professional, clerical, or consultant services as

provided by G.S. 120-32.02. If the Task Force hires a consultant, the consultant shall not be a State employee or a person currently under contract with the State to provide services.

All State departments and agencies and local governments and their subdivisions shall furnish the Task Force with any information in their possession or available to them.

"**SECTION 49.7.** The Task Force shall submit a ~~final~~ report of the results of its study and its recommendations to the 2010 Regular Session of the 2009 General Assembly. The Task Force may make a report of the results of its study and recommendations to the 2011 General Assembly and shall submit a report to the 2012 Regular Session of the 2011 General Assembly. The Task Force shall terminate ~~on May 1, 2010, or upon the filing of its final report, whichever occurs first.~~upon the convening of the 2012 Regular Session of the 2011 General Assembly."

PART XXVII. JOINT LEGISLATIVE STUDY COMMITTEE ON THE CONSOLIDATION OF EARLY CHILDHOOD EDUCATION AND CARE (S.B. 1116 – Blue, Purcell, Swindell; H.B. 1781 – Rapp, Glazier, Insko)

SECTION 27.1. Committee Established. – There is created the Joint Legislative Study Committee on the Consolidation of Early Childhood Education and Care. The Committee shall consist of 18 members to be appointed as follows:

(1) Five members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Five members of the Senate appointed by the President Pro Tempore of the Senate.

(3) Seven ex-officio nonvoting members as follows:
   a. The Secretary of the Department of Health and Human Services.
   b. The Chairman of the State Board of Education.
   c. The President of the North Carolina Partnership for Children, Inc.
   d. The Executive Director of the Office of Early Learning at the Department of Public Instruction.
   e. The Director of the Head Start State Collaboration Office at the Office of Early Learning at the Department of Public Instruction.
   f. The President of the Child Care Services Association.
   g. The Executive Director of the North Carolina Licensed Child Care Association.

(4) A developmental pediatrician appointed by the Governor as a nonvoting member.

The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Vacancies on the Committee shall be filled by the same appointing authority making the initial appointment.

The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Committee may meet at any time upon the joint call of the cochairs. The Committee may meet in the Legislative Building or the Legislative Office Building. The Committee may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02.

The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. The House of Representatives and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Committee, and the expenses relating to the clerical employees shall be borne by the Committee. Members of the Committee shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 27.2. Duties. – The Committee shall continue the work of the Task Force on the Consolidation of Early Childhood Education and Care created under S.L. 2009-451 by continuing to work toward the development of an integrated system of early childhood education and care. To that end, the Committee may consult with and receive reports from the appropriate State departments, agencies, and board representatives on issues related to early childhood education and care and consider any other issues the Committee deems relevant.

SECTION 27.3. Report. – The Commission may make a final report, including any proposed legislation, to the 2011 General Assembly upon its convening. The Commission shall

SECTION 25.1. Section 2 of S.L. 2009-281 reads as rewritten:

"**SECTION 2.** The General Statutes Commission shall study and recommend to the ~~2010~~2011 Regular Session of the ~~2009~~2011 General Assembly ways to ensure that the General Statutes properly and uniformly refer to federal or state military organizations. These may include a single term that will include all organizations that compose the reserve components of the armed forces. The recommendations may include a process to be authorized by the General Assembly whereby changes that do not change the law can be made administratively by the Attorney General."

SECTION 25.2. Section 1 of S.L. 2009-273 reads as rewritten:

"**SECTION 1.** The General Statutes Commission shall study and recommend ~~to the 2010 Regular Session of the 2009 General Assembly and the 2011 Regular Session of the General Assembly~~ ways to make the General Statutes and the North Carolina Constitution gender neutral. These may include recommending legislative changes needed to make the General Statutes and the Constitution gender neutral and a process to be authorized by the General Assembly whereby changes that do not change the law can be made administratively by the Attorney General to make the General Statutes gender neutral."

PART XXVI. REESTABLISH LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (S.B. 1153 – Purcell; H.B. 1827 – Yongue, Brown, Hughes, Insko)

SECTION 26. Part XLIX of S.L. 2009-574 reads as rewritten:

"**PART XLIX. LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (Yongue)**

"**SECTION 49.1.** There is created the Legislative Task Force on Childhood Obesity.

"**SECTION 49.2.** The Task Force shall consist of 12 members as follows:

(1) Six members of the House of Representatives.

(2) Six members of the Senate.

"**SECTION 49.3.** The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Terms of the initial members begin on appointment and continue until the convening of the 2011 Session of the General Assembly. Subsequent appointments begin during the 2011 Session of the General Assembly and continue until the Task Force terminates. Vacancies on the Task Force shall be filled by the same appointing authority that made the initial appointment. A quorum of the Task Force shall be a majority of its members.

"**SECTION 49.4.** The Task Force shall include, but should not be limited to, study of issues relating to childhood obesity. In the course of the study, the Task Force shall consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity and encouraging healthy eating and increased physical activity among children through:

(1) Early childhood intervention;

(2) Childcare facilities;

(3) Before and after-school programs;

(4) Physical education and physical activity in schools;

(5) Higher nutrition standards in schools;

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SECTION 27.3. Report. – The Commission may make a final report, including any proposed legislation, to the 2011 General Assembly upon its convening. The Commission shall

Legislative Task Force on Childhood Obesity

2010 Interim

SENATE APPOINTMENTS	Telephone / Office
• Sen. William Purcell, MD (Co-Chair)	733-5953 / 625 LOB
• Sen. Charlie Dannelly	733-5955 / 2010 LB
• Sen. Donald Davis	733-5621 / 525 LOB
• Sen. Jean Preston	733-5706 / 1121 LB
• Sen. Jerry W. Tillman	733-5870 / 628 LOB
• Sen. Michael Walters	733-5651 / 2108 LB
• Sen. Bob Atwater (Advisory Member)	715-3036 / 312 LOB
• Sen. Josh Stein (Advisory Member)	715-6400 / 410 LOB

HOUSE APPOINTMENTS	
• Rep. Douglas Yongue, (Co-Chair)	733-5821 / 2207 LB
• Rep. Larry Brown	733-5607 / 609 LOB
• Rep. Bob England, MD	733-5749 / 303 LOB
• Rep. Robert Grady	715-9644 / 302 LOB
• Rep. Sandra Spaulding Hughes	733-5754 / 537 LOB
• Rep. Jennifer Weiss	715-3010 / 532 LOB
• Rep. Verla Insko (Advisory Member)	733-7208 / 307 B1 LOB
• Rep. Ray Rapp (Advisory Member)	733-5732 / 2213 LB

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

December 2, 2010

MEMORANDUM

TO: Members, Task Force on Childhood Obesity

FROM: Chairman Bill Purcell and Chairman Doug Yongue

SUBJECT: Meeting Notice

DAY	DATE	TIME	ROOM
Tuesday	December 7, 2010	3:00 pm	Room 643, LOB

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.net/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Katie Stanley at 919.733.5821.

cc: Committee Record _X_
Interested Parties _X_

TASK FORCE ON CHILDHOOD OBESITY

Agenda

December 7, 2010
3:00 pm, Room 643 LOB

Update on Farm to School Program
Gary Gay, Director, Food Distribution Division, NC Department of Agriculture and Consumer Services

Report from NC Local Sustainable Food Advisory Council
Dan Gerlach, Executive Director, Golden Leaf Foundation

Alice Ammerman, Director, Center for Health Promotion and Disease Prevention, UNC School of Public Health; Chair, Childhood Obesity Subcommittee

Update on Healthy Cafeterias Recommendation from Legislative Task Force on Childhood Obesity
Jennifer MacDougall, Program Manager, Community Relations, Blue Cross Blue Shield of NC

Updates on Senate Res. 1151-Supplemental Nutrition Assistance Program (SNAP) Education & House Bill 1726- Improve Childcare Nutrition/Activity Standards
Maria Spaulding, Deputy Secretary, Long Term Care and Family Services, Department of Health and Human Services

Discussion: In light of the General Assembly's needed attention to Fiscal Issues, what can be accomplished at the local, state, and federal level in 2011-2012?

VISITOR REGISTRATION SHEET

Jt. Leg. Education Oversight Committee — December 7, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Walters	Centurylink
Linda Dunker	NCAE
[illegible]	UA 10
[illegible]	NCAIS
[illegible]	NC New Schools Project
[illegible]	NCAE

VISITOR REGISTRATION SHEET

Jt. Leg. Education Oversight Committee — December 7, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Davis	UNC
Anita Watkins	UNC
Lesley Cates	UNC
Ginger Bowles	UNC GA
JIM CERESNAK	UNC GA
JONI LUETHINGTON	UNC GA
Joey Stansbury	office of Senator Goodall
Kara Wells	Arts North Carolina
Jennifer Haygood	NCCCS
Kennon Briggs	NCCCS
Betty Gwaltney	Bank of America

VISITOR REGISTRATION SHEET

Task Force on Childhood Obesity — December 7, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCICH
Gene Causby	NCFSA
[signature]	NC SBA
Katherine Joyce	NCASA
Mark Flemry	BCBSNC
[signature]	Retired soon
Jennifer MacDougall	BCBSNC Foundation
Gilroy Zuckerman	N.C. State Univ.
Jani Kozlowski	Division of Child Development
HEATHER WASSER	NUTRITION SERVICES BRANCH
Arnette Cowan	Division of Public Health Nutrition Services Branch

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	CaDSN [illegible]
Cameron Graham	NC Health and Wellness Trust Fund
Richard C. Reich	NCDA+CS
Joy Hicks	NCDA&CS
[signature]	Stokes Co Schools/SNA-NC
Myron F. Floyd	N.C. State University
Jason Bocarro	NC State University
[signature]	NCRMA

VISITOR REGISTRATION SHEET

Task Force on Childhood Obesity — December 7, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nathan Acosta	NCAAHPERD, PO Box 27751 Raleigh NC 27611
Ron Morrow	NCAAHPERD "
Cynthia Barnett	Christian Science Committee on Publication (for NC)
Ben Matthews	NCDPI
Butch Gunnells	NC Beverage Assoc
Amy McConkey	NC Beverage Assoc
Betsy Setzer	AHA
Pam Seamans	NC Alliance for Health
Veronica Wilson	NC DHHS
Carolyn Dunn	NC Cooperative Extension
LINDEN ELDER	UNC-CH Nutrition Doctoral Student

VISITOR REGISTRATION SHEET

Task Force on Childhood Obesity — December 7, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ALICE AMMERMAN	UNC-Chapel Hill

Committee Sergeants at Arms

NAME OF COMMITTEE Leg Task Force Childhood Obesity

DATE: 12-7-10 **Room:** 643

House Sgt-At Arms:

1. **Name:** Dusty Rhoades
2. **Name:** Judy Turner
3. **Name:** James Worth
4. **Name:** _____
5. **Name:** _____

Senate Sgt-At Arms:

1. **Name:** _____
2. **Name:** _____
3. **Name:** _____
4. **Name:** _____
5. **Name:** _____

North Carolina Sustainable Local Food Advisory Council

2010 Annual Report

October 2010

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EXECUTIVE SUMMARY

The North Carolina Sustainable Local Food Advisory Council (NCSLFAC) was established in August 2009. It's purpose, as mandated in NC G.S. 106-830, is "to contribute to building a local food economy, thereby benefiting North Carolina by creating jobs, stimulating statewide economic development, circulating money from local food sales within local communities, preserving open space, decreasing the use of fossil fuel and thus reducing carbon emissions, preserving and protecting the natural environment, increasing consumer access to fresh and nutritious foods, and providing greater security for all North Carolinians."

The Council met four times in 2010: February 2, April 22, July 22 and September 9. The three Subcommittees of the Council met a total of nine times, and there were several additional meetings and conference calls of various working groups. A Good Agricultural Practices (GAP) working group, called to formation and action by the Chair of the Council, also met two times, and the members corresponded many times on the list serve in working on the details of the GAP pilot program.

Agriculture Commissioner Steve Troxler provided a number of staff to assist the Council, the Subcommittees and work groups. Additional program assistance was provided to the Council, the Subcommittees and work groups via funding from a Golden Leaf Foundation Local Foods Initiative grant secured by the Department of Agriculture and Consumer Services. The Department established a new Web page dedicated to the Council and created a listserve to facilitate information transfer among Council members.

The major items included in this, the first report of the Council, are recommendations to the General Assembly as charged in 106-833, and an account of the proceedings of the Council, Subcommittees and work groups.

The NCSLFAC recommends that the General Assembly establish through legislation the following:

- **Modify municipal annexation:** Require that no municipality may annex farm or forest land nor may any municipality regulate farming and forestry activities in their extra territorial jurisdiction if the land is within a voluntary agricultural district, enhanced voluntary agricultural district or is subject to a conservation easement designated to maintain property as "working lands".

- **Fund ADFP for Military Support:** Provides additional financial match for the Agricultural Development and Farmland Preservation (ADFP) Trust Fund above the FY 2010 funding level to work with military bases, training zones and other areas to protect the military presence in North Carolina and to protect the local food production on farmland in these designated areas.

- **NC Farm Transition Network (NCFTN) Support:** The NCDA&CS and North Carolina Cooperative Extension Service (NCCES) re-establish the NCFTN in partnership and:

- A new position provided to NCDA&CS to manage farmland transition activities within the ADFP Trust Fund; and
- A new position provided to NCCES to manage educational and land-link activities; and,
- Adequate funding for the 2 positions & program activities

- **Funding for NCSLFAC:** Recurring funding for Council staff and operating expenses should be provided to fully leverage the expertise and resources of the Council, Subcommittees and working groups. The Council recommends that a full-time organizational manager be based within the NCDA&CS to coordinate the work of the Council, follow up with members on commitments and represent the Council to various other organizations. The Council recommends and requests that staff would serve at the pleasure of the Council. Further, the Council recommends that input and direction from Council members should be core to the hiring process. In addition to a staff person, the Council recommends recurring monies for on-going Council operating expenses.

- **Establish a Liaison Position to the North Carolina Agricultural Task Force:** Name a member of the North Carolina Local Sustainable Foods Advisory Council as liaison to the North Carolina Agricultural Task Force (ATF) that is headquartered within the NCDENR Division of Soil & Water Conservation.

- **That NCDA&CS and NCSU should develop an All-Farm GAPs Pilot Program for Small Farmers:** Support the state's small and diversified fruit and vegetable farmers by working with the North Carolina Fresh Produce Safety Task Force and its partners to develop an All-Farm GAPs (Good Agricultural Practices) pilot program.

- **Continue Support of Farm To School:** Support the Farm to School Program that connects schools (K-12) and local farms and promote the objectives of serving healthy meals in school cafeterias, improving student nutrition, providing agriculture, health and nutrition education opportunities, and supporting local and regional farmers.

- **Continue to grow the USDA Supplemental Nutrition Assistance Program-Education (SNAP-ED)** This would include expanding social marketing, removing barriers to participation, nutritional education and inclusion of a local food component of the SNAP-ED program.

- **Plan for the Future of Electronics Benefit Transfer (EBT) and Women, Infants and Children (WIC) Programs:** Encourage efforts to reach more people with healthy food access and increasing revenue for more farmers. Provide support for farmers markets to purchase wireless electronic benefit transfer (EBT) devices and promote efforts for outreach and education programs that encourage residents of lower-income neighborhoods and SNAP-ED and WIC recipients to use farmers markets and farm stands.

BACKGROUND

The history of agriculture and local food systems in North Carolina, including the institutions and organizations that fostered them, is very long. Increasing citizen interest in local food production and consumption has strengthened attention to these areas over the past few years, and led to the recommendation for the creation of the NC Sustainable Local Food Advisory Council in 2009.

Nationally, the first Food Policy Council started in 1982 in Knoxville, Tennessee. Since then Food Policy Councils have been established at state, local and regional levels across the country. These Councils began as a way to address the food system as a whole, often bringing the weight of local, county or state government behind grassroots initiatives, a group of representatives and stakeholders from many sectors of the food system.

Councils generally have four functions:

- To serve as forums for discussing food issues,
- To foster coordination between sectors in the food system
- To evaluate and influence policy, and
- To launch or support programs and services that address local needs.

The concept of a Local Food Council is not new to North Carolina. In fact, from 2001 to 2003, North Carolina had a Council with membership from many of the same groups represented today. However, this initial Food Policy Council was funded through a grant received by Drake University in 2001 and because it lacked a legislative mandate, it was disbanded when the grant funds were expended.

Under the leadership of the Center for Environmental Farming Systems, renewed interest in the need for a viable Local Food Advisory Council began. Drs. Nancy Creamer and John O'Sullivan of the Center for Environmental Farming Systems provided this statement of the history, of the needs and the goals of North Carolina's sustainable local food economy in their introduction to the *"Farm to Fork, A Guide to Building North Carolina's Sustainable Local Food Economy."* (Curtis, Jennifer, et al. April 2010).

> "Agriculture and fisheries are the foundations of our food system in North Carolina. Developing viable and lasting production systems to meet the consumption demands of a growing population and to confront challenging natural resource realities requires a multi-disciplinary approach that understands and is responsive to social, political and economic trends."

From the report's recommendation, working with many agricultural partners, a request for legislation to create the North Carolina Sustainable Local Food Advisory Council was made. After months of negotiations, on August 7, 2009, Senate Bill 1067 was ratified as AN ACT TO ESTABLISH THE NORTH CAROLINA SUSTAINABLE LOCAL FOOD ADVISORY COUNCIL TO ADDRESS PROGRAM AND POLICY CONSIDERATIONS REGARDING THE DEVELOPMENT OF A SUSTAINABLE LOCAL FOOD ECONOMY IN NORTH CAROLINA, beginning a new chapter in the local food movement in North Carolina.

COUNCIL PROCEEDINGS

The NCSLFAC members were appointed in the winter of FY 2009-10. (*See Attachment B*) The following list provides the highlights of the four quarterly meetings that were held, fulfilling the statutory requirement for the year.

February 2, 2010: The Council held its first meeting in Raleigh and heard the following presentations:

- **"Local Food: NC Highlights"** - Dr. Richard C. Reich, Assistant Commissioner, NCDA&CS
- **A Farmer's Perspective** – John Vollmer, Vollmer Farm
- **Council's Purpose and Duties** – Joy Hicks, Policy Development Analyst, and Ray Starling, General Counsel, NCDA&CS

Agriculture Commissioner Steve Troxler was unanimously elected as the Chair of the Council, and Dr. Nancy Creamer, Director, Center for Environmental Farming Systems, was unanimously elected as Vice Chair.

April 22, 2010: The Council met in Raleigh and heard the following presentations:

- **Food Safety**: Debbie Hamrick, Director, Specialty Crops, NC Farm Bureau Federation
- **Statewide Action Guide:** Jennifer Curtis, Project Director, NC Choices, Center for Environmental Farming Systems
- **Farmland Preservation Update:** Dewitt Hardee, Program Manager, Agricultural Development Farmland Preservation Trust Fund (ADFP), NCDA&CS

Subcommittee guidelines were discussed and adopted. (*See Attachment C*) Three Subcommittees of the Council were established and Subcommittee Chairs elected:

- **Economic Development and Infrastructure**: Ms. Debbie Hamrick, Director, Specialty Crops, NC Farm Bureau Federation
- **Health, Wellness, Hunger and Food Access:** Dr. Alice Ammerman, Gillings School of Global Public Health, UNC-Chapel Hill
- **Land, People and Natural Resources:** Dr. Edwin J. Jones, Professor and Associate State Program Leader ANR/CRD, NCSU

The Council adopted a resolution supporting the Agricultural Development and Farmland Preservation Trust Fund, requesting the North Carolina General Assembly appropriate $5 million to further the purpose of the fund. (*See Attachment E*)

The resolution was delivered to the General Assembly.

July 22, 2010: The Council met in Raleigh and heard the following presentations:

- **Regulatory Issues of Animal Processing in North Carolina:** Donald H. Delozier, Director, Meat and Poultry Inspection Division, NCDA&CS
- **Local Foods and Economic Development Potential in NC: the Western North Carolina Example:** Charlie Jackson, Executive Director, The Appalachian Sustainable Agriculture Project (ASAP)
- **GAP Certification – A Farmer's Perspective:** Joe Martin, Zydeco Farm and New River Organic Growers
- **Potential "Whole Farm" GAP Certification:** Dr. Ben Chapman, Assistant Professor and Extension Food Safety Specialist, NCSU
- **Southeastern N.C. Food Systems Project:** Dr. Leslie Hossfeld, Associate Professor, Public Sociology Program Director, UNC-Wilmington

September 9, 2010: The Council met in Fletcher and heard the following presentations:

- **Regional Local Food Council Input:** Aaron Newton, Cabarrus County Local Food System
- **How Local and County Governments Interface with Local Foods Businesses and Farms:** John Day, Cabarrus County Manager
- **WNC Regional Livestock Center:** L.T. Ward, WNC Communities
- **Financing Local Food Businesses and Farms:** Anna Tefft, NC Sr. Business Lender, Natural Capital Investment Fund

The Council also received and discussed recommendations from the individual Subcommittees for inclusion in the Annual Report. (*See Recommendations Section*)

SUBCOMMITTEE AND WORKING GROUP PROCEEDINGS

Three Subcommittees were established at the second meeting of the Council in April 2010 to create focus areas for further concentrated study. These Subcommittees each met at least twice. The following sections detail those meetings, along with the findings and recommendations.

Economic Development and Infrastructure:

At its initial meeting, the Subcommittee determined the need to establish working groups to provide more detailed activities on several fronts:

- Study Working Group: Chair Roland McReynolds, assigned G.S. 106-832 (4): In-depth analysis of potential impacts of production of sustainable local food on economic development.
- Regulation Working Group: Chair Ron Fish, assigned G.S. 106-832 (5) & (6): ID and development of solutions to statutory, regulatory and policy barriers.
- Literature Review Working Group: Chair Barry Nash: Using From Farm to Fork as the core document, identify documents and publications that members can determine items of interest for the Subcommittee that will forward the agenda of the Council.
- Infrastructure Working Group: Chair Debbie Hamrick: Work on issues surrounding financing, education, logistics, broad band, cold storage and others that can be brought before the Council.

In subsequent meetings, the Subcommittee concentrated on specific issues of importance to the Council and heard from a number of speakers who could address materials pertinent to the business of the Subcommittee working groups:

The Subcommittee heard presentations from two North Carolina regulatory agencies with oversight of various food laws: Department of Agriculture and Consumer Services Food and Drug Protection Division and Department of Environment and Natural Resources Divisions of Water Quality and Environmental Health. Presenters included:

• NCDA&CS Food and Drug Protection Division: Jim Melvin, Assistant Director for Regulatory Programs, and Anita MacMullan, Food Compliance Supervisor

• NCDENR: Coleen H. Sullins, Director, Division of Water Quality, and Mike Kelly, Deputy Director, and Larry Michael, Environmental Programs Supervisor, Food Protection Branch, Division of Environmental Health

Study Report: Roland McReynolds, working group chair, has met with Dr. Olha Sydorovych, Agricultural and Resource Economics, NC State University. Dr. Sydorovych is preparing a preliminary assessment of what a study for North Carolina would contain as well as a budget. Working group chair recommends that the Council review studies from other states and two publications from USDA ERS: *"Comparing the Structure, Size and Performance of Local and Mainstream Food Supply Chains"* and *"Local Food Systems: Concepts, Impacts and Issues."*

Literature Review Report, Barry Nash, chair (absent), filling in was Charlie Jackson: The working group is collecting research-based reports from across North Carolina and from select communities along the eastern seaboard to learn what has and is being done to create successful local food economies. The goal is to review and recommend documents to the other working groups with the Economic Development & Infrastructure Subcommittee to evaluate in more depth. Progress: To date this working group has compiled nearly 30 assessments, and more are being collected.

At its September 9, 2010, meeting, the ED&I subcommittee approved a work plan for 2011:

Assess the Market
Develop a plan for conducting an in-depth analysis of the current and future economic impacts of production of sustainable local food.

- Develop parameters and a scope of work for an assessment of the impact of the current and future local food market.
- Identify sources of funding to conduct an assessment of the impact of the current and future local food market.
- Develop a timeline and action plan to conduct an assessment of the impact of the current and future local food market.
- Identify existing sources of data and survey resources that may be used to develop an assessment of the impact of the current and future local food market.

Facilitate Entrepreneurial Development
The Subcommittee determined that maintaining awareness of local foods businesses and farms is critical so the issues they face regarding regulations can be addressed. As many more farmers and businesses begin to produce value added crops and start food processing enterprises, they find a confusing regulatory framework that was built for larger scale businesses and farms or altogether unrelated businesses. Ensuring that small local foods businesses and farms are able to access local foods markets with value added, processed farm products is critical to their long-term success and can be an important source of job growth for North Carolina's rural economies. The working group will continue discussions with regulatory agencies to gain an understanding of hurdles to local food entrepreneurs and on-farm value added production and processing.

- Develop and maintain lines of communication with regulatory agencies that have jurisdictional authority for local foods businesses/farms to cultivate a proactive climate of cooperation
- Conduct outreach to local foods entrepreneurs and farmers to determine the most significant regulatory issues and hurdles they face
- Encourage development of regulatory guidance documents (such as "Requirements for the Producer/Grower 20,000 Poultry Exemption" issued in August 2010 by NCDA&CS Meat & Poultry Inspection Division) for various aspects of local foods businesses and on-farm value added production and processing.
- Work to develop and/or access a comprehensive regulatory reference so that local food business entrepreneurs and farmers may quickly surmise which regulations/governmental entities pertain to various types of local foods businesses/farms.

- Engage with the State of North Carolina Administration's efforts to boost small businesses through the Governor's Regulatory Reform Initiative by developing specific recommendations regarding regulatory reform for local foods businesses and farms.

Seek Guidance from Existing Resources
Conduct a literature review of existing studies and publications related to local foods in North Carolina that can be used to inform the Council's work and referenced by the public.

- Collect research-based reports from across North Carolina and from select communities along the Eastern Seaboard to learn what has and is being done to create successful local food economies
- Summarize each publication with bullets highlighting important conclusions and results
- Create an online catalog of the bibliographies with links to the publications on the Council website.

Build and Strengthen Local Foods Infrastructure
Build and strengthen the underlying foundation for local food systems in North Carolina by focusing on public and private infrastructure as a determinant of economic growth and job creation. Infrastructure may be hard or soft. For instance, hard infrastructure includes the physical network and capital investments that enable sustainable production and delivery of local food to markets. Soft infrastructure includes institutions and services that maintain the infrastructure network. Within this broad definition of Infrastructure, the first focus will be on distribution and processing infrastructure to help complete the distribution chain from farm to fork.

- Identify important aspects and critical issues of the existing local foods business and farming distribution and processing infrastructure.
- Isolate one to two critical issues within the existing local foods business and farming distribution and processing infrastructure and develop an action plan to positively address change.
- Support efforts to encourage local foods processing by state, federal or Non-Governmental Organizations (NGOs) agencies such as the NC Department of Agriculture and Consumer Services, NC Department of Commerce, NC Rural Center, Advantage West and others.

The Good Agricultural Practices (GAP) Working Group: At the July 22, 2010, meeting of the Council, the Chair charged a group within the Council to form a GAP Working Group to meet and determine a strategy to deal with all the many issues facing North Carolina's farmers in meeting the growing demand surrounding certification and auditing under the various Good Agricultural Practices specified by the buyers in the marketplace.

At its August 10, 2010, meeting, the GAP Working Group established a goal to develop and test a model "whole farm" GAP program that allows small-scale, diversified farms to participate in institutional and wholesale markets for produce.

The plan was to work with farms participating in New River Organic Growers cooperative, which has identified an institutional buyer that wants to purchase the cooperative's products, and other small diversified farms to establish such a model program.

To achieve this goal, the development and testing of this model program must

- Be accepted by buyers
- Be effective in controlling produce safety risks
- Have a low cost of compliance for farms
- Ensure that record-keeping requirements for farms are consistent with the normal course of business operations
- Analyze the actual economic barriers to GAP audit participation for small diversified farms
- Analyze the actual production practice barriers to GAP audit participation by small diversified farms
- Analyze possible modifications of USDA GAP recommendations to accommodate small diversified farms' barriers to GAP audit participation
- Be easily adapted by small diversified farms
- Be easily adapted by organic farms
- Limit farm inspection to once per year
- Be accepted by public health agencies
- Identify potential obstacles to buyer acceptance of a whole farm GAP program

The target date for commencement of the program is January 2011, and it is expected to be a one-year program.

Drs. Ben Chapman, Chris Gunter and Trevor Phister and Ms. Diane Ducharme of North Carolina State University developed a one-page description of a research proposal designed to achieve these objectives.

Health, Wellness, Hunger and Food Access Subcommittee

The initial meeting provided opportunity for the members to hear presentations from the Farm-To-School Program (F-to-S) with Gary Gay, Director, NCDA&CS Food Distribution Division, and Tommy Fleetwood of the Marketing Division. Discussion was held on (1) How can we expand to pre-schools and universities? and, (2) How can we encourage more participation from school districts?

There was further discussion on GAP certification: the process, who sets the rules, who audits, what are barriers to F-to-S. A recommendation was made to explore fully funding NCDA&CS with additional Food Distribution staff and other identified needs to expand the Farm-To-School Program.

Three action items were agreed to be given emphasis by the Subcommittee:

1. Meet with Child Nutrition Group at conference on October 21, 2010, to highlight the F-to-S Program.

2. Survey schools on participation in the Program.

3. Look at GAP certification issues that might impede a grower's participation.

Discussion was held on the US Department of Agriculture Food and Nutrition Service's Supplemental Nutrition Assistance Program Education (SNAP-ED) funding opportunities and an action item approved: Determine what other states are doing to participate in SNAP-ED and meeting the match/documentation requirements.

There was continued discussion on Update on the Farm to Fork Public Health and Food Access Disparities Working Interest Team (CEFS Farm to Fork summit) and potential coordination of efforts with this group, review and consideration of relevant North Carolina General Assembly Obesity Task Force Recommendations.

The Subcommittee, in following meetings, approved a number of action items:

- Have someone present at the Child Nutrition Conference on October 21, 2010, to gain insight in participation barriers related to the Farm to School Program.
- Continue to explore other state examples of SNAP-ED administration.
- Conduct a working session on SNAP-ED, including a variety of stakeholders to explore how the system could be revamped to encourage participation, increase funding, and have broad state impact.
- Look to other states and offer to NCDA&CS information on what might be the role of the position dedicated to support the F-to-S Program.
- Conduct a working session surrounding use of Electronic Benefit Transfer (EBT) cards at farmer's markets, including future use with WIC benefits. Discuss options to support these programs and potential funding for current gaps in the 21st Century Farmer's market program.

Land, People and Natural Resources Subcommittee:

At its initial meeting, the Subcommittee agreed that in accordance with the General Assembly's charge for the Council, this particular subcommittee would focus on as its top priority all the many issues surrounding preservation of farmlands and water resources.

In addition to this issue, members indicated an interest in the following issue items for further study in the Subcommittee:

- VAD ordinances and inconsistencies county-to-county
- Present use value issues for smaller operations
- Profitability is bottom line … how is this impacted by GAP certification, land preservation, VAD policies, etc.?
- Value-added, commercial grade kitchens
- One-size fits all regulations
- Information technology and transfer

- Tracking of policies and regulations – environmental, land, etc. – in lay language for general dispersal
- How do farmers get access to land?
- Farming issues often based on scale, can we define the levels?
- Costs of goods, fertilizers, labor (and access to labor), paperwork, staff to manage ever-increasing regulation
- Eminent domain
- Extraterritorial Jurisdiction (ETJs) – municipalities that impede or prohibit agricultural practices
- Getting all agencies on same page … adhering to the General Assembly's goals on sustainable local food economy
- Is there a means to determine intervention points in government programs and activities at which point the Council might bring notice to the General Assembly?
- Farm Transition … "Always have one foot in each generation which creates difficulty in farm transitioning programs … how do we bridge the gap?"
- Land … access, costs, government intervention, utilities, regulations, water availability
- Air quality issues around local/regional processing

Subsequent discussions by the Subcommittee were on how to better utilize the efforts of the members to bring greater focus to the highest items of priority on the initial list.

SUPPORT ACTIVITIES AND VOLUNTEER SERVICES

The NCSLFAC did not receive an appropriation and must rely on financial support and in-kind contributions from outside entities. In 2010 those were:

NC Department of Agriculture & Consumer Services
The Council was designated to be housed in the NCDA&CS and the Department was obligated to provide meeting space, per diem for members, and staff resources for the Council. Commissioner Steve Troxler assigned Joy Hicks, Policy Development Analyst as the lead staff person to the Council. Additional departmental specialists were also assigned to work with the Subcommittees and work groups (*See Attachment D*). The Department also established a dedicated web page for the Council (http://www.ncagr.gov/localfood) and an email listserv to serve as a conduit for Council members to share information. The NCDA&CS, when not provided an appropriation to defray the operational costs of the Council, sought and secured a grant from the Golden Leaf Foundation for $100,000 to provide additional staff support and operating expenses for the Council.

The Golden Leaf Foundation, as part of its continued support of its Local Foods Initiative, awarded the $100,000 grant over two years to the Department to "support the operations of the NC Sustainable Local Foods Advisory Council." The Foundation grant was provided to support the Department's efforts in staffing through contractual services, marketing and promotions, website development and logistical expenses.

Volunteer Support
A number of other agencies and organizations have come forward to also provide support for the Council. Major contributors are as follows:

- Appalachian Sustainable Agriculture Project: Working with WNC Communities and NCDA&CS staff, organized a local food reception for the Council at the September 9th meeting. Additionally organized Asheville-region farm tours for the members.

- NC Farm Bureau Federation: Hosted lunch for the Council at the JC Raulston Arboretum on July 22, catered by Q Shack, Owner Tom Meyer, who works with local producers of meats and vegetables; provided meeting space for a number of subcommittee and working group meetings and conference calling services so subcommittee members could call into meetings.

- NC State University: Provided meeting rooms for a Council meeting and several subcommittee meetings; provided support for developing a GAP research proposal and speakers at Council meetings.

- WNC Communities: Linda Lamp, Executive Director, organized a reception showcasing Western North Carolina products at the September 9th Council meeting in Fletcher. (Please see Attachment X for a complete listing of contributors to the reception)

COUNCIL RECOMMENDATIONS

On September 9, 2010, the three Subcommittees presented and received Council approval on the following recommendations:

The NCSLFAC recommends that the General Assembly establish the following items through legislation:

- **Modify municipal annexation:** Require that no municipality may annex farm or forest land nor may any municipality regulate farming and forestry activities in their extra territorial jurisdiction if the land is within a voluntary agricultural district, enhanced voluntary agricultural district or is subject to a conservation easement designated to maintain property as "working lands".

- **Fund ADFP for Military Support:** Provides additional financial match for the ADFP Trust Fund above the FY 10 funding level to work with military bases, training zones and other areas to protect the military presence in North Carolina and to protect the local food production on farmland in these designated areas.

- **NC Farm Transition Network Support**: The NCDA&CS and NCCES re-establish the NCFTN in partnership and:
  - A new position be provided to NCDA&CS to manage farmland transition activities within the ADFP Trust Fund; and
  - A new position be provided to NCCES to manage educational and land-link activities; and,
  - Adequate funding for the 2 position & program activities

- **Permanent Council Staff and Operating Budget:** To fully leverage the expertise and resources of the Council, Subcommittees and Working Groups, the Council recommends that a full-time organizational manager be based within the NCDA&CS to coordinate the work of the Council, follow up with members on commitments and represent the Council to various other organizations. The Council recommends and requests that staff would serve at the pleasure of the Council. Further, the Council recommends that input and direction from Council members should be core to the hiring process. In addition to a staff person, the Council recommends recurring monies for on-going Council operating expenses.

- **Reporting Date Modification:** The Council recommends that the reporting date mandated in G.S. 106-833 for the Council's annual report be modified from October 1 to December 1.

- **Agricultural Task Force Liaison**
  Name a member of the North Carolina Local Sustainable Foods Advisory Council as liaison to the North Carolina Agricultural Task Force (ATF) that is headquartered within the NCDENR Division of Soil & Water Conservation. The Council liaison would serve as a communications link to share water

quality regulatory concerns with the ATF, to raise awareness of the Council and to bring information and perspective from the ATF back to the Council.

The ATF was established to provide input into agricultural nonpoint source pollution control under the federally funded 208 Program for controlling nonpoint source pollution. Today the ATF is a voluntary working group that advises and makes recommendations to the Soil & Water Conservation Commission. (http://portal.ncdenr.org/web/swc/agtaskforce) As more farmers and outside entrepreneurs start up new local foods businesses or on-farm value added operations, they find themselves in a complex regulatory framework of local, county, state and federal regulation. The Ag Task Force liaison would help to create a higher level of awareness of the needs of local foods farmers and businesses among a broad swath of the state's water regulatory framework.

- **Develop an All-Farm GAPs Pilot Program for Small Farmers**
  Support the state's small and diversified fruit and vegetable farmers by working with the North Carolina Fresh Produce Safety Task Force and its partners to develop an All-Farm GAPs (Good Agricultural Practices) pilot program. Many institutional and retail buyers require third party GAPs audits of their fruit and vegetable suppliers. In addition, in order to sell to schools through the farm to school program, farmers must be GAP certified through a third party audit. Many of North Carolina's small and diversified local foods suppliers seek to access these markets in-state. However, common thinking among small fruit/vegetable farmers is that in many instances implementing GAPs is expensive. Many larger fruit/vegetable farms implement GAPS that are commodity specific. Each different commodity thus requires a separate third party audit, which can become expensive. This approach is not feasible for many fruit/vegetable farmers because one small, highly diversified fruit and vegetable farmer may cultivate 30 different crops. Also, there is concern among small and diversified farms that GAPs practices may be unattainable and documentation requirements unrealistic. Additionally, there is concern among certified organic producers that GAPs' record-keeping requirements could duplicate records they already keep. A few organic producers who have worked with GAPs note that there can also be conflict between organic practices and GAPs. All small, diversified fruit and vegetable farmers have concerns regarding on-farm costs for changes in production, equipment purchases and labor changes that might have to be made to attain the certification.

  While there is a GAP Farm Audit, most farmers currently do not choose to use this certification program. Instead, they chose commodity-specific GAP audits to meet buyer requirements. However, the GAP Farm Audit may be able to form the basis for an All-Farms GAP program for small and diversified fruit and vegetable farms. By working with farms in North Carolina to determine what practices are already being employed that work for GAPs and to learn which practices may be unrealistic, the resulting All-Farm GAPs pilot program would focus on food safety on the farm holistically. Such a GAPs program would in essence be an expansion of the existing GAP Farm Audit

and result in a continual focus on food safety by the farmer. By helping to develop such a program and working with institutional buyers to obtain recognition for the program, the Council can empower smaller, diversified local market fruit and vegetable farmers to approach wholesale markets that are currently out of their reach as a result of the cumbersome and excessively costly third-party audit requirements. The data and insights gained by the Pilot will help to shape an All-Farm GAP program through NCDA&CS and USDA.

- **Continue Support of Farm To School:** Support the Farm to School Program that connects schools (K-12) and local farms and promote the objectives of serving healthy meals in school cafeterias, improving student nutrition, providing agriculture, health and nutrition education opportunities, and supporting local and regional farmers.

- **Continue to grow the USDA Supplemental Nutrition Assistance Program-Education (SNAP-ED)** This would include expanding the social marketing, removing barriers to participation, nutritional education and inclusion of a local food component of the SNAP-ED program.

- **Plan for the Future of Electronics Benefit Transfer (EBT) and Women, Infants and Children (WIC) Programs:** Encourage efforts to reach more people with healthy food access and increasing revenue for more farmers. Provide support for farmers markets to purchase wireless electronic benefit transfer (EBT) devices and promote efforts for outreach and education programs that encourage residents of lower-income neighborhoods and SNAP-ED and WIC recipients to use farmers markets and farm stands.

The Council also adopted a resolution on April 22, 2010 supporting funding for the North Carolina Agricultural Development and Farmland Preservation Trust Fund and transmitted the resolution to the President Pro Tempore of the Senate and the Speaker of the House of Representatives:

> **Now Therefore Be It Resolved** that the North Carolina Sustainable Local Food Advisory Council urges the General Assembly of North Carolina to appropriate five million dollars to the North Carolina Agricultural Development and Farmland Preservation Trust Fund for the 2010-2011 fiscal year.

Appendix A: Authorizing Legislation

The North Carolina Sustainable Local Food Advisory Council was established in August 2009 upon the ratification of Senate Bill 1067. The purpose and responsibilities of the Council can be found in Session Law 2009-530, Chapter 106-830 through 833 of the General Statutes:
http://www.ncga.state.nc.us/EnactedLegislation/SessionLaws/HTML/2009-2010/SL2009-530.html

Appendix B: NCSLFAC Membership

Name	Position	Appointed By	Term	Pos. No.
Commissioner Steve Troxler	Commissioner of Agriculture or the Commissioner's designee	Ex officio		1
Jeffrey P. Engel, M.D.	State Health Director or the Director's designee	Ex officio		2
Secretary J. Keith Crisco	Secretary of Commerce or the Secretary's designee	Ex officio		3
Linda Harris	Local organic food producers, organic animal producer	Hackney	7/1/2012	4
Ted Burch	Local organic food producer, organic crop producer	Hackney	7/1/2012	5
Tommy Porter, Jr.	Conventional food producer, animal producer	Commissioner	7/1/2012	6
Randall Patterson	Conventinal food producer, crop producer	Commissioner	7/1/2012	7
Jamie Ager	Sustainable animal producer	Commissioner	7/1/2012	8
Mary James	Sustainable crop producer	Commissioner	7/1/2013	9
Willy Phillips	Representative of commercial fishing industry	Basnight	7/1/2013	10
Phil Hudson	Representative of the NC State Grange	Hackney	7/1/2013	11
Debbie Hamrick	Representative from the NC Farm Bureau Federation, Inc	Hackney	7/1/2013	12
Barry Nash	Representative of the Sea Grant College program	Basnight	7/1/2013	13
Roland McReynolds	Representative of the Carolina Farm Stewardship Association	Governor	7/1/2013	14
Dr. Nancy Creamer	Representative of the Center for Environmental Farming Systems	Governor	7/1/2013	15
Dania Davy	Representative of the NC Association of Black Lawyers' Land Loss Prevention Project	Commissioner	7/1/2013	16
Charlie Jackson	Representative of the Appalachian Sustainable Agriculture Project	Basnight	7/1/2014	17
Mac Legerton	Representative of the Center of Community Action, Inc.	Commissioner	7/1/2014	18
John Day	Representative of the NC Association of County Commissioners	Basnight	7/1/2014	19
Dr. Lynn Harvey	Representative of the Department of Public Instruction, Child Nutrition Services Section	Basnight	7/1/2014	20
Dr. Ed Jones	Representative of the NC Cooperative Extension Service, jointly administered by NCSU and NC A&T	Governor	7/1/2014	21

Dr. Alice Ammerman	Representative of the Center for Health Promotion and Disease prevention at the UNC-Chapel Hill	Basnight	7/1/2014	22
Earline Middleton	Representative of a food bank located in NC	Governor	7/1/2014	23
LaTisha Watford	Representative of the food retail or food service industry	Governor	7/1/2014	24
Andrew Branan	Representative of the NC Farm Transition Network, Inc.	Hackney	7/1/2014	25
Billy Ray Hall	Representative of the NC Rural Economic Development Center, Inc.	Hackney	7/1/2014	26
Uli Bennewitz	Representative of a business engaged in the processing, packing, or distribution of food	Hackney	7/1/2014	27

Appendix C: Subcommittee Guidelines

NORTH CAROLINA SUSTAINABLE LOCAL FOOD ADVISORY COUNCIL
SUBCOMMITTEE GUIDELINES
ESTABLISHED APRIL 22, 2010

1. The Council shall establish Subcommittees with responsibility to make recommendations to the full Council regarding the issues assigned to each.

2. Council members will be assigned to serve on one Subcommittee if they desire. Council members' assignment preference will try to be accommodated. Council members can serve on more than one Subcommittee.

3. Members of each Subcommittee shall elect a Council member from among the Subcommittee membership to serve as Chair. Council members can only serve as Chair on one Subcommittee.

4. The Chair of each Subcommittee will serve on the Executive Committee of the Council and shall be liaison between the Subcommittee and Council Staff.

5. The Executive Committee will be composed of the Chairs of each Subcommittee, and the Council Chair and Vice Chair.

6. Any Subcommittee may invite members of the public to present information to the Subcommittee. Requests for presentations to the full Council must be recommended through the relevant Subcommittee.

7. The Council may alter, adjust, add, or otherwise change the number, responsibilities or other aspect of Subcommittee structures in any duly authorized meeting of the full Council.

8. A quorum of Subcommittee members must be present to take formal action. Only appointed members of the Council may vote on Subcommittee items. A quorum is constituted by a simple majority.

9. The Chair and Vice Chair of the Council shall be Ex officio members of all Subcommittees.

10. Subcommittees will keep official minutes of meetings and at the first meeting shall determine how they will conduct business, whether it will be by general consensus or Robert's Rules of Order.

11. Ad hoc committees may be appointed by the Chair and Vice Chair to work on issues as needed.

12. The Executive Committee shall report Subcommittee activities to the Council; will set Council meeting agendas; and will ensure the Council carries out the legislative mandates of its enabling legislation.

Appendix D: Subcommittee Membership

Updated August 30, 2010

Economic Development	Health, Wellness, Hunger and Food Access	Land, People and Natural Resources
Debbie Hamrick*	**Alice Ammerman***	**Ed Jones***
Jamie Ager	Ted Burch	Andrew Branan
Uli Bennewitz	Jeffrey Engel	Ted Burch
Keith Crisco	Lynn Harvey	Dania Davy
Billy Ray Hall	Mary James	John Day
Charlie Jackson	Earline Middleton	Linda Harris
Mac Legerton	LaTisha Watford	Phil Hudson
Roland McReynolds		Randall Patterson
Willy Phillips		Tommy Porter
9	**7**	**9**

Notes:

- Subcommittee Chairs are listed first and in bold font
- Commissioner Steve Troxler and Dr. Nancy Creamer serve as ex-officio members of each of the subcommittees by virtue of their Council leadership positions.
- NCDA&CS subcommittee staff are as follows:
    - Economic Development – Ron Fish, Assistant Director, Marketing Division
    - Health, Wellness, Hunger and Food Access – Jim Melvin, Assistant Director of Regulatory Program, Food and Drug Inspection Division
    - Land, People, and Natural Resources – Dewitt Hardee, Program Director of the ADFP Trust Fund

Appendix E: Farmland Preservation Resolution

NORTH CAROLINA
SUSTAINABLE LOCAL FOOD ADVISORY COUNCIL

RESOLUTION

SUPPORTING FIVE MILLION DOLLARS BE DEDICATED TO THE NORTH CAROLINA AGRICULTURAL DEVELOPMENT AND FARMLAND PRESERVATION TRUST FUND

Whereas, the General Assembly established in 2009 the North Carolina Sustainable Local Food Advisory Council to address program and policy considerations regarding the development of a sustainable local food economy in North Carolina; **and**

Whereas, the General Assembly established in 2005 the North Carolina Agricultural Development and Farmland Preservation Trust Fund to encourage the preservation of agricultural, horticultural and forest lands to foster the growth, development and sustainability of family farms; **and**

Whereas, North Carolina has lost more than 600,000 acres of farmland since 2002; **and**

Whereas, the Council finds that it is critical to integrate farmland preservation into the development of a sustainable local food economy; **and**

Whereas, protecting and preserving farmland is an important part of the Council's effort to rebuild our local food infrastructure and our local food economy that will benefit North Carolina by creating jobs, stimulating statewide economic development, preserve open space, decrease the use of fossil fuel, preserve and protect the natural environment, increase consumer access to fresh and nutritious foods, and provide greater security for all North Carolinians;

Now Therefore Be It Resolved that the North Carolina Sustainable Local Food Advisory Council urges the General Assembly of North Carolina to appropriate Five Million Dollars to the North Carolina Agricultural Development and Farmland Preservation Trust Fund for the 2011 fiscal year.

Further Be It Resolved that a copy of this resolution be presented to the members of the North Carolina General Assembly.

Adopted April 22, 2010

Commissioner Steve Troxler
Chair

Dr. Nancy Creamer
Vice Chair

Jamie Ager
Alice Ammerman
Uli Bennewitz
Andrew Branan
Ted Burch
Keith Crisco
Dania Davy
John Day
Jeffrey Engel
Billy Ray Hall
Debbie Hamrick
Linda Harris
Lynn Harvey
Phil Hudson
Charlie Jackson
Mary James
Mac Legerton
Roland McReynolds
Earline E. Middleton
Barry Nash
Jon Ort
Randall Patterson
Willy Phillips
Tommy Porter, Jr.

Appendix F: Council Meeting Agendas and Minutes

The Agendas and Minutes of the Council are available on:

http://www.ncagr.gov/localfood/

Appendix G: Subcommittee Meeting Agendas and Minutes

The Agendas and Minutes of the Subcommittees are available on:

http://www.ncagr.gov/localfood/

Appendix H: In-kind Contributors

- Donations and assistance at the reception included:
  - Doug Sutton, Market Manager, WNC FARMER'S MARKET
  - PEREZ FARMS at WNC Farmer's Market
  - ASHE COUNTY CHEESE at WNC Farmer's Market
  - SWEETHINGS BAKERY at WNC Farmer's Market
  - COATES PRODUCE at WNC Farmer's Market
  - SMOKY MOUNTAIN PICKLING COMPANY at WNC Farmer's Market
  - WOODY FARMS at WNC Farmer's Market
  - APPLE WEDGE at WNC Farmer's Market
  - George Ivey & Anne Lancaster, BUY HAYWOOD
  - SUNBURST TROUT COMPANY, Canton, NC
  - LINGERING THYMES FARM Waynesville, NC
  - Laurey's Catering
  - J.W. Johnson Tomato Company, Canton, NC
  - The Wholesome Agrarian, Waynesville, NC
  - Leatherwood & Sons Farm, Cruso, NC
  - The Ten Acre Garden, Bethel, NC
  - Balsam Gardens, Sylva, NC
  - Mary Lou Sturgi, Executive Director, Jill Frazer, Product Development, BLUE RIDGE FOOD VENTURES
  - WINTER SUN FARMS at Blue Ridge Food Ventures
  - THE MOUNTAIN BBQ SAUCE at Blue Ridge Food Ventures
  - SPICY MUSTARD SAUCE at Blue Ridge Food Ventures
  - George Lenze, EVERETT FARMS
  - Jamie Ager, HICKORY NUT GAP FARMS
  - Ross Young, MADISON FARMS
  - MCCONNELL FARMS, Hendersonville, NC
  - HOUSER FARMS, Vale, NC
  - Megan Ray, Program Coordinator, APPALACHIAN SUSTAINABLE AGRICULTURE PROJECT
  - L. T. Ward, Vice President, Linda Lamp, Executive Director, WNC COMMUNITIES

- **Farm tours were provided by the following farms:**
  - **Gladheart Farm**
  - Hickory Nut Gap Farm

Schools that Purchased NC Apples for 2010-11

Alamance Burlington
Alexander County
Alleghany County
Anson County
Asheboro City
Avery County
Beaufort County
Bladen County
Brunswick County
Burke County
Cabarrus County
Camp Lejeune
Chatham County
Cherokee County
Clay County
Cleveland County
Cumberland County
Davie County
Edenton-Chowan
Edgecombe County
Fort Bragg
Franklin County
Graham County
Guilford County
Harnett County
Haywood County
Hickory Public Schools
Hoke County
Hyde County
Iredell Statesville School
Jackson County
Johnston County
Kannapolis City
Macon County
Madison County
Montgomery County
Mooresville Graded
Nash-Rocky Mount
New Hanover County
Newton Conover City
Northampton County
Orange County
Pamlico County
Perquimans County
Person County
Randolph County
Richmond County
Robeson County
Roanoke Rapids
Rockingham County
Stokes County
Surry County
Union County
Vance County
Wake County
Washington County
Wilson County
Yadkin County
Yancey County

Senate Resolution 3307: Healthy, Hunger Free Kids Act of 2010

Child Nutrition Reauthorization 2010

What's in the bill?:
The Healthy, Hunger Free Kids Act takes several steps forward to ensure that low-income children can participate in child nutrition programs and receive the meals they need, including:

- Expanding the Afterschool Meal Program to all 50 states;
- Supporting improvements to direct certification for school meals and other strategies to reduce red tape in helping children obtain school meals;
- Allowing state WIC agencies the option to certify children for up to one year;
- Mandating WIC electronic benefit transfer (EBT) implementation nationwide by October 1, 2020;
- Improving area eligibility rules so more family child care homes can use the CACFP program;
- Enhancing the nutritional quality of food served in school-based and preschool settings; and
- Making "competitive foods" offered or sold in schools more nutritious.

HIGHLIGHTS OF THE BILL

Out-of-School Time Provisions

- **Expands the Afterschool Meal Program (through the Child and Adult Care Food Program) to all states.** The program currently is available in only 13 states (Connecticut, Delaware, Illinois, Maryland, Michigan, Missouri, Nevada, New York, Oregon, Pennsylvania, Vermont, West Virginia, and Wisconsin) and the District of Columbia.
- **Requires school food authorities to coordinate with Summer Food sponsors** on developing and distributing Summer Food outreach materials.
- **Eliminates the requirement that private nonprofit Summer Food sponsors** serve no more than 25 sites with no more 300 children at any of the sites unless the sponsor receives a waiver.
- **Extends the California year-round Summer Food pilot** until 2015 (the length of the reauthorization).
- **Authorizes $20 million dollars for Summer Food Support grants** for sponsors to establish and maintain programs

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School Nutrition Program Provisions

Download the in-depth School Nutrition Program Provisions summary (pdf).

Supports new paperless options for universal meal service.

- Creates a new option that will allow schools in high-poverty areas to offer free meals to all students without collecting paper applications, which will expand access to more children and reduce administrative burdens on schools. The reimbursement levels will be based on the level of direct certification in each school building.
- Establishes a demonstration project to use census data to determine eligibility rates in school districts with high concentrations of low-income children.
- Establishes a three-year demonstration project in up to three school districts to use community survey data to establish eligibility rates in schools instead of paper applications.

Improves direct certification.

- Eliminates the "letter method," which requires families to return a letter to the school to establish eligibility.
- Establishes a demonstration project to test and implement the use of Medicaid for direct certification.
- Sets performance benchmarks for direct certification and provides incentive bonuses to states that show improvement.
- Makes foster children automatically eligible for free meals, eliminating the need to complete paper applications for school meal benefits.

Enhances school nutrition quality.

- Adds a six cent performance-based increase in the federal reimbursement rate for school lunches (six cents per meal) for schools that meet forthcoming updated nutrition standards for breakfast and lunch.
- Gives the Secretary of Agriculture the authority to establish national nutrition standards for all foods sold on the school campus throughout the school day.
- Directs the U.S. Department of Agriculture (USDA) to develop model product specifications for USDA commodity foods used in school meals.
- Provides $40 million over five years in mandatory funding for farm-to-school programs.
- Strengthens Local School Wellness Policies by updating the requirements of the policies, and requiring opportunities for public input, transparency, and an implementation plan.
- Allows only lower-fat milk options to be served, as recommended in the Dietary Guidelines.
- Ensures that water is available free of charge during the meal service.

Authorizes grants for expansion of School Breakfast Programs

- Subject to available appropriations, grants could be used to establish or expand school breakfast programs, with priority going to schools with 75 percent free and reduced-price eligible students.

Includes new school food financing provisions.

- Directs the Secretary of Agriculture to provide guidance on allowable charges to school food service accounts to prevent inappropriate school expenses that are not related to the school meal programs from draining school meal resources.
- Requires a review of local policies on meal charges and the provision of alternate meals (i.e. cold cheese sandwich) to children who are without funds to purchase a meal.
- Requires school districts to gradually increase their "paid" lunch charges until the revenue per lunch matches the federal free reimbursement level. This is a significant change in public policy which likely will result in decreased participation, especially among children whose household income is between 186 and 250 percent of poverty. If these families and higher-income families stop participating in the program it will create the perception that the program is only for "poor" children, causing more children to drop out. Decreases in student participation could cause schools to stop participating in the school meal programs all together.

Child and Adult Care Food Program (CACFP) Provisions

Download the in-depth CACFP summary (pdf).

Promotes good nutrition, health and wellness in child care.

- Revises the nutrition standards for meals, snacks and beverages served through CACFP to make them consistent with the most recent U.S. Dietary Guidelines.
- Provides education and encouragement to participating child care centers and homes to provide children with healthy meals and snacks and daily opportunities for physical activity, and to limit screen time.
- Increases USDA training, technical assistance and educational materials available to child care providers, helping them to serve healthier food.
- Authorizes ongoing research on nutrition, health and wellness practices, as well as the barriers and facilitators to CACFP participation, in child care settings.
- Requires interagency coordination focused on strengthening the role of child care licensing in supporting good nutrition, health and wellness and maximizing the value of CACFP.
- Provides $10 million in funding to USDA for training, technical assistance and materials development.

Expands eligibility, reduces paperwork and simplifies program requirements.

- Expands eligibility by allowing the use of high school and middle school free and reduced-priced school lunch participation levels to determine Tier 1 area eligibility for family child care homes.
- Eliminates the block claim requirement completely.
- Allows providers to facilitate the return of participating children's family income forms.
- Allows permanent operating agreements and renewable applications.

- Continues the USDA working group to reduce paperwork and improve program administration and requires USDA to report the results to Congress.
- Establishes a simplified method of determining sponsor monthly administrative funding by requiring only the number of homes multiplied by the administrative reimbursement rates calculation to determine the sponsors' administrative reimbursements.
- Permits sponsoring organizations to carry over a maximum of 10 percent of administrative funds into the following fiscal year, which will allow sponsors more flexibility to use their funds effectively from one fiscal year to the next.
- Allows state WIC agencies to permit local WIC agencies to share WIC nutrition education materials with CACFP institutions at no cost if a written materials sharing agreement exists between the relevant agencies.

Enhances audit funds and provides protections for states and institutions.

- Allows USDA to increase the state audit funds made available to any state agency from 1.5 percent to up to a total of two percent if the state agency demonstrates that it can effectively use the funds to improve program management.
- Requires the federal-state agreement to make clear the expectation that the federal funds provided to operate the Child Nutrition Programs be fully utilized for that purpose and that such funds should be excluded from state budget restrictions or limitations, including hiring freezes, work furloughs and travel restrictions.

Women, Infants and Children (WIC) Provisions

Allows state WIC agencies the option to certify children for up to one year. (The current requirement is six months.)

Promotes breastfeeding by expanding the collection of WIC breastfeeding data, creating performance bonuses for state agencies with high rates of breastfeeding; and allowing contingency reserve funds to be used to purchase breast pumps.

Specifies that the WIC food package should be updated based on a scientific review at least every 10 years.

Mandates WIC electronic benefit transfer (EBT) implementation nationwide by October 1, 2020, though it grants exemptions in the case of unusual technological barriers or operational costs.

- Provides new cost sharing provisions for state agencies and retailers and requires standards.
- Provides $1 million in annual funding to USDA to develop a national universal product code database.

Provides for $14 million for **WIC infrastructure and special projects**, $30 million to support **WIC management information systems**, and $90 million for **breastfeeding counselors, performance bonuses and other special nutrition education.**

Changes WIC rebate reporting requirements.

Increases WIC research funding from $5 million to $15 million.

Allows state WIC agencies to permit local WIC agencies to share WIC nutrition education materials with CACFP institutions at no cost if a written materials sharing agreement exists between the relevant agencies.

Requires USDA to incorporate a provision in the agreement with state agencies that specifies that federal funds should be fully utilized by state agencies and that such funds should be excluded from state budget restrictions or limitations, including hiring freezes, work furloughs and travel restrictions.

Other Child Nutrition Provisions

Provides $40 million to conduct research into causes and consequences of hunger and to develop demonstration projects to end childhood hunger, including to enhance SNAP/Food Stamp benefits, to enhance or provide innovative delivery models in school meals, afterschool snacks, and CACFP, and to target federal, state, and local assistance (such as housing assistance or family preservation services) to households experiencing hunger or food insecurity.

Directs USDA, in consultation with the Health and Human Services, to establish a research, demonstration, and technical assistance program to promote healthy eating and reduce obesity especially among children, by applying the principles of behavioral economics research in schools, child care programs, and other settings.

Total New Child Nutrition Funding: $4.5 billion over 10 years



Guiding Principles:

- Expand program access to reduce childhood hunger
- Improve nutritional quality to promote health and address childhood obesity
- Simplify program management and improve program integrity

Highlights of S.3307: PROMOTING HEALTH AND REDUCING CHILDHOOD OBESITY

Helping Schools Improve the Nutritional Quality of School Meals

- A performance-based increase in the federal reimbursement rate for school lunches — 6 cents per meal — will help schools meet new meal standards to provide children with healthier school meals.

Establishing National Nutrition Standards for All Foods Sold in Schools

- The bill includes a provision that represents an historic agreement between major public health organizations, leaders in the food and beverage industries, and parent and community advocates to safeguard the health and wellbeing of our nation's schoolchildren by providing the Secretary of Agriculture with the authority to establish national nutrition standards for all foods sold on school campuses throughout the school day.

Promoting Nutrition and Wellness in Child Care Settings

- This section establishes nutrition requirements for child care providers participating in the Child and Adult Care Food Program and provides guidance and technical assistance to help providers improve the health of young children.

Connecting More Children to Healthy Local Produce through Farm-to-School Programs

- The bill provides $40 million in mandatory funding to help schools establish school gardens and source local foods into their cafeterias.

Strengthening Local School Wellness Policies

- The 2004 Child Nutrition Reauthorization required each school or district participating in the National School Lunch Program to establish a local school wellness policy. The Healthy, Hunger-Free Kids Act will update the requirements for those policies by requiring opportunities for public input and transparency in the formulation of the policies, as well as plans for implementation and measuring compliance.

Supporting Breastfeeding in the WIC Program

- The fiscal year 2010 agriculture appropriations bill provided mandatory funding for a program to recognize exemplary breastfeeding practices at the WIC clinic and state agency levels. The Healthy, Hunger-Free Kids Act permanently authorizes this program within child nutrition law and expands the collection of WIC program data on breastfeeding rates.

Improving School Food Financing

- USDA data suggest that federal reimbursements intended for children in the free and reduced price income categories are being diverted from their intended purpose and instead are supporting other parts of schools' food service accounts. The Act includes new initiatives designed to empower school food service directors, improve the financial solvency of school food service accounts, protect the federal investment in healthy school meals, and ensure that low-income children receive the full value of their meal benefits.