S. HRG. 110–962

CONFRONTING CHILDHOOD OBESITY: CREATING A ROADMAP TO HEALTHIER FUTURES

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN AND FAMILIES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

ON

EXAMINING CHILDHOOD OBESITY, FOCUSING ON HOW TO CREATE A ROADMAP TO HEALTHIER FUTURES FOR YOUNG PEOPLE GROWING UP IN AMERICA

DECEMBER 3, 2008 (Santa Fe, NM)

Printed for the use of the Committee on Health, Education, Labor, and Pensions

Available via the World Wide Web: http://www.gpoaccess.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE

45–808 PDF WASHINGTON : 2009

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CONFRONTING CHILDHOOD OBESITY: CREATING A ROADMAP TO HEALTHIER FUTURES

WEDNESDAY, DECEMBER 3, 2008

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN AND FAMILIES, COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Santa Fe, NM.

The committee met, pursuant to notice, at 10:00 a.m. in Room 321, New Mexico State Capitol Building, 490 Old Santa Fe Trail, Santa Fe, New Mexico, Hon. Jeff Bingaman, presiding.

Present: Senator Bingaman.

OPENING STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Soon-to-be Senator Udall and I are glad to be here and to welcome everybody.

This is a hearing of the Subcommittee on Children and Families of the U.S. Senate Health, Education, Labor, and Pensions Committee. It is focused on a very important issue, in my view, that is childhood obesity and how we can create a roadmap to healthier futures for young people growing up in this country.

We ought to thank whoever arranged to let us use this wonderful hearing room here in the Capitol. They have much nicer hearing rooms here than we do in Washington.

[Laughter.]

Also much nicer art on the walls, I would point out.

Now we have four great panelists here, and I will introduce them in just a minute, who are going to give us their views on this important issue. The idea here is to bring together national and State leaders in combating childhood obesity to talk about what are the most effective strategies available to our State and to other States and also to communities, and to the country as a whole.

I think we are all aware of the problem. Over the past two decades, the prevalence of childhood obesity has grown to staggering proportions in this country. Almost 32 percent of American children and adolescents—that is 23 million in total—are considered overweight or obese.

The problem is even worse among certain minority groups. Hispanic and Native American communities are disproportionately affected by this epidemic.

Obviously, it is a costly problem for us in New Mexico. It is a costly problem for our healthcare system, healthcare delivery system generally.

According to the Centers for Disease Control, the rate of new diabetes cases nearly doubled in the United States in the last 10 years. About 80 percent of the cases are type 2 diabetes, the form that is linked to obesity.

The findings echo geographic trends seen with obesity and physical inactivity, which are also tied to heart disease. In total, more than 23 million Americans have diabetes today.

It is not just type 2 diabetes that is the problem. Also, the incidence of high blood pressure and progressive liver disease, these are ailments that used to be only associated with adults. Their incidence is rising among overweight children.

We need to have policies to address this. To this end, I introduced a bill in the Senate this year called the Obesity Prevention, Treatment, and Research Act of 2008. The legislation would develop a national strategy to organize our efforts to combat childhood and adult obesity.

Let me just acknowledge Frederick Isasi and Dan Derksen. Dan was working as a fellow in our office, helping with the preparation of this. Frederick does all of our healthcare issues and worked on this as well.

This legislation would help develop a national strategy. It would result in increased collaborations and collective actions across agencies, among private entities, individuals, and communities. We have also tried to champion efforts to improve access for beneficiaries in Medicare and Medicaid and other Federal programs to nutrition counseling, as well as improved training and access to prevention services and physical education programs.

One other related effort we have made in the Congress is to increase funding for the Fresh Fruits and Vegetables Program in New Mexico schools. This year, that program will receive $700,000 in Federal funding. It is scheduled to increase under the Farm bill that we passed, up to $2 million by 2012 to provide healthy foods to children in more of our schools.

We have a great group of panelists, as I indicated. Before I introduce our panelists, let me call on Congressman Udall, soon-to-be Senator Udall for his comments.

This is a group of issues that he has been vitally interested in during his entire time in the Congress, and I look forward to working with him on these when he gets sworn in to the Senate on the 6th of January.

So go right ahead.

STATEMENT OF HON. TOM UDALL, U.S. REPRESENTATIVE FROM THE STATE OF NEW MEXICO

Mr. UDALL. Thank you very much, Senator Bingaman. It is a pleasure to be here with you today, and it is a real honor for you to have invited me.

Distinguished members in the panel and guests, it is also an honor to be here with you, especially to discuss an issue that I think is of such great importance to both New Mexico and the Nation.

In Senator Bingaman's opening comments and the written testimony of our witnesses, the challenges we face are outlined starkly and clearly. For most of us here today, this crisis is not news. For

years, we have seen the headlines—"Healthcare Crisis Looms," "Diabetes Epidemic," "Increase in Childhood Obesity."

Everyone seems to have a solution, but the one that could make a real difference—prevention—is only paid lip service. We say an ounce of prevention is worth a pound of cure, but then we fail to re-invent our healthcare policy to make prevention a cornerstone.

That is why it is so refreshing to read your testimony today. All of the work you are doing is very important and is greatly needed by our Nation. I think what you are trying to do is get our healthcare system on the right track.

I have heard some people say that we don't have a healthcare system, we have a sick care system and that we should really orient ourselves toward prevention. I notice, Dr. Sanchez, you say in your testimony, your written testimony, "Shifting the healthcare paradigm away from treating diseases after they occur and toward preventing them from ever occurring." That statement, I think, is particularly poignant.

Senator Bingaman and I have been saying this for years, and today, we spend 95 percent of our healthcare dollars on treating chronic and acute illnesses, many of which could be prevented in the first place. In other cases, we could at least delay the onset of disease for a number of years and provide a higher quality of life.

The dollars we spend on prevention are miniscule, and we do not track the outcomes in a meaningful way. This Nation needs a new approach to healthcare, which puts prevention front and center. The key to prevention is personal responsibility and personal action. If people are given the facts and alternatives, they can take charge of their health.

Senator Bingaman, like you, I am very eager to hear the witnesses and appreciate, once again, being here with you today.

Senator BINGAMAN. Great. Thank you very much.

Why don't we do this? Let me introduce and call up two of our witnesses, and we will hear from them and ask them questions. Then we will call forward the other two witnesses and do the same thing with them.

First, let me call Eduardo Sanchez up and let me say a little bit about his background. He is currently the vice president and chief medical officer at Blue Cross Blue Shield of Texas. He serves on the Institute of Medicine on the National Academy's Committee on Progress in Preventing Childhood Obesity. He is chairman of the IOM's Childhood Obesity Prevention: Actions for Local Government Project.

So he has spent a lot of time on this issue. If you would just take a seat up there, that would be great.

Our other witness on this first panel will be Joseph Thompson, who is a physician, also the surgeon general of the State of Arkansas, the director of Arkansas Center for Health Improvement. He is board certified in both pediatrics and preventive medicine, serves on the faculty of the University of Arkansas for Medical Sciences.

He has been instrumental in the very aggressive effort that the State of Arkansas has made to try to deal with this problem. I had the good fortune to hear his testimony on this subject when he testified to our full Health and Education Committee in the Senate earlier this year.

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Thank you both for being here. I guess, Eduardo, why don't you go ahead and start, and give us your thoughts as to—I guess there are microphones that are picking this up? OK. Terrific.

Well, please, go right ahead.

STATEMENT OF EDUARDO SANCHEZ, M.D., FACP, VICE PRESIDENT AND CHIEF MEDICAL OFFICER, BLUE CROSS AND BLUE SHIELD OF TEXAS, RICHARDSON, TX

Dr. SANCHEZ. Good morning, Mr. Chairman and Senator-elect Udall. Congratulations to you, sir.

Mr. UDALL. Thank you.

Dr. SANCHEZ. My name, as stated, is Eduardo Sanchez. I am vice president and chief medical officer of Blue Cross Blue Shield of Texas, a division of Health Care Service Corporation, a non-investor-owned health plan.

I previously served as the Texas commissioner of health from 2001 to 2006, leading the Texas Department of Health and then the Texas Department of State Health Services as the State health officer.

I am here today, however, as a member of the Institute of Medicine's Standing Committee on Childhood Obesity Prevention. I am grateful for the opportunity to appear before you today and thank you, Senator Bingaman, for your leadership.

This morning, I want to focus my comments on solutions to prevent, to reverse childhood obesity in the United States. In order to succeed and to offer parents some assurance that our children will outlive us, we need to concentrate on four key areas—leadership and commitment at the highest levels, monitoring the problem, identification and funding of best practices, and evaluation of our efforts.

Please allow me to set the stage. Health experts have warned that for the first time, children today are in danger of having a shorter lifespan than their parents.

More children are obese now than at any other time in history and are experiencing unprecedented levels of type 2 diabetes, something that was called "adult onset" diabetes when Dr. Thompson and I were going to medical school, and early risk factors for cardiovascular disease. A recent study found that the arteries of obese 10-year-olds resemble those of 45-year-olds.

Obesity is more prevalent among poor and nonwhite children. That is important because the demographic shift in our Nation, particularly the race/ethnicity shift, is one that will shift the burden of obesity fairly significantly in some States more than others. As Senator-elect Udall said already, prevention is the key to reversing childhood obesity trends.

According to the Department of Health and Human Services, obesity and overweight in U.S. adults cost from $69 billion to $117 billion annually. The State of Texas decided to look at Texas cost of obesity and estimated that the cost will increase from around $10.5 billion today to $39 billion by the year 2040 if current trends continue. That is a doubling in the cost because the population will have quadrupled.

Obesity cost Texas business an estimated $3.3 billion in 2005 and could cost employers $15.8 billion by the year 2025 if trends continue. These are very conservative figures.

Point being, obesity is a health issue and an economic issue. It is time for a national strategy to reverse childhood obesity in the United States. Your bill addresses that national strategy.

I want to suggest that we could use the Federal pandemic influenza efforts that started in 2005 as a model. The United States should develop a comprehensive, coordinated plan led by the U.S. Departments of Health and Human Services, Agriculture, and Education, and that involve every department and agency of the Federal Government, including the legislative branch; State and local governments, including health departments; businesses, foundations, communities, schools, families, and individuals.

The plan must outline clear roles, responsibilities, and objectives. In Texas, a State strategic plan is driving efforts in the State. The Texas Department of State Health Services, as part of that, developed what is called a Texas Obesity Policy Portfolio to help decisionmakers decide what makes sense, what doesn't make sense.

Much like the challenge of preparing for a flu pandemic, our leaders should challenge the entire Nation to share in the responsibility to reverse childhood obesity and do their part to improve our Nation's health. We must make the healthy choice the easy choice by giving our communities, our schools, businesses, and the people of this country the tools they need to make it easier to follow the dietary and physical activity guidelines for Americans.

Effectively addressing childhood obesity requires adequate monitoring of national, regional, State, and local obesity prevalence rates and its related risk factors. Doing so will make the case for what works and what does not work.

The evidence gathering must extend beyond the public health and healthcare systems, however, to include food systems, education systems, and transportation systems. We need evidence of the effectiveness of prevention interventions, of clinical treatment interventions, of system-level interventions, and of all of those interventions in the context of diverse communities and stage of child development.

The CDC National Center for Health Statistics and some individual States have developed a monitoring system for some, but not all of those data needs. Data and information systems are the backbone for informed policymaking. Yet they are under-resourced and sometimes under-utilized. They track critical health risk behaviors and health problems, and they are used to plan and evaluate responses and to target populations with the greatest needs.

Texas has funded the School Physical Activity and Nutrition, SPAN, Survey Project, a statewide childhood obesity surveillance system, using Federal funds. Preliminary data show that the prevalence of obesity in Texas among 4th, 8th, and 11th grade students is higher than the national average. The trend among fourth graders appears to be leveling off and possibly decreasing in some parts of Texas, namely El Paso, where implementation and funding of coordinated school health and community-wide nutrition and physical activity programming has made a difference.

Texas is also now requiring fitness assessments among children in grades 3 through 12. FITNESSGRAM assesses aerobic capacity, strength, and flexibility. Last year, two thirds of 3.4 million students were tested. Less than one third of 3rd grade students are fit, and by 12th grade, less than 10 percent of students met the health standards in all six tests. We are going backwards as our children go through the school system.

We can ill-afford to treat the ever-increasing numbers of medical conditions associated with increasing childhood obesity. In Texas, type 2 diabetes as a pediatric condition is no longer an uncommon finding. Fifty percent of the new pediatric diabetes in some parts of our State are type 2 diabetes, again, a condition that was not seen in children when Dr. Thompson and I were going to medical school.

Prevention of childhood obesity is the key to a healthier future for the United States. We have enough evidence about what works to act now, but we need the political leadership, more political leadership like yours, Senator Bingaman, to adequately fund programs that have proven effectiveness.

In Texas, we have seen results with CATCH, the Coordinated Approach to Child Health, the coordinated school health program for elementary schools. In 1997, based on the results of a clinical trial and subsequent 3-year follow-up study, the board of the Paso del Norte Health Foundation approved the first of two grants for CATCH in El Paso.

CATCH focuses on balanced nutrition, physical activity, health education, and tobacco avoidance and proved successful through its coordinated, multi-platform approach—classroom instruction, healthy cafeteria lunches, activity-based physical education classes, at-home parent involvement, and after-school community-based programs.

CATCH does make a difference. The Texas SPAN survey of fourth grade students in El Paso County suggests that CATCH was a contributing factor to a 7-point drop in student obesity rates measured from 2000 at 25 percent to 2005 at 18 percent. Paso del Norte Health Foundation funded CATCH at $4.2 million over a 7-year period and estimated the cost of implementation at $10 per student per year.

Not every community has a benefactor like Paso del Norte Health Foundation. Nevertheless, over 2,100 Texas elementary schools and nearly 10,000 schools nationwide have been trained in the use of CATCH.

Here, in New Mexico, the New Mexico Plan to Promote Healthier Weight calls for increasing the number of schools offering CATCH. New Mexico health, education, and cooperative extension agencies are working together to implement CATCH in grades K through 5. Funded largely with tobacco settlement funds, each CATCH school is encouraged to include all components of the intervention.

In 2008, a total of 45 elementary schools and after school programs were funded to provide the CATCH program. Not only does CATCH improve diet, physical activity, and obesity, but Texas researchers have documented significant improvements on Stanford achievement test scores.

Among the group for predominantly poor Latino elementary school students, the CATCH classroom physical activity intervention produced significant increases in achievement in math problem solving. Among children identified as not adapting well to school, CATCH produces significant improvements in Stanford math and reading scores.

If we want our children to lead healthy, productive lives, we need a national strategy to address childhood obesity. The challenge to our Nation's future, health, and economic prosperity warrants Federal leadership to bring together all levels of Government, private and nonprofit sectors, as well as parents and teachers, to emphasize wellness and enhance nutrition and physical activity.

Fully funding and implementing coordinated school health programs like CATCH and others—and there are others—with a proven track record is low-hanging fruit that can assure our communities and our Nation a large cohort of healthier children and a much brighter future.

A national response to the obesity epidemic should be commensurate with the scope of the problem. The obesity epidemic should be met with a fire hose instead of a garden hose, with boots on the ground to mobilize communities and to assure sustained application of the evidence. Anything less threatens our economic welfare and the very future of our children.

Thank you again for the opportunity to testify.

[The prepared statement of Dr. Sanchez follows:]

PREPARED STATEMENT OF EDUARDO J. SANCHEZ, M.D., FACP

Good morning, Mr. Chairman and Members of the Senate HELP Committee. My name is Eduardo Sanchez, Vice President & Chief Medical Officer of Blue Cross Blue Shield of Texas, a division of Health Care Service Corporation, and former Texas Commissioner of Health. I am here today, however, as a member of the Institute of Medicine Standing Committee on Childhood Obesity. I am grateful for this opportunity to appear before you today on behalf of the children of Texas, my home State, and the children of the United States.

I would first like to thank the Chairman and members of the subcommittee for your past support of programs and initiatives that invest in our Nation's young people and for the opportunity to testify today on a very serious issue—the declining health of America's children, which is closely linked to our Nation's obesity epidemic.

Recent natural disasters such as the fires in California and Hurricane Ike in Texas shine a spotlight on the critical role that public health plays in preparing our communities and in the relief efforts that followed. In these events, storms or fires swelled out of control with little or no warning, and with little time to respond. Inadequate preparation and inadequate heed to warnings of some people in communities contributes to the protracted recovery from these disasters.

In the case of obesity, Mr. Chairman, we see the forecast, and "perfect storm" conditions are brewing. The effects of this storm will be more devastating than the wind and waves in Louisiana, Mississippi, and Texas. Its damage will impact generations to come. What will be lost is more precious than buildings, houses, and infrastructure: it is human life. Unlike our natural disasters, the good news is we can control this storm.

Today, I am here to discuss the extent of childhood obesity and diabetes in America, their associated health and economic impact, and my thoughts on coordinating the strategic national response necessary to confront this growing health problem. In order to succeed and to offer American families assurance that our children will outlive us, we need to concentrate on four key areas: leadership and commitment at the highest levels, monitoring of the problem, identification and funding of best practices, and evaluation of the effects of our strategic response.

SCOPE OF THE PROBLEM

Recognizing that health behaviors acquired during youth follow into adulthood, the current health status of youth is alarming. Health experts have warned that, for the first time, children today are in danger of having a shorter lifespan than their parents.[1] More children are obese now than at any other time in history and are experiencing unprecedented levels of type 2 diabetes and early risk factors for cardiovascular disease.

Overall, approximately 23 million children in the United States are obese or overweight, and rates of obesity have nearly tripled since 1980, from 6.5 percent to 16.3 percent.[2] Eight of the ten States with the highest rates of obese children are in the South.[3] Obesity is striking poor and non-White children at much higher rates compared to whites and wealthier populations. In Texas, the School Physical Activity and Nutrition surveillance study in 2000–2001 found that 35 percent of Hispanic 4th grade boys, 20 percent of African-American, and only 14 percent of white were obese.[4] We should set as a a national goal childhood obesity rates of 5 percent, the level prior to the start of this epidemic.

As a result of increasingly overweight Americans, the United States is also experiencing an epidemic of diabetes. Type 2 diabetes is on the rise among children and accounts for almost half of new cases in teenagers in some areas of the country. CDC projects that one in three children born in the United States is expected to develop diabetes in their lifetimes. However, the projection for Hispanic/Latino populations is even more alarming: one in every two. This is a statistic we take very seriously in the State of Texas, where it is projected that by 2025, the non-White population will exceed the White population (as is already the case in California, Hawaii, New Mexico, and the District of Columbia). These four States and the District of Columbia represent one quarter of the total U.S. population, and we know that unhealthy eating and physical inactivity are risk conditions that are disproportionately represented among some of our States' racial and ethnic groups.[5]

A recent study shows that among children as young as 10 years old, increased body fat is related to arterial stiffness in otherwise *healthy children*, independent of blood pressure and heart rate.[6] The study shows that obese 10-year-olds have the arterial thickness of many 45-year-olds. Dr. Henry McGill, the noted pathologist from San Antonio, reports that 77 percent of young men killed in the Korean war had advanced atherosclerosis; 18 years later, Vietnam casualties had a similar prevalence of atherosclerosis. *Dr. McGill's research shows that a substantial proportion of today's young people have coronary artery lesions with the potential to develop premature coronary heart disease*.[7] The recent recommendation by the American Academy of Pediatrics for cholesterol screening of kids—with the possibility of prescribing cholesterol lowering drugs for young children—is just another tragic example of how much obesity has negatively affected the health of our children.

ECONOMIC IMPACT

These health impacts come at a great cost to our Nation. According to the Department of Health and Human Services, obese and overweight adults cost the United States anywhere from $69 billion to $117 billion per year.[8] One study found that

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[1] Olshansky, S Jay; Passaro, Douglas J.; Hershow, Ronald C.; Layden, Jennifer; Carnes, Bruce A.; Brody, Jacob; Hayflick, Leonard; Butler, Robert N.; Allison, David B.; Ludwig, David S. A Potential Decline in Life Expectancy in the United States in the 21st Century. Obstetrical & Gynecological Survey. 60(7):450–452, July 2005.

[2] Ogden, C.L., M.D. Carroll, and K.M. Flegal. "High Body Mass Index for Age Among U.S. Children and Adolescents, 2003–2006." *Journal of the American Medical Association* 299, no. 20 (2008): 2401–2405.

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *National Survey of Children's Health 2003*. Rockville, MD: U.S. Department of Health and Human Services, 2005, *http://www.mchb.hrsa.gov/overweight/techapp.htm* (accessed Nov 20, 2008)

[4] Hoelscher DM, et al., 2004. Measuring the prevalence of overweight in Texas school children. *American Journal of Public Health*; 94(6): 1002–1008.

[5] U.S. Department of Health and Human Services (USDHHS). *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*. Washington, DC: USDHHS, 2001.

[6] Sakuragi, S, et al. 2008. Influence of Adiposity on Arterial Stiffness in Healthy Children. Circulation 118: S_1115–a.

[7] McGill Jr H, et al., 2008. Preventing Heart Disease in the 21st Century. Implications of the Pathobiological Determinants of Atherosclerosis in Youth (PDAY) Study. *Circulation,* 2008;117:1216–1227.

[8] U.S. Centers for Disease Control and Prevention. "Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity." U.S. Department of Health and Human Serv-

obese Medicare patients' annual expenditures were 15 percent higher than those of normal or overweight patients. The cost of childhood obesity is also growing. Between 1979 and 1999, obesity associated hospital costs for children (ages 6 to 17 years) more than tripled, from $35 million to $127 million. In a report published by the Texas Department of Health, the estimated costs of health care, lost work days, and premature death related to overweight and obesity in Texas adults may increase from $10.5 billion in 2001 to $39 billion by 2040 if the obesity epidemic continues.[9] This is a call to action for all States.

The poor health of Americans of all ages is putting the Nation's economic security in jeopardy. More than a quarter of U.S. health care costs are related to physical inactivity, overweight and obesity. Health care costs of obese workers are up to 21 percent higher than non-obese workers. Obese and physically inactive workers also suffer from lower worker productivity, increased absenteeism, and higher workers' compensation claims. Obesity cost Texas businesses an estimated $3.3 billion in 2005 and could cost employers $15.8 billion annually by 2025 if the trend continues unchecked.[10] To maintain our economic competitiveness and our general health and well-being, we must improve the health of America's next generation. To do that, we must improve diet and increase physical activity levels.

LEADERSHIP

Clearly, it has taken decades for the child obesity epidemic to develop, and it will take a coordinated effort to begin to mitigate it. Today, in the United States, we have no national, coordinated effort to combat obesity. As a country, we are falling behind even as nations adopt solutions, such as the Foresight[11] project, which is centrally funded to produce a sustainable response to obesity in the U.K. over the next 40 years. The United States needs a comprehensive, realistic plan (akin to the Nation's avian influenza pandemic planning efforts) that involves every department and agency of the Federal Government, State and local governments, businesses, communities, schools, families, and individuals. It must outline clear roles and responsibilities.

The U.S. economic situation, while dire, provides a window of opportunity to act boldly, implement new programs and policies, and achieve health-related goals. Now, more than ever, when critical economic and social decisions are being made, the positive and negative impact on the health of Americans must be considered. Our leaders should challenge the entire Nation to share in the responsibility and do their part to help improve our Nation's health. All levels of government should develop and implement policies to make the healthy choice the easy choice—by giving our communities, our schools, American businesses, and the American people the tools they need to make it easier to follow the Dietary[12] and Physical Activity[13] Guidelines for Americans. Our leaders must take up the challenge of making safe, affordable, healthy food choices and recreational places available for all Americans.

The trend, over the past 5 years, has been to decrease our Federal investments in child health.[14] Real discretionary spending on children has declined by more than 6 percent since 2004, while at the same time all other non-defense discretionary spending has increased by more than 8 percent. Only one penny of every new, real non-defense dollar spent by the Federal Government has gone to children and children's programs. Our children are our future and they deserve better.

MONITORING

Effectively addressing childhood obesity will require continued investments in the development of evidence, measures, and longitudinal data. The evidence needed spans all levels of the public health and health care systems: we need annual na-

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ices, *http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm.* (accessed Nov 20, 2008).

[9] *The Burden of Overweight and Obesity in Texas, 2000–2040, 2003*. Texas Department of State Health Services. 2005.

[10] Susan Combs, Texas Comptroller's Office, Counting Costs and Calories Measuring the Cost of Obesity to Texas Employers March 2007 *http://www.window.state.tx.us/specialrpt/obesitycost/* (accessed Nov 20, 2008).

[11] Foresight. Tackling Obesities: Future choices *http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/KeyInfo/Index.asp* (accessed Nov 20, 2008).

[12] USDA, Dietary Guidelines for Americans, *http://www.health.gov/DietaryGuidelines/* (accessed Nov 20, 2008).

[13] CDC, Physical Activity Guidelines for Americans *http://www.health.gov/PAGuidelines/* (accessed Nov 20, 2008).

[14] First Focus. Childrens Budget 2008. *http://www.firstfocus.net/pages/3391/* (accessed Nov 20, 2008).

tional, regional, and State-level monitoring of child obesity and its related risk factors, we need evidence of the effectiveness of prevention interventions, evidence of the effectiveness of clinical treatment interventions, evidence of the effectiveness of system level interventions, and evidence of the effectiveness of these interventions in the context of diverse communities and stage of child development.

The CDC National Center for Health Statistics and some individual States have developed information systems for some, but not all, of these pressing data requirements. These systems are the backbone for informed policymaking. They track critical health risk behaviors, providing timely data for State and metro areas, which are used to identify health problems, plan and evaluate responses, and target populations with the greatest needs. These measures need to be coordinated and consistent throughout the States, so that data can be used for comparisons by State and across the Nation.

In Texas, over the past few years, the Department of State Health Services has been able to fund the development and implementation of a statewide childhood obesity surveillance system called the School Physical Activity and Nutrition (SPAN) survey project using Preventive Health and Health Services Block Grant funds. Thus far, two surveys have been funded by the block grant in 2000–2002 and 2004–2005, at a total cost of about $1.5 million. Using these data, Texas has been able to establish a baseline prevalence rate for childhood obesity and observe trends over time. Preliminary data show that although the prevalence of obesity in Texas among 4th, 8th, and 11th grade students is higher than the national average, the trend among 4th graders appears to be leveling off and possibly decreasing, especially in certain regions of the State. This trend is reflected in El Paso, TX where extensive implementation and funding of coordinated school health and community-wide nutrition and physical activity programming have occurred for at least 5 years.

In 2007, Texas added to it's monitoring system by requiring fitness assessments among children in grades 3–12. FitnessGram is composed of six measures: aerobic capacity; body composition; abdominal strength and endurance; trunk strength and flexibility; upper body strength and endurance; and flexibility. During the program's first year, 2.6 of the almost 3.4 million students were tested. Preliminary results show that only 32 percent of third-grade girls and 28 percent of third-grade boys reached the "Healthy Fitness Zone." By 12th grade, just 8 percent of the girls and about 9 percent of the boys met the health standards in all six tests. Clearly our children need some help.

TREATMENT

Reimbursement for medical services related to childhood obesity is emerging as a major issue surrounding childhood obesity management throughout the country.[15] The bad news is the likelihood of extremely obese children (or adults) ever returning to normal weight is small because treatment strategies, in the long term, remain largely ineffective.[16] This includes the use of radical, expensive, and invasive interventions such as gastric bypass and stomach lap-banding surgeries. Treatment, while necessary for many, cannot be expected to solve the child obesity epidemic.

PREVENTION

The time is right to look at innovative ways to reduce and prevent child obesity and the staggering long-term health and productivity costs. We need a paradigm shift away from treating diseases after they occur and towards preventing them from ever occurring. By definition, prevention of chronic diseases means focusing on the generation growing up, the children that are overweight at age 2 or 3 and living with type 2 diabetes and high blood pressure by the time they are 8 years old. We cannot afford to wait. We need to place prevention at the center of our health priorities.

We cannot afford to wait for our healthy children to become obese and seek medical treatment for diabetes, cardiovascular disease, sleep apnea, gall bladder disease, and orthopedic problems. In 2004, we spent $117 billion on conditions related to obesity and $132 billion on type 2 diabetes. What if we invested that kind of money to make healthy choices the easy choices? To fully fund school-and-community based health programs? To build parks, playgrounds, and community-supported agriculture and local farmers markets? We might begin to reverse the alarming health

[15] National Initiative for Children's Health Care Quality. **Childhood Obesity: The Role of Health Policy**, *http://www.nichq.org/NICHQ/Programs/ConferencesAndTraining/ChildhoodObesityActionNetwork.htm* (accessed Nov 20, 2008).

[16] Summerbell CD, et al., 2003. Interventions for treating obesity in children. Cochrane Database Syst Rev;(3):CD001872.

trends we are seeing in our children. What if we could put that money into preventive medicine, after school programs, senior recreation centers, and workplace wellness? If we want to see a bright and healthy future, we must change the way we think about health priorities and focus on prevention.

We do not need more data to act now—just the political will to adequately fund programs that work. In Texas, we've seen prevention in action with an elementary school program called the Coordinated Approach To Child Health (CATCH). Based on the solid results of a clinical trial[17] and the subsequent 3-year follow-up study,[18] in 1997 the Board of the Paso del Norte Health Foundation approved the first two grants for the CATCH Program in El Paso, TX. CATCH quickly gained momentum and support because of its focus on balanced nutrition, physical activity, health education, and tobacco avoidance. CATCH proved successful through its coordinated, multi-platform approach—classroom instruction, healthy cafeteria lunches, activity-based physical education classes, at-home parent involvement, and after-school community-based programs. CATCH does make a difference. The Texas SPAN survey of 4th grade students in El Paso County suggested that CATCH was a contributing factor to a 7-point drop in student obesity rates measured from the year 2000 (25 percent) to the year 2005 (18 percent). PdNHF funded CATCH at $4.2M over a 7-year period and estimated the costs of implementation at $10 per student per year. Our children deserve programs like CATCH.

Since then, over 2,100 Texas elementary schools and nearly 10,000 schools nationwide have been trained in the use of CATCH. As Commissioner, I estimated that if CATCH could avert diabetes in only 1 or 2 obese children per school, it will have more than paid for itself.

Here in New Mexico, CATCH is a popular prevention program. The NM State Plan calls for increasing the number of schools offering the CATCH program (Activity 2.2.A–2).[19] A collaboration between New Mexico Health, Education and Cooperative Extension agencies is implementing CATCH in grades K through 5. Funded largely by tobacco settlement funds, each CATCH school is encouraged to include all components of the intervention. In 2008, a total of 45 elementary schools and after-school programs were funded to provide the CATCH program.

Not only does CATCH improve diet, physical activity and obesity, but Texas researchers have documented significant improvements on Stanford Achievement test scores.[20] Among a group of predominantly Hispanic, economically disadvantaged elementary school students, the CATCH classroom physical activity intervention produced significant increases in achievement in math problem-solving. Among children who were *not adapting well* to school, CATCH produces significant improvements in Stanford Math and Reading scores.

I know I have given a gloomy forecast, Mr. Chairman. We have a long way to go before we will make a significant impact on this enormous problem we are trying to tackle. However, there is hope of sunnier days ahead. We know that nutrition and physical activity are cross-cutting risk factors and that effective prevention of obesity also prevents diabetes, cardiovascular disease, and some cancers. Fully funding and implementing coordinated school health programs like CATCH and others with a proven track record can assure our communities and our Nation of healthier children and a much brighter future.

CONCLUSION

Our country needs to focus on developing policies and making funding decisions that help Americans make healthier choices about nutrition and physical activity. We know that even small changes can make a big difference in people's health—and that individuals don't make decisions in a vacuum. If we want our children to lead healthy, productive lives, we need a strong partnership from the government, private and nonprofit sectors, as well as parents and teachers, to emphasize wellness and enhance nutrition and physical activity. The challenge is a big one, but we can make a difference together. Thank you again for the opportunity to testify.

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[17] Luepker RV, et al. Outcomes of a field trial to improve children's dietary patterns and physical activity: The Child and Adolescent Trial for Cardiovascular Health (CATCH). J Am Med Assoc 1996; 275: 768–776.

[18] Nader P, et al. Three-Year Maintenance of Improved Diet and Physical Activity: the CATCH Cohort. Arch Pediatr Adolesc Med. 1999; 153(7): 695–704.

[19] The New Mexico Plan to Promote Healthier Weight *A Comprehensive Plan to Reduce Obesity, Overweight, and Related Chronic Diseases* 2006–2015.

[20] Personal communication, Dr. Nancy Murray, University of Texas, School of Public Health.

Senator BINGAMAN. Well, thank you very much for your excellent testimony.

Dr. Thompson, why don't you go right ahead?

STATEMENT OF JOSEPH THOMPSON, M.D., M.P.H., ASSOCIATE PROFESSOR, THE COLLEGES OF MEDICINE AND PUBLIC HEALTH AT THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES, CHIEF MEDICAL OFFICER FOR THE STATE OF ARKANSAS, LITTLE ROCK, AR

Dr. THOMPSON. Sure, sure. Thank you, Senator Bingaman and Senator-elect Udall. I appreciate being here. Dr. Sanchez and I will, I think, make a good team here in front of you.

I am a father of two, a pediatrician. I am the director of the Center for Health Improvement, which is the policy development center for our State. I am now serving my second governor as the cabinet-level advisor on health as the State surgeon general.

I know that you are faced with fiscal crises that are acute and impending and immediate, but I think we are here today talking about a health crisis that may dwarf the current fiscal crisis in the future if we don't take action soon.

I am going to submit my written record in full and also re-submit a letter to the committee that I sent after our last discussion with the fiscal issue, so that there is a written record of the fiscal comments and touch on some of those.

This economic crisis—if I could—in our State, we have actually documented. We know that in our Medicaid program, about 35 percent of our kids are either overweight or obese and that they are costing our Medicaid program 9 percent more. That the children who are obese cost 9 percent more than the children who are normal weight.

We know that when we get into the teenage years that the difference is 29 percent more, and we have tracked that through the adult State employee population, the largest insured group of employees in our State. I would be willing to suggest across all States, except maybe Rhode Island.

In that State employee population, 26 percent of their healthcare costs are associated with either obesity, physical inactivity, or tobacco use. As they age, our obese State employees, full-time workers, cost 100 percent more than our normal weight full-time workers. One hundred percent more, and we put them on the doorstep of Medicare.

We cannot find that Medicare has in their future of Medicare actuarial projections a factor that takes into account the obesity risk burden that is in the growing population that is coming to the doorstep of Medicare for healthcare services in the future.

This starts in childhood. We pay for it through our employed populations as they are working adults, and the Federal Government has a huge fiscal liability for the future if we do not turn this spigot off and address with the treatment, the prevention, and the research issues that you called for in your act of 2008. We cannot afford not to act.

Let me spend a few minutes on focusing on our actions in Arkansas. We are now in our sixth year of actions that we took in 2003 under our legislative proposal, where we tried to tackle childhood

obesity after it was announced by the Centers for Disease Control and others that we were in a nationwide epidemic.

They had said approximately 30 percent of children were either obese or overweight in 2003. Our legislature initiated and our then-Governor Huckabee supported major changes in our schools and our environments. We changed the education that cafeteria workers had. We changed what was in the vending machines, restricting sugared soft drinks in vending machines.

We restricted vending machines to only be available after lunch so that kids didn't get breakfast and lunch from a vending machine. They got it from the cafeteria. They used vending machines for snack products after lunch and after school.

We established physical activity requirements in every grade, K through 12. I will need to come back to that when we look at where we are currently. Now we created, in advance of the Federal requirements, local parental advisory committees to try to get engagement of parents to change the school system and the environment.

We required publicly disclosing so-called "pouring contracts," basically advertising privileges that companies have inside of the school setting to advertise their products. Historically, not something that we thought was harmful, but that we now know may be influencing children's consumptions of soft drinks or foods of minimal nutritional value.

Somewhat controversially in 2003, we started and followed the Academy of Pediatrics national physician organization's recommendations, as well as the Institute of Medicine's recommendations, to make sure that every parent knew their child's body mass index so that parents have warning, because we have slowly become heavier and heavier.

If you look at a kindergarten class from 1970, it is a bunch of thin kids. If you look at a kindergarten class from 2007, it is hard to find the thin child. We have gradually turned the thermostat up of what we accept. The BMI is a way to quantify that and make sure people know where their risk is.

We started in 2003 reporting every child's body mass index across 380 school districts, 1,300 schools, almost half a million children each year in our relatively poor and southerly, sisterly State with you.

Our BMI information pushed things forward. It provided an annual report. It provided parent information. It provided legislative stamina to stay the course. I am proud to say now that we are in our sixth year, that over the last 3 years, we have been able to claim with hard data that we have halted the progression of the childhood obesity epidemic.

We cannot say for sure that we have reversed it, although what we will be coming out with later this year are communities within which we have reversed that epidemic and some other communities that we might need to make additional investments in.

As I think you are well aware, those other communities frequently are poor communities, more isolated communities, minority communities, disenfranchised communities. So those communities that need more help, we need to provide more help to.

Our BMI assessments from an external evaluation by our College of Public Health have been found to be helpful by parents. Sixty-one percent of school districts now have policies prohibiting vending machines from selling junk foods, up from just eighteen percent in 2004.

Twenty-six percent of vending items in schools are healthy, up from eighteen percent. That is if they are allowed vending items, a fifty percent increase in the healthy category.

Parents are changing their home environment, what they purchase for their children. They are reducing the television and video-game screen time because they have been made aware of the obesity risk as an issue.

In 2007, 72 percent of students reported that they increased their physical activity, up 10 percent from just a year before. Some of these changes have raised awareness, changed the environment within which kids go to school every day, and wrapped support around parents to make those changes that they need to.

We have another evaluation coming out this January that I look forward to providing you. I will also say that in our last legislative session, we repealed the physical activity requirement in every grade K through 12 because of the academic performance needs necessary to reach the No Child Left Behind standards.

While we had achieved 30 minutes of physical activity requirements in every grade K through 12 across 4 or 5 years, not intentionally, but the pressure for academic performance over here in an isolated silo eroded our ability to support physical activity across all grades, K through 12.

Now we are back to where we have it in kindergarten through fifth grade, half a semester in middle school, half a semester in high school. That is all the physical education requirements that we have across our 1,300 schools in the State.

There is a role for everyone to play, and I think this is a call for all of us—families, communities, churches, schools, States, and our Federal leaders—to play.

The Robert Wood Johnson Foundation, the Nation's largest healthcare foundation, has made a commitment to invest half a billion dollars—a dollar amount that has never been previously invested from a private corporation—to change something for which they don't make any money on, and many of the programs that they put in place are important.

In schools, the Alliance for a Healthier Generation with the Clinton Foundation and the American Heart Association, a joint initiative, has put efforts in schools in all 50 States, almost 1,900 schools. You have 18 schools here in New Mexico that are signed up and trying to change the cafeteria environment, the physical education environment, the parental engagement along similar lines to those we took in Arkansas.

We have State evaluation projects in States that have taken efforts. That report that I mentioned from Arkansas, and also Delaware, Mississippi, New York, Texas, West Virginia—are coming forth with new and innovative strategies that we look forward to sharing and incorporating in our State, as I am sure Texas will and others.

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The National Governors Association Healthy Kids, Healthy America Project has funded governors' offices in 15 States, including here in New Mexico, where you now have within the Office of the Health Secretary a coalition composed of more than 40 State agencies across 8 departments with 60 private organizations and public organizations working together to break down these silos, to wrap support around parents, and to make this be a real change.

Safe Routes to School program, Food Trust, community-based programs. Yesterday, Healthy Kids, Healthy Communities announced funding opportunities for 60 new communities to get funding from the foundation to make changes. Half of those are targeted for the Southern States, where the risk burden is the greatest. From Georgia on the east coast all the way across to Arizona and California on the west coast, draw a line below that line, these Southern States need to come together to take advantage of this.

We need coordination, and we need a national plan. I think your proposed prevention, treatment, and research is an important and critically needed first step, but there are other challenges. You are going to be faced with major pieces of legislation in an acute, compressed timeframe where action needs to be taken. There can be small steps that make a difference—your reauthorization of the State Children's Health Insurance Program, the K through 12 education program, the Child Nutrition and WIC program, the transportation reauthorization. You will have the opportunity on each of those to make a major change that wraps support around States, communities, and families.

For example, you could include explicitly obesity as a treatable condition in the State Children's Health Insurance Program. You could provide funding to implement in force the federally required school wellness policies, which are required of schools now, but that don't have adequate funding flowing through.

We could require nutrition standards for competitive foods offered within the school system. Right now, those are outside of the Department of Agriculture requirements.

We could align the reimbursable school meal programs with the recently released dietary guidelines for Americans to make two different agencies in the Federal Government work together to be telling schools the same thing. We are telling them different things right now.

The intensity and duration of quality physical activity in schools—just a performance indicator to say how physically fit kids are when they graduate would actually change the balance to not just look at academic performance, but also look at physical fitness as a component of a healthy lifelong educational strategy.

The physical fitness index, "Complete Streets," and through the transportation bill to make sure that new roads that we are going to build for part of the stimulus package and over the next 5 years due to transportation advancements also incorporate safe and convenient mechanisms for people to use pedestrian or cycles or nonpetroleum fuel-generated forms of transportation.

Then, finally, you have existing programs within your agencies—the Centers for Disease Control, many of the outreach programs across Education, Agriculture—that if there was a requirement within their authorization bill to at least pay attention to the needs

of childhood obesity, that is going to re-inforce the cross-agency collaboration that you have called for in your 2008 bill.

Finally, in conclusion, let me just say we need the Federal Government and State governments to join together to support communities and families. I have never yet met a mom, as a pediatrician or as a father, who wanted a healthy, uneducated child or an educated, unhealthy child. They want both, and we need to make our programs work together to give that.

I will tell you that I think the most serious threat to the future of our children and also I think to the future of our Nation is this obesity epidemic that is, quite candidly, very similar, from my perspective, to the financial crisis we are in.

Let me just draw the parallel. Ten years ago, nobody really thought about the number of credit card free applications you were getting in the mail, but today, people are thinking about it differently. Today, people are not thinking about as much as we need them to not getting the super-sized fries or not selling the school environment out to advertisement or not having physical activity in the 8 hours of school that the kids are sitting down all day.

We need to change that. We need to have it be just like we are focused on the fiscal crisis today to focus on this health crisis before it becomes the fiscal crisis of tomorrow.

Thank you very much for being here.

[The prepared statement of Dr. Thompson follows:]

PREPARED STATEMENT OF JOSEPH W. THOMPSON, M.D., M.P.H.

Senator Bingaman, members of the subcommittee, thank you for this opportunity to testify about the No. 1 health threat facing our children today and generations to come—obesity.

I am Dr. Joe Thompson, a father, a pediatrician, the Surgeon General of the State of Arkansas and the Director of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity.

First, I would like to thank all of you for your dedication to this issue. During this time of true economic crisis that is affecting families all across the United States, it is more important than ever that we get on track to reversing this epidemic. As people resort to cheaper, less nutritious foods because of the rising cost of fresh produce, some researchers already are predicting higher obesity rates within 3 years.

Obesity-related expenses already cost State Medicaid budgets $21 billion annually. If we think the cost of obesity is high now, just wait until our current generation of obese and overweight youth reaches adulthood and begins to experience the ill health and disability of chronic disease—not in their 50s and 60s but in their 30s and 40s.

Let me state emphatically: "We cannot divert our attention. We must reverse this epidemic of obesity or it threatens to undermine America's future far more than the current economic crisis."

Through a series of hearings held in this subcommittee over the summer, you examined the environmental factors that have led us to where we are today: supermarket flight, food and recreation deserts, urban sprawl, unsafe places to play, squeezed physical education time, vending machines in schools and increased time in front of a screen—television, video game or cell phone, just to name a few.

We did not intentionally allow our families to be negatively affected by our decisions, but we must intentionally reverse these effects. We need your leadership now.

This epidemic cuts across all categories of race, ethnicity, family income and geography, but some populations are at higher risk than others. Low-income individuals, African-Americans, Latinos and those living in the southern part of the United States are among those affected more than their peers.

Arkansas is similar to many other southern States—at risk for and paying the price for poor health. Compared with the Nation as a whole, we have disproportionately high rates of disease and infant mortality, low life expectancy and low economic status. Like other southern States, Arkansas is also disproportionately bur-

dened by obesity risks in both adults and children. Almost one out of every three adults in Arkansas is obese.

Unlike other southern States, we are doing something about childhood obesity. In 2003 we passed Act 1220, which led to the first and most comprehensive legislatively mandated childhood obesity prevention program in the country. We had three 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; and
• enhance awareness of child and adolescent obesity to mobilize resources and establish support structures.

Specifically the law included provisions aimed at:

• improving access to healthier foods in schools, including changing access to and contents of vending machines;
• establishing physical activity requirements;
• creating local parent advisory committees for all schools;
• publicly disclosing so-called pouring contracts; and
• reporting each student's body mass index (BMI) to his or her parents in the form of a confidential health report.

As the Director of the Arkansas Center for Health Improvement, I led the implementation of the BMI assessment program, and I am proud to say that we have halted the epidemic in Arkansas. It took the work of the schools, the community, parents, teachers and kids alike to commit to this system-wide change for the good of their own health and the future of our State and our country. We changed the environment through policies and programs that now support a healthier and more active lifestyle.

When we began measuring our kids' BMIs during the 2003–2004 school year, a little less than 34 percent of children ages 2 to 19 nationally were either overweight or obese. Based on statewide evaluations of virtually all public school students in Arkansas, more than 38 percent of our children and teens were in the two highest weight categories. However, during the next 3 years (2005–2007) we found that we had stopped progression of the epidemic—the rate of overweight and obesity remained virtually unchanged at 38 percent per year.

While the rate of childhood obesity in Arkansas is still too high, we are encouraged that our efforts have been successful and that the epidemic has been halted in our State. Now, we can turn our efforts to reversing the trend in our State and sharing lessons learned to inform national efforts.

The most recent evaluation from the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences shows that Arkansas's law is working to create a healthier environment in schools across the State—and that some families are starting to make healthy changes at home. Some of the key findings of the report include the following:

• The BMI assessments have been accepted and found helpful by parents—and recognition of specific health problems associated with obesity, such as diabetes, high blood pressure, asthma and high cholesterol, has increased over the first 3 years. Student teasing about weight has not increased since BMI screenings started in public schools—a finding that counters initial concerns proposed by opponents of the act who feared that the BMI mandate would lead to more children being the target of jokes about body fat.
• Sixty-one percent of school districts in Arkansas have policies prohibiting vending machines from selling junk foods, up from just 18 percent in 2004.
• Twenty-six percent of vending items at schools are in a healthy category, up from 18 percent 4 years ago.
• Parents are making efforts to create healthier environments at home by limiting junk foods—and limiting the time their children spend in front of a television or video game screen and by encouraging more physical activity.
• In 2007, 72 percent of students increased their physical activity overall, up 10 percent from the 2006 study. There is still work to be done, especially in schools. Only 41 percent of students reported participating in daily PE in 2007—a drop from 71 percent in 2004.

Every year since implementation we are learning more about how this law is working and we look forward to the next evaluation report from the College of Public Health which will be issued this January.

Beyond the statistics, the positive impact that our policy changes are having on individual kids like "Samantha" has been the one of most encouraging success sto-

ries. Samantha was 10 years old when a routine screening at her school showed that she was at serious risk for obesity. Her mother, who thought Samantha was going through a harmless phase she'd outgrow, got the message. In addition to embracing changes made at school, Samantha's family also took steps to improve their health at home: eating better, reducing TV time and becoming more physically active. Samantha's BMI percentile dropped, and her weight classification changed from the highest category to a healthy weight. She's kept extra weight off and feels better than ever before.

This is what has worked for Arkansas. In order to help other States model this program and the changes we made in our State, we need to identify and disseminate best practices. I want to ask the U.S. Congress for help in sustaining our State-based effort and expanding it to the Nation.

Beyond what is happening in my home State, there is a real opportunity for everyone to play in reversing this epidemic.

That is why the Robert Wood Johnson Foundation has committed $500 million over 5 years to reverse childhood obesity rates by 2015. For millions of young people, the Foundation wants to avert, the life-limiting consequences increasingly associated with obesity—type 2 diabetes, heart disease, stroke, asthma, certain kinds of cancer and many other debilitating diseases. We are investing in three interlocking areas—research, action and advocacy—with a specific focus on children at greatest risk for obesity.

In order to coordinate and maximize our efforts, next month we will launch the new Robert Wood Johnson Foundation Center to Prevent Childhood Obesity. The Center will be the only national institution focused solely on reversing the epidemic that threatens our country's children and adolescents.

We will provide expertise and support to organizations, policymakers and communities. The Center will help shape and coordinate these groups' efforts and build a nationwide movement to solve this critical health issue. The major programs funded by RWJF on the ground and in communities across the Nation will form the core of this movement.

I want to share some of these programs with you—and how in addition to what we are doing in Arkansas—we are starting to craft creative solutions that will help fight this epidemic.

As you will see, we are concentrating our efforts broadly—in schools, at the State level and within vulnerable communities—by investing in systemic and lasting changes that will improve healthy eating and active living. Our goal isn't to drop in, spend some money and then leave. We want to create systems so the change carries on.

The Alliance for a Healthier Generation's Healthy Schools Program is our biggest investment in school-based solutions to the epidemic. The Alliance is a joint initiative of the Clinton Foundation and the American Heart Association. The Healthy Schools Program works with schools nationwide to develop and implement policies and practices that promote healthy eating and increased physical activity for students and staff. The program places special emphasis on reaching schools that serve students at highest risk for obesity.

After 2 years of operation, the Healthy Schools Program now provides on-site support to more than 1,900 schools and online assistance to more than 1,900 schools in all 50 States, including 18 schools in New Mexico. The online assistance includes a Web site providing tools to help schools create a healthier environment and evaluate the nutritional value of foods and beverages. To date, the program has reached more than 1.66 million students, held three annual forums and recognized nearly 70 schools for creating healthier environments. We expect the program to expand to more than 8,000 schools by 2010.

We are also investing in statewide change through State evaluation projects and funding the National Governors Association's Healthy Kids Healthy America Project. RWJF funds evaluations of State-wide policies designed to prevent childhood obesity in six States: Arkansas, Delaware, Mississippi, New York, Texas and West Virginia. Some States have changed policies to provide healthier foods at schools, improve physical education and assess the body mass index of school children, while others are addressing the foods and services offered through their Women, Infants, and Children (WIC) programs.

The evaluations examine whether or not the policies are being implemented as they should be, if they are effective in addressing childhood obesity, and what residents think of them. Each of these evaluations will have valuable lessons to share once their evaluations are completed.

The Healthy Kids, Healthy America initiative, which encourages governors and State leaders across the country to support increased physical activity and healthy eating among children, is funding projects in 15 States. Such projects include: inte-

grating healthy messages into the classroom through hands-on activities; increasing physical activity levels in daycare settings; developing school and community action plans; creating model voluntary guidelines for nutrition, physical activity and screen time for after-school providers; tracking students' physical fitness; and providing comprehensive wellness screenings for children in school.

New Mexico is a Healthy Kids Healthy America State. Building off momentum already present in the State, Gov. Bill Richardson (D) has improved alignment and collaboration among the State's obesity prevention efforts by creating a senior-level, childhood obesity advisory position in the Office of the Health Secretary. A coalition—composed of more than 40 State agencies in 8 departments and more than 60 private and public organizations—agreed to deliver consistent youth obesity prevention messages across all their programs. The importance of this cross-cutting coordination cannot be stressed enough and needs to be a model for what we are doing at the Federal level as well.

Other programs we fund reflect the importance of increasing opportunities for active living and healthy eating, as well as complement State government-led efforts that are already under way. Our work with the Safe Routes to School National Partnership and The Food Trust demonstrates this approach. Safe Routes to School is a national and federally funded program to create safe, convenient and fun opportunities for children to bicycle and walk to and from school. The national partnership supports organizations, government agencies and professional groups in their efforts to develop coalitions and action plans to make this happen. The partnership focuses on nine key States and the District of Columbia, chosen because they have large populations at a greater risk for childhood obesity.

The Food Trust helps to expand the supply of food resources available to low-income communities by advocating policies that increase the availability of fresh food in communities, creating model programs, undertaking research studies on food disparities and disseminating findings to government officials and policymakers. Collectively, these efforts are addressing the systemic issues that prevent our food and farming system from adequately serving hundreds of thousands of individuals throughout the region every year.

The Food Trust was a partner in creating the Pennsylvania Fresh Food Financing Initiative, the Nation's first statewide program to address the lack of access to healthy food in low-income neighborhoods. With RWJF funding, The Food Trust is working with partners in Illinois, Louisiana and New Jersey to explore State-level solutions to the problem of poor food access in these States.

We are also right in the middle of launching three new community-based programs, the largest of which is our Healthy Kids, Healthy Communities Program. Healthy Kids, Healthy Communities is a $44 million initiative that is the Foundation's largest investment to date in community-based solutions to childhood obesity. Just yesterday we announced nine leading sites that will receive grants of up to $400,000 over 4 years to help make policy and environmental changes to increase opportunities for physical activity and healthy eating among children and their families

The leading sites are urban and rural, large and small. They include: Chicago; Columbia, MO; Louisville, KY.; Seattle; Somerville, MA; Washington; and Baldwin Park, Central Valley and Oakland in California. Through impressive partnerships of neighborhood associations and public agencies, all are pursuing an array of strategies to reshape their communities and promote active living and healthy eating—through farmers markets in public schools and community gardens, new bicycle lanes and wider sidewalks, even a pedestrian-only boulevard on weekends.

The program will grow to approximately 70 communities when another round of funding is awarded late next year. The leading sites will then act as mentors for these additional cities and counties. Yesterday, RWJF released a call for proposals for the second round of Healthy Kids, Healthy Communities funding. Preference will be given to applicants from communities in 15 States where rates of childhood obesity are particularly high—Alabama, Arizona, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and West Virginia. About five dozen grants of up to $360,000 will be awarded to qualified community partnerships. I ask that all of you present today share this news with your community organizations here in New Mexico, since you are one of the target States.

In addition to the Healthy Kids, Healthy Communities program, we are going to be launching another national program called Communities Creating Healthy Environments that aims to prevent childhood obesity by increasing access to healthy foods and safe places to play in communities of color. Grants totaling $2.5 million will be awarded to 20 diverse, community-based organizations and federally char-

tered tribal nations to develop and implement effective, culturally competent policy initiatives to address childhood obesity at the local level.

The Foundation soon will be funding 22 faith-based coalitions across the country—many of them centered in Latino communities—to push forward policy and environmental changes that can make the biggest difference such as: building community gardens; increasing access to healthy and affordable foods and safe places to play in low-income communities and communities of color; and fostering urban agriculture and youth engagement.

We are enthusiastic about all the programs under way, but we understand that we can't solve this crisis alone.

We know it is crucial to work with Federal, State and local leaders—those from public health and public schools, industry and business executives, and physicians, hospitals and nonprofit organizations in the community.

In August, the Foundation was pleased to partner with Trust for America's Health in releasing the 2008 F as in Fat Report. The report issued a clarion call for a National strategy to fight obesity.

"This needs to be a comprehensive, realistic plan," according to the report. One that "involves every agency of the Federal Government, State and local governments, businesses, communities, schools, families, and individuals."

And, the report continued, the strategy "must outline clear roles and responsibilities and demand accountability. Our leaders should challenge the entire Nation to take responsibility and do their part to help improve our Nation's health."

I am pleased to endorse, your plan, Senator Bingaman, to create an interagency coordinating task force or council, across all agencies within the Federal Government to create strategies and synergies to prevent childhood obesity. With a new Administration and a new Congress and a renewed focus on prevention, I am hopeful we will be able to really take a wholesale look at how the Federal Government is organized and identify opportunities to push a comprehensive active living and healthy eating agenda.

Additionally, as Congress is faced with major pieces of legislation to reauthorize SCHIP, No Child Left Behind, Child Nutrition and WIC and SAFETEA-LU, I would be remiss not to make recommendations. At a minimum, I urge Congress to:

- Include obesity as a treatable condition in the State Children's Health Insurance Program;
- Provide funding to implement and enforce federally required school wellness policies;
- Require nutrition standards for competitive foods;
- Align the federally reimbursable school meal programs with the Dietary Guidelines for Americans;
- Increase the intensity, duration and quality of physical activity in schools;
- Incorporate a physical fitness index or physical education quality score in school performance ratings;
- Implement complete streets that are designed and operated to enable the safe and convenient travel of all users of the roadway, including pedestrians, bicyclists, users of public transit, motorists, children, the elderly and people with disabilities;
- Support Safe Routes to School; and,
- Adequately fund Centers for Disease Control and obesity prevention grants to States.

As I said at the beginning, we must intentionally reverse this epidemic. All of us have a role to play. I believe the reforms we have put in place in Arkansas are working and are replicable. I believe that the programs funded by the Robert Wood Johnson Foundation will help the Nation chip away at this problem. None of this is enough. We need the Federal Government and State governments to lead by promoting and incentivizing model policies—some of which I touched on today.

As research points us to new and innovative solutions, we must remain flexible to fund and implement them as well. We must change the toxic environment that unwittingly reinforces poor nutrition and sedentary lifestyles and exacerbates health conditions that threaten the future of our children and our Nation.

As you face the acute crises facing the Nation today, please do not fail to look for strategies to support the long-term changes needed to reverse this epidemic. As you reauthorize important programs in the coming year, on behalf of the Nation's families, please incorporate steps to intentionally align Federal incentives with supportive environments.

We did not develop this problem overnight. We must act now to start the process in reversing the epidemic of obesity that threatens to rob our children, our families, and our Nation of its future.

We simply cannot fail to take action.

Senator BINGAMAN. Thank you very much for your excellent testimony.

Let me start with a few questions, and then Congressman Udall will have some, I am sure.

Let me ask, this whole issue of measuring body mass or physical fitness, doing a physical fitness index, I guess Arkansas has done more than any other State to sort of make that universal? At least that is my impression.

Has there been a lot of pushback? Have you had a lot of folks come back and say this is none of the State's business, none of the school's business? You shouldn't be getting into this? What has been the favorable response and the unfavorable balk?

Dr. THOMPSON. Sure. Let me just start. We have had a lot of news stories, I can promise you that. We have had a lot of press coverage, and let me get below the press coverage to give you a kind of boots-on-the ground report.

We are now in our sixth year, and when we started this, we really didn't mean to step out as far in advance probably as we did. We were just following what the Academy of Pediatricians and the Institute of Medicine said, that every parent should know their child's BMI.

When we turned to parents to say do you know theirs, almost none did. Just like hearing screening or vision screening or developmental screening that the schools did, we thought how do we get to all kids quickly, and we put it into the process of the school assessment program.

We did take cautions to make sure that kids were measured in a high-quality way. They were measured in a confidential way. The child did not know their weight or their height and that the report that we generated was sent home confidentially to the parents with things that explained what the BMI was, what they could do about it if it indicated a potential problem, where they could turn to for help.

Then I think, over time, we really, through the external evaluation, have dramatically increased the awareness of parents who have obese children—that their child may have a health risk—from less than a third to more than two thirds now of parents of obese children are taking steps and think that their child has a health risk that they need to address.

Having said that, the first year, we sent that health report home to 90,000 parents who had an obese or an overweight child. My name and phone number was at the bottom of it. So, I think I can fairly confidently tell you what the pushback was.

We got 300 phone calls. Half of those were parents who wanted more information, and half of those were parents who felt like we had infringed upon their rights as parents or penetrated the safe zone of their child in school. They did not appreciate—some very vociferously—being told that their child had a weight problem.

Out of 90,000 that we sent, I have got 150 that felt strongly enough to just pick up the phone and call or to send in a letter. I think any business would take that as a complaint rate over time, particularly given the risk that we were addressing.

Over time, we have now moved to where we have a written method that if a parent wants to say, "I will take responsibility for

my child's health," they can opt out of the school-based screening. We want the parents to take responsibility for that screening process and that health risk. We don't want to go blind just because there is some tacit resistance to the issue of: Is obesity a problem we should be worried about?

We are now in our sixth year. Now we measure every other year. Kindergarten, 2nd, 4th, 6th, 8th, 10th grades. So a parent gets a health report every 2 years.

We coordinate that with their vision screening and their hearing screening so that they get all of that as a health report from the school. That enables the school nurse personnel and others to focus more on the kids that need help in the off-years when we are not doing that annual assessment.

Senator BINGAMAN. Your conclusion is that this is an essential part of dealing with the problem, as I gather?

Dr. THOMPSON. It hits multiple leverage points in a way that nothing else does. It gives the parents a number that they can track. It gives the school personnel a profile of the school that they both have internal mechanisms to understand what their risk is, but they have some external accountability for what they are doing about it.

It gives our legislative bodies—we publish by legislative district what the obesity rates are. That lets local constituents engage their legislators more substantively and actually holds the legislature accountable for the educational and health goals.

At our State level, just like at the Federal level, we are running the Medicaid program over here, and we are running the education program over here. How do we get those two programs to link together? This data has been one source that has been critical in helping us link those two programs together.

Senator BINGAMAN. Dr. Sanchez, let me ask you a question and then defer to Congressman Udall here.

This CATCH program that you talked about is privately funded, as I understand it, through this foundation?

Dr. SANCHEZ. The CATCH program is funded in different ways in different parts of Texas. While the State of Texas has passed legislation that has requirements for physical activity, has passed rules about nutrition policy, has passed legislation about a requirement for coordinated school health programs, like sometimes happens in our poorer States, it was done in a way that didn't have the funding attached to that policy change.

Communities have been finding different ways. When there are benefactor foundations—El Paso, as I mentioned, Paso del Norte Health Foundation helped fund. In Austin, TX, Travis County, the Michael and Susan Dell Foundation have helped fund CATCH implementation in Travis County. In Harris County, which includes Houston, the Houston Endowment has been a large funder.

Other communities have used other sources of funds, but there was no—it has been privately funded perhaps to a greater degree than one would like.

Senator BINGAMAN. What percent of the elementary schools in Texas are currently involved with this CATCH program?

Dr. SANCHEZ. It is 2,100 schools out of about 4,000, so about 50 percent. The degree to which they have incorporated CATCH is

variable, though. Because that funding of $10 per student per year sometimes is not consistent and schools sometimes do parts of, not all of the CATCH program.

Senator BINGAMAN. You referred to the fact that in New Mexico, we are also using this CATCH program to some extent. Is that right?

Dr. SANCHEZ. Correct. The State health plan, called the New Mexico Plan To Promote Healthier Weight, calls for increasing the number of schools, and there are now about 45 schools. There are other programs that have actually been incorporated in New Mexico. One is called OrganWise, and one is called Healthier Opportunities—Healthier Options for Public School Children.

Those are programs that have some evidence base, not nearly as robust as the evidence base for CATCH. There are a handful of schools in New Mexico that are using that coordinated school health program.

Senator BINGAMAN. Tom, you go ahead.

Mr. UDALL. Thank you, Senator Bingaman.

Dr. Sanchez, first of all, do you have any comment on this idea that Dr. Thompson has put on the table about the BMI and how that would relate in terms of the things that you have discussed and the parental involvement that he is talking about that seems so important to this?

Dr. SANCHEZ. Sure, absolutely. Parental involvement, very, very important. CATCH includes a parental involvement component.

Dr. Thompson knows that when the State of Texas first looked at the notion of doing BMI, I was a bit reluctant. I was worried about how we would address what we were going to learn.

I have changed my mind on that. I absolutely believe that the only way for us to, in an informed way, make policy decisions at a policy level or make personal decisions or family decisions at that level is to have information.

A BMI, particularly as it has been constructed now in Arkansas, FITNESSGRAM, which actually includes BMI within it—that is what we are doing in Texas—is a way to provide information.

I think the other thing, though, that I know Dr. Thompson was alluding to and has addressed is that we can measure progress by doing these kinds of annual assessments. Whether it is at the family level, your child has gone from here to here. Whether it is at the school district level, the school population has gone from here to here. Or at the State level, then one can determine whether those particular interventions that might have been different in different school districts worked or didn't work.

Then inform the next set of decisions about what programs should we be promoting and what programs should we put on the shelf. Monitoring BMI is one element that is very, very important, I believe, or some surrogate of BMI.

And then evaluating programs so that we have a sense of progress. We have the sense of what worked, and then we can continue building the evidence base and making sense about what we are doing.

Mr. UDALL. Thank you.

Now, Dr. Thompson, the things that you have recommended were part of this Act 1220, and what I am wondering is you have men-

tioned some very laudable successes there. Is there anything you might structure differently in the act? Is there anything that was particularly important that was included?

Then in pulling the coalitions together to pass this piece of legislation, is there anything that you can share with us in terms of encouraging us to maybe do differently or to do in terms of moving forward with comprehensive legislation in this area?

Dr. THOMPSON. Sure. Let me offer, and I think there are two or three things if we can unbundle them. The Act 1220 really did target the school environment and the place, the food, the activity levels where kids spent most of their day each day. We were in parallel doing everything we could with the adult environment, too, with the State employees plan. I mentioned the assessments that we have done.

We actually added obesity treatment preventions to their health benefit plan, and we tiered their health insurance premiums. So that if people smoked or were physically inactive or were overweight, they ended up paying slightly more in their health insurance premiums.

Remember, all of our schoolteachers were in that same plan. It really was—we did everything we could think of to make these changes during the last 5 years.

With respect to Act 1220 and the school-based initiative, I do want to caution, I think there is a right way and a wrong way to do the BMI assessment.

The BMI assessment needs to be done in a confidential, protected way, and that information treated just like you would grades or anything else provided to the parents as a reflection of the health risk, just like we provide to parents their educational grades that reflect their academic risk or performance.

I have been on several news shows where it has been the way we did it versus the way somebody else did it, where they just weigh the kids and they give the kids the BMI. I mean keep it confidential. Do it right. Have it be a high-quality assessment, and I think it can be safely done.

In fact, we have actually not seen any of the adverse risks that people had concerns about, myself included—eating disorders and other things. We have not seen any of those because we followed a safe path.

With respect to passing the act itself, and I think today would be different than it would have been 5 years ago or in 2003, 2002. We passed it then, it was a 4-page act, double-spaced with no funding. It didn't get a whole lot of attention. It kind of went through, and then we had it and we made something out of it.

I think today that awareness of the obesity risks, the willingness, candidly, of communities, of governors, of our elected leaders, industry to come to the table is much greater. I think what I would encourage is really to think about how do you get the different programs, the different agencies to work together?

Have something with teeth in every agency's budget that forces them to work together on childhood obesity as opposed to staying isolated. Because that is how you are actually going to get the most work done.

I think in this obesity act that we did, we have seen—we have seen our health department led by Dr. Halverson, our education department by Commissioner James, our human services department, they are starting to work together more effectively and efficiently.

We now have coordinated school health programs that are trying to reach the community resources that Dr. Sanchez has reflected are present in Texas with our Medicaid resources, with our school resources. If we can align the incentives, there are some very powerful local leaders that will take advantage of that.

If we set the programs up to not have those incentives, the local leaders get frustrated and can't make things happen. It is our kids who end up suffering.

Mr. UDALL. Thank you. Thank you both very much for your excellent testimony.

Senator BINGAMAN. Yes, I appreciate it as well. We could go on with questions here for quite a while, but I think your written testimony and what you have also testified to today gives us a lot of good suggestions for things we could be doing in Washington.

I hope we can take those suggestions and make some progress here in the new Congress. Thank you all very much.

Dr. THOMPSON. I appreciate the opportunity to be here, and I know Dr. Sanchez and I would be glad to help any way we can because this is a major issue facing our Nation.

Dr. SANCHEZ. I also thank you. I think that childhood obesity is—creates the issue around which we can think about health system reform in a different way than we have. If all we do is focus on the medical care side of things, we are going to lose the opportunity, as Dr. Thompson talked about, to try to slow the spigot down.

If we don't slow the spigot down, all of the medical care system reform in the world is not going to be enough to address what is coming our way.

Senator BINGAMAN. You commented that you didn't think Medicare in their current projections has taken into account the bow wave of problems that they are going to be faced with when folks get to the age for Medicare and find that a lot of them are overweight.

You have looked into that, and you don't think it is part of their projections. Is that right?

Dr. THOMPSON. We cannot find either the data source they would use or the calculations that they have employed to consider that—I mean, in my State employee population, 8 percent of my State employees of all 110,000 State employees have type 2 diabetes.

Thirty percent are obese. We have 300 who have a BMI, if the level for obesity is 30, I have got 300 State employees that have a BMI of 50. Those we will deposit on Medicare's doorstep pretty soon.

I think this is an issue, critical issue, particularly on the House side on the pay-go rules and on the financing side, to get the mechanism for assessing future cost to consider what the current risk burden is so that it provides some flexibility to make an investment upstream, not just an investment, as Dr. Sanchez says, on how we

are going to treat the diabetic who needs renal dialysis or heart surgery or foot amputation.

Those are coming. We have got to figure out how we justify the investment upstream and what that investment is to keep those from overwhelming us in the future.

Dr. SANCHEZ. We are both willing to help. I would like to provide both of your staffs—send additional documents from Texas—the strategic plan that I alluded to, the Texas Obesity Policy Portfolio (go to *http://www.sph.uth.tmc.edu/uploadedFiles/Centers/Dell/obesityportfolio.pdf*), and some information about CATCH (go to *www.sph.uth.tmc.edu/catch*), the Healthier Options for Children, and OrganWise. I will get those to your respective staffs, if that is OK?

Senator BINGAMAN. That would be great. We would appreciate it.

Thank you very much.

We have got two other witnesses here, and we would welcome them, invite them to come to the table.

Patricia Morris is a Ph.D. She is a senior advisor with the Office of the Secretary in the Department of Health here in New Mexico. She serves as the director for New Mexico's Interagency for the Prevention of Obesity. She is the coordinator for more than 40 programs in New Mexico's public obesity prevention efforts.

And Lynn Walters has initiated a program here in Santa Fe called Cooking With Kids. She initiated this in 1995, serves over 4,000 kindergarten through sixth grade students in the Santa Fe area. The program was awarded by the Department of Health and Human Services, with a 2007 National Innovation in Prevention Award.

Thank you both for being here very much.

Dr. Morris, why don't you go right ahead?

STATEMENT OF PATRICIA MCGRATH MORRIS, PH.D., DIRECTOR, NEW MEXICO INTERAGENCY FOR THE PREVENTION OF OBESITY WITH THE NEW MEXICO DEPARTMENT OF HEALTH, SANTA FE, NM

Ms. MORRIS. Thank you very much, Senator Bingaman. I appreciate the opportunity.

It is nice to see you, Senator-elect Udall.

I think it is particularly appropriate that the hearing is here in New Mexico. The State has recognized the growing incidence of childhood obesity epidemic, and we have initiated what we think are some very promising practices that might not only be models for the State of New Mexico, but for other States as well.

My written testimony discusses in detail the growing health epidemic of childhood obesity in New Mexico. In the interest of time, and given that both Dr. Sanchez and Dr. Thompson really talked about this, let me pass and talk specifically about what the State of New Mexico is doing.

I would, however, like to just make sure that we note in New Mexico, Native Americans and Hispanics are at tremendous risk for obesity and childhood obesity. I am not sure I heard that statistic in some of the discussion. I just want to make sure.

The other one that I think is always very interesting is those who are food insecure. We somehow can't quite wrap our minds

around, "If I am hungry, how I can also be obese?" I think because of the economic disadvantages of people who are food insecure, they are often having to purchase the high-calorie, sort of low-dense foods. The cheap foods tend to be the unhealthier foods.

With that, let me just tell you a little bit about what the State of New Mexico is doing. Recognizing the growing childhood epidemic, Governor Richardson charged the Health and Human Services cabinet secretaries to establish the New Mexico Interagency Council for the Prevention of Obesity.

It was started in 2006. Under the leadership of the Department of Health, it was charged to develop consistent and collaborative efforts and messages across more than 40 State programs in 9 different departments. It also was charged to increase public/private partnerships, to build community-wide obesity prevention programs, and develop policies for obesity prevention.

Currently, we have 9 State departments, and as I said, they represent over 40 public programs. They include Aging and Long-Term Services; Children, Youth, and Families; the Department of Agriculture; Health; Transportation; Human Services Department; Public Education Department; Energy and Natural Resources; and, most recently, the Indian Affairs Department.

We also have nonvoting affiliates. These organizations play very important roles in the development and the implementation of programs and policies. They include the American Heart Association, Envision New Mexico, the New Mexico Food and Agriculture Policy, the New Mexico Healthier Weight Council, and the New Mexico State Cooperative Extension Services.

When I look back over the last year and I say, "Well, what have we accomplished?" I think that there are several sort of key pieces that we have accomplished.

One is we have begun to build some of those consistent messages across programs around obesity prevention, such as healthy eating, increased physical activities. We are also beginning the process of really identifying the State and Federal regulatory and administrative barriers.

For example, in the State of New Mexico, the U.S. Department of Agriculture has over 12 different food assistance and nutrition programs. They are administered in five different departments here. As you can imagine, it creates a lot of administrative barriers, and it is easy for people to go into their silos, as we speak.

In addition, we try to fill gaps where we see that maybe there are issues or problems or programs that are needed in the States. One good example of where the interagency really worked in close corroboration with a specific department was in the efforts to develop a Team Nutrition Grant that was awarded to the public education department to really create healthier meals in schools.

The Team Nutrition Grant I think also really is a good sort of representation or a good example of how interagency members can really share resources and reduce on duplication. Public education leads the Team Nutrition effort. However, there was a piece in that proposal which asked for the creation of a child's healthy eating Web page. The Department of Health had already begun to develop one.

It became really clear that we didn't need two different Web pages in two different departments doing basically the same thing. And so, the Department of Health was given that leadership role to develop that.

Another major accomplishment is really our community-wide program that we have started, called Healthy Kids Las Cruces. We received last fall, just a year ago, $100,000 from the National Governors Association as sort of start-up money to create a community-wide experimental pilot program.

We used the New Mexico Plan to Promote Healthier Weight to develop, sort of, what did we want to do in the community? What were the target groups that we wanted to look at? What we did was we brought together stakeholders in Las Cruces as well as the State to develop a plan.

The plan aims to really create and sustain community efforts that motivate children, youth, and families to eat healthier, to increase physical activity, and to achieve healthier weight. It is a strong collaboration with the city of Las Cruces, the Las Cruces public schools, Dona Ana County Cooperative Extension, interagency members, and nearly 50 local leaders.

It focuses on really creating healthy environments in the community, and we focused on five different settings based, again, on this New Mexico Plan to Promote Healthier Weight. The five settings are schools; the food system, which includes restaurants; food retailers; the healthcare system; the built environment; and then community and families.

I detail in my written testimony the sort of specific accomplishments that have really happened over the last year in each of those settings. Let me just highlight a few of them that I think represent what the Healthy Children—Healthy Kids Las Cruces is all about.

Healthy Kids Las Cruces has partnered with the city of Las Cruces and the mayor's office to develop and promote the mayor's Fitness and Nutrition 5-2-1-0 Challenge. This challenge was just released within the last month.

Basically, the mayor's office is using his office as a bully pulpit in many ways to challenge elementary school-age kids to eat at least five fruits and vegetables a day, to watch no more than 2 hours of TV or other screen time, to increase physical activity to at least 1 hour a day, and no sodas.

Now many times, you can see it to cut back on your sodas, but the mayor felt it was really important because we are beginning to see cirrhosis of the liver in very young people. A lot of people say it is due to the consumption of highly sweetened sodas. It is the 5-2-1-0 challenge.

We have increased the number of schools in Las Cruces that are implementing the Safe Routes to School. Three of the seventeen elementary schools in Las Cruces receive State Department of Transportation funds.

Again, this was really a function of the interagency. Because we brought the interagency State members with the local members together to develop the plan, the State understood that Safe Routes to School was important, and so they made sure that Las Cruces knew about the Safe Routes to School grants so that people could prepare in advance and really write for those applications.

We have also developed more than a dozen walking and bicycling paths. We have increased the number of schools holding fresh fruit and vegetable tastings, providing PE to students for 30 minutes 3 times a week, and having recess before lunch.

Recess before lunch is a no-cost and very simple idea, and what we have found when we have done plate waste studies on it is kids who actually go and have their recess before lunch, they come back. They will drink more of the milk, and they will throw away less of the food because they are hungry. They will sit down and settle in.

We also have established a flagship school at Conlee Elementary. What we wanted to do is make sure that we were putting as many of our resources as we could into one school. We consider Conlee Elementary really a microcosm of the larger Las Cruces community, and so we have got more than a dozen programs going into the Conlee school, both during school as well as out of time.

We also have tried to include the neighborhood in that, and we are trying to deal with the local grocers. We are trying to deal with disclosure in chain restaurants in those neighborhoods to see if we can create a whole sort of neighborhood community intervention project.

One of the important parts of it, I think, is really bringing together multiple community organizations all around healthy eating and active lifestyles. Just last month, Healthy Kids Las Cruces held a Fall Fitness and Fun Family Fiesta at Conlee. It was an extraordinary event, where the city of Las Cruces really led in the leadership of organizing that.

The Las Cruces mayor, Ken Miyagishima, opened the event, announcing his Fitness and Nutrition 5–2–1–0 Award. More than 425 children and their family participated in the different events on this Saturday afternoon, which is quite an extraordinary number of people.

We had over two dozen community organizations participating and sort of leading different physical activity and healthy eating events. For example, the Las Cruces Police Department and the Las Cruces Fire Department provided activities, which included a bike rodeo, a canine demonstration, and they also did blood pressure checks.

We had more than 200 people receive flu immunizations. The new edible school garden was dedicated. Two Conlee schoolchildren won free bikes.

Our funding is over. We have no money left in Las Cruces, but we have built sustainability. We have got the commitment from the Department of Health, from the Interagency Council, from the city of Las Cruces, the public health, and the 50 local stakeholders that we are going to continue this.

We came together in October, and we developed our second-year action plan. I think it says a lot about what communities can do in terms of sharing resources and building that synergy that I think is so important.

What are our next steps in terms of the interagency? I think we would really like to replicate our Healthy Kids Las Cruces in other communities. It is not that we are trying to replicate a blueprint or the exact programming, but rather the process and a framework.

The New Mexico Healthier Weight Council in many ways gives us a framework and a direction for where we want communities to be. We have a good process that we think brings together the necessary sort of leadership at the State and the local level to develop the local plan. Ultimately, the plan has to be locally determined.

It is the local communities who know where their strengths are. They know where their gaps are. It is for the State to sort of come in and say, "How can we help build what you are doing, support what you are doing," as well as bringing in innovative ideas.

In many ways, we will continue to coordinate and strengthen our collaborative State and local efforts, and I really do think it is very important that we build some kind of a State obesity prevention monitoring system. Whether it is the use of the FITNESSGRAM, the BMI, it is really necessary. In New Mexico, we have no way to measure or track how kids are doing in elementary school.

How can we create programs, how can we identify where the needs are if we don't know what the status is? I think it is really critical that we do it. I do agree with Dr. Thompson that it needs to be done in a way where we have privacy and confidentiality.

With Government and the interagency and what we are doing in the State, we are really only part of the solution. It is great for us to build consistent messages, to build collaboration across State partners, and build private partners. We still have to counter, and this certainly isn't enough, to counter the more than $20 billion spent annually by industry in food marketing to kids and billions more to the adults.

Sharing resources and eliminating duplication, they are important. Again, it is not the time to reduce or eliminate spending on obesity prevention as we all face very tight budgets. I think Dr. Thompson made very compelling arguments for why we shouldn't.

A roadmap to healthier futures remains, I believe, largely uncharted. We know the problem, but I think we still lack a clear, comprehensive solution. Part of the solution may lie in taking what I call a more social entrepreneurial approach.

Governments tend to look at problems programmatically. Even when we build collaborative efforts, we tend to frame solutions from traditional nutrition and health perspectives. But, obesity is only one part of a quality of life issue in a modern industrial society. If we step back and look at the larger picture, we may find ways to connect fighting the rising tide of obesity with other efforts aimed at improving the quality of life.

For instance, the new Federal Government's efforts to increase the number of bicycle paths and pedestrian walkways. Well, a social entrepreneur might further suggest adopting the model of some European systems, which are providing free use of bicycles.

Combining these two ideas would be good for the environment, and if more people have easy access to bicycle to work or to school, they may become fitter—or they will become fitter and reduce the healthcare costs.

I think it is an untapped resource that we are only beginning to think about. One of the things that I keep thinking about is how do we convert all of the mechanical energy that we use in our workout gyms and convert that so it becomes electrical energy to actually provide energy for buildings.

In conclusion, let me say that the road to reversing childhood obesity trends is long. We shouldn't expect changes overnight. It took decades to reach this obesity epidemic. This insidious problem grows slowly, just like our personal weight gain, and it will take years to change the culture of our communities.

I think it is incredibly important that we all work toward building that as a social norm, a norm in which our children have an equal chance of making healthy choices as making unhealthy choices.

Thank you very much.

[The prepared statement of Ms. Morris follows:]

PREPARED STATEMENT OF PATRICIA MCGRATH MORRIS, PH.D.

Thank you Senator Bingaman for the opportunity to testify at this hearing "Confronting Childhood Obesity: Creating a Roadmap to Healthier Futures."

It is particularly appropriate that this hearing is taking place here in Santa Fe, New Mexico. The State has recognized the growing incidence of childhood obesity among its citizens and has initiated some exciting and promising measures to stem the increase. The innovative approach the State is using may not only help New Mexico's children but may well be a model for others to follow.

As you and the committee well know, childhood and youth obesity is a growing public health epidemic in our Nation and in New Mexico. Nearly one-quarter of New Mexico's high school students (24.4 percent) and its 2–5-year-olds (26.3 percent) who participate in the WIC program are overweight or obese.[1] Far more American Indian and Hispanic high school students are overweight or obese compared to White non-Hispanic students. In 2007, 32.4 percent of American Indians and 26.0 percent of Hispanic high school students were overweight or obese compared to 18.6 percent of White non-Hispanic students.[2]

Childhood obesity rates continue to grow and occur at younger ages. Obesity rates for New Mexico's children ages 2–5 years participating in the WIC program increased by nearly 30 percent in just 7 years going from 9.0 percent in 2000 to 12.7 percent in 2007 (WIC data).[3] Further, New Mexico's youth fare worse than youth in other States. New Mexico ranks 10th highest in youth obesity rates compared to other States (Trust for America's Health, 2008).[4]

Increases in childhood obesity have resulted in dramatic increases in youth-onset diabetes. No longer do we call type 2 diabetes adult-onset because of its alarming rates in our youth—a phenomenon that rarely existed a generation ago. Overweight and obese children are more likely to be overweight adults and suffer from chronic diseases, such as heart disease, certain cancers and diabetes (Dietz, 1998).[5] Some health experts have predicted that this generation of children will be the first in our Nation's history destined to have a shorter life than its predecessor.

Paradoxically, food insecurity and obesity go hand in hand. A major factor in this seemingly contradictory connection is that families experiencing food insecurity have limited incomes and are thus likely to purchase cheaper, higher fat or calorie-dense foods to satiate appetite and stretch food dollars. Such nutritious foods as fresh fruit and vegetables are often beyond their financial means to purchase. Low-income families often have limited access to affordable and quality retail food stores. Some who experience food insecurity may also store fat more efficiently than others in order to conserve energy for times of food deprivation. Other New Mexico groups identified as being at greatest risk for obesity are Hispanic and Native Americans, those living on annual incomes of $10,000 or less, non-college graduates, people with disabilities, and those living in the Northwest and Southeast quadrants of the State (NMDOH, 2006).[6]

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[1] Currently there is no statewide system in place in New Mexico to collect weight-related data on children from Kindergarten through eighth grade.

[2] New Mexico Department of Health and New Mexico Public Education Department (2007). *New Mexico Youth Risk and Resiliency Survey*, Santa Fe, NM.

[3] New Mexico Women, Infants, and Children Nutrition Program provided the statistics.

[4] Trust for America's Health (2008). *F as in Fat: How Obesity Policies are Failing in America*. Washington, DC.

[5] Dietz, W. (1998). Health Consequences of Obesity in Youth. *Pediatrics*, 101(3) Suppl:518–525.

[6] New Mexico Department of Health. (2006). The New Mexico Plan to Promote Healthier Weight: A Comprehensive Plan to Reduce Obesity, Overweight, and Related Chronic Diseases.

Research consistently shows that healthy eating behaviors and regular physical activity decrease the risk for childhood obesity, youth-onset diabetes, increased risk for chronic diseases and a lower quality of life. Unfortunately, New Mexico's youth fare poorly in terms of eating healthfully and being physically active. According to the State's 2007 Youth Risk and Resiliency Survey[7] only 17.9 percent of students eat five or more daily servings of fruits or vegetables. Only 28.0 percent of New Mexico high school students drink three or more glasses of milk a day. In terms of physical activity more than one-half (56.4 percent) of students do not meet recommended levels of either moderate or vigorous physical activity.

BUILDING A FIT FUTURE

Recognizing the growing obesity epidemic among children and youth, Governor Bill Richardson charged the State's Health and Human Services (HHS) Cabinet Secretaries to establish the New Mexico Interagency Council for the Prevention of Obesity. Created in the fall of 2006, the DOH-led Interagency Council is charged to: (1) build greater alignment across State programs to create sustainable, consistent, and collaborative efforts and messages that increase physical activity, improve nutritional well-being, and prevent obesity; (2) partner with the private sector to strengthen and support obesity prevention efforts; (3) build community-wide obesity prevention programs; and (4) develop policies for obesity prevention. Currently, Interagency Council voting members represent more than 40 State programs (see Appendix A for complete listing) across the following eight State departments: Aging and Long Term Services Department; Children, Youth and Families; Department of Agriculture; Department of Health; Department of Transportation; Energy and Natural Resources, Division of State Parks; Human Services Department; and the Public Education Department.

The Indian Affairs Department recently agreed to become a member. In addition, the Interagency Council has five affiliate (non-voting) member organizations: the New Mexico Healthier Weight Council, NMSU Cooperative Extension Services, NM Food and Agriculture Policy, Envision, and American Heart Association.

INTERAGENCY COUNCIL'S KEY ACCOMPLISHMENTS IN 2008

Building Consistent and Collaborative Messages and Programs

Interagency Council members agreed to focus their nutrition and physical activity messages and programming on the behavior changes recommended by the *Expert Committee on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity* (January 25, 2007). The recommendations focus on the following 9 behaviors:

- Increase physical activity to 1 hour a day;
- Limit TV and other screen time to 2 hours a day;
- Eat 5 or more fruits and vegetables a day;
- Drink fewer sweetened beverages;
- Eat breakfast daily;
- Limit eating out at restaurants, especially fast food restaurants;
- Encourage family meals;
- Limit portion size; and
- Promote infant breastfeeding.

The State Nutrition Action Program (SNAP), which represents public and private State and local agencies involved in food security issues, joined the Interagency Council's effort by agreeing to focus its messages and programming on the above nine behavior outcomes. One of the results was that the NM Human Services Department established these behavior outcomes as the State's focus for its 2009 Food Stamp Nutrition Education program.

Building consistent messages and programming across public efforts is important. This alone is not enough to counter the more than $12 billion spent annually by industry in marketing directed to kids and billions more directed to adults.

The Interagency Council is also working to identify State and Federal regulatory and administrative barriers to building collaborative efforts among publicly-funded programs. USDA alone has more than a dozen nutrition and food assistance programs which are administered in at least five different New Mexico Departments. This administrative fragmentation, compounded by regulatory restrictions, has the unintended negative consequence of making it harder to effectively build obesity prevention collaborative efforts. For example, the Food Stamp Nutrition Education

[7] New Mexico Department of Health and New Mexico Public Education Department (2007). *New Mexico Youth Risk and Resiliency Survey*, Santa Fe, New Mexico.

program supports nutrition education programs for low-income families focusing on the U.S. dietary guidelines. While its goals are laudable, the regulations make it near to impossible to tap this stream of revenue to address the specific issue of obesity. This is but one of many possible examples for which the Interagency Council is well-suited to address.

Addressing Gaps in the Continuum of Nutrition and Physical Activity Efforts

Recognizing the need to improve school lunches, the Interagency Council worked closely with the New Mexico Public Education Department to develop and apply for a 2-year $200,000 USDA Team Nutrition grant. PED was awarded the grant in September 2008. The grant provides for the development of kid-friendly healthy school meals' recipes, technical assistance to school cafeteria staff to learn how to purchase and prepare healthier school meals, educational and promotional materials to motivate students to make healthier school meal options, and provide materials to parents and classroom teachers to support students efforts in making healthier choices in and outside of school.

The Team Nutrition grant is also a good example of how Interagency Council members can share resources to strengthen programs and reduce duplication. While PED leads the Team Nutrition effort, DOH was asked to take the lead in the development of a Web page. DOH was in the process of developing a Healthy Kids New Mexico Web page and many of the elements proposed in the Team Nutrition grant were already part of the DOH design. It was quickly decided that it made no sense to develop two similar Web sites, one at DOH and one at PED.

Sharing resources across programs and eliminating duplication are extremely important, especially now as Federal, State and local governments face huge budgetary shortfalls. However, this is not the time to reduce or eliminate spending on effective obesity prevention programs. The long run health costs to cope with a nation of obese children growing up into obese adults will far exceed funds spent now in prevention. Beyond the financial cost, there is an enormous human cost. These children face a dim future of premature death, physical ailments, and a lower quality of life. Cutting funds now would be truly a case of being penny wise and pound foolish.

Building Community-wide Obesity Prevention Initiatives

Under the leadership of DOH, the Interagency Council is piloting a community-wide childhood and youth obesity prevention initiative in Las Cruces. The Interagency Council was awarded a $100,000 1-year grant from the National Governors Association for start-up funding. The focus of the initiative is best captured in a *Las Cruces Sun-News editorial* (April 29, 2008): "If we want to be a healthy Las Cruces, it starts with healthy kids; and if we want healthy kids, it starts with a healthy Las Cruces."

Healthy Kids—Las Cruces: Building a Fit Future One Community at a Time

Healthy Kids—Las Cruces aims to create and sustain public and private efforts to build healthy environments that motivate children, youth and families to eat healthier, be more physically active, and achieve healthy weights. It is a local and State collaborative effort of nearly 50 local leaders representing government, education, healthcare, human and social services, agriculture, non-profit and faith-based organizations, academia, foundations and businesses and State leaders representing the Interagency Council.

Healthy Kids—Las Cruces focuses on building healthy environments in five community settings reaching children and youth where they are: in schools, restaurants (the food system), the healthcare system; the built environment; and families and community. Below is a brief description of the overall aim and key first year accomplishments in each setting.

Schools: The aim is to motivate Las Cruces students to make healthy food choices and increase physical activity in the classroom, cafeteria and school at-large. Key accomplishments include: (1) increasing the number of Las Cruces (LC) elementary schools participating in monthly fresh fruit, vegetable and grain tastings; (2) increasing the number of LC elementary schools using the *Cooking with Kids* curriculum during school and in after-school programs; (3) the creation of edible school gardens in two LC elementary schools; (4) the promotion of healthy snacks and non-food rewards in schools; (5) increasing the number of LC elementary schools holding recess before lunch; (6) increasing the number of LC elementary schools requiring Physical Education for 30 minutes, three times a week; and (7) piloting a half credit health class in one LC high school.

Food System: The aim is to increase access to a nutritious, affordable and seasonal food supply and to provide point of purchase nutritional information on foods offered in schools and chain restaurants. Key accomplishments include: (1) holding

weekly cooking demonstrations in the Income Support Division's waiting room; (2) exploring the availability and cost of a healthy food market basket in low-income neighborhoods; (3) working with the LC Farmers' Market Coordinator to encourage local producers to sell their produce at local farmers' markets; (4) creating a community garden in the Mesquite Historic District; and (5) exploring ways to assist consumers make informed food choices at chain restaurants.

Healthcare System: The aim is to increase obesity prevention and treatment healthcare services. Key accomplishments include: (1) providing a half day best practices obesity prevention training session to more than 70 pediatricians, nurses, school-based health center staff and other health care personnel; (2) developing walking paths on hospital and medical facility properties; and (3) conducting the Healthy Eating Active Lifestyle (HEAL) program by the LC public health regional office to empower at-risk or obese children and youth to make healthier choices.

Built-Environment: The aim is to improve "walkability" in Las Cruces. Key accomplishments include: (1) developing more than a dozen new walking trails for the LC community; (2) receiving State funding for a Safe Routes to School program (SRTS) in three schools; (3) conducting a LCPS district-wide parent survey to determine concerns and needs for the establishment of a SRTS program in their child's school; (4) conducting an inventory of bike racks at schools; and (5) testifying before the LC City Council on creating a built environment that promotes healthy lifestyles.

Families and Community: The aim is to increase opportunities and support for community activities that motivate children, youth and families to be more physically active and make healthy food choices. Key accomplishments include: (1) The LC Mayor's Fitness and Nutrition 5-2-1-0 Challenge. It challenges elementary students to eat 5 or more fruits and vegetables a day, watch 2 hours or less of TV and other screen time, get 1 hour or more of physical activity a day, and drink zero sodas and other sweetened beverages; and (2) the creation of a Healthy Kids New Mexico Web page designed to provide parents, teachers and community organizations with fun-filled activities, lesson plans, recipes and useful tips to assist elementary-age children in making healthy food choices and increase physical activity. The Web site address is: healthykidsnm.org.

Conlee Elementary School: Conlee Elementary is the initiative's flagship school for SY 2008–2009. Nearly a dozen new programs are being implemented this school year (See Appendix B for a complete listing of programs). Not only is the initiative adding new programs during the school day but also outside of school. A key to its success is bringing in multiple community organizations to promote and support healthy eating and active lifestyle behaviors.

A good example of this is the Conlee Elementary Fall Family Fiesta that was held last month. Sponsored by *Healthy Kids—Las Cruces* roughly 425 people participated. Las Cruces Mayor Ken Miyagishima opened the event announcing his Fitness and Nutrition 5-2-1-0 Challenge. The Mayor is calling on elementary students to eat at least five servings of fruit and vegetables a day, spend no more than 2 hours a day watching TV or playing videos, get at least 1 hour of exercise a day, and eliminate soda from their diet—for 3 straight weeks. Throughout the day there were numerous physical activities, food and nutrition events sponsored by more than 2 dozen community organizations. The Las Cruces Police Department and Las Cruces Fire Department provided activities that included a bike rodeo, K–9 demonstration, Identi-child, and blood pressure checks. 203 flu immunizations were provided to both children and adults. The school garden was dedicated with past, present and future students planting flowers in the garden along with encouragement to parents and community members to assist with the garden throughout the year. Two Conlee Elementary students won new bikes provided by the city of Las Cruces Public Service Department and another student won a year-long free admission pass to the New Mexico State Parks.

Despite NGA funding ending last month, DOH, the city of Las Cruces, the Las Cruces Public School District, community leaders and the Interagency Council have agreed to continue and expand *Healthy Kids—Las Cruces*. Local and State leaders met on October 22, 2008 and developed the second-year action plan. Building sustainability was certainly a goal of the initiative and in thinking about what made sustainability a reality there are at least three key structural elements:

• *High-level State Leadership:* The Interagency Council reports to the Health and Human Services Cabinet Secretaries and the Director of the Interagency Council resides in the Office of the Secretary, DOH. This gives the director authority to move across divisions and bureaus in DOH and across different Health and Human Services Departments. The result is a unified vision for Healthy Kids New Mexico and an increased number of collaborative efforts and sharing of resources across public programs to motivate children and youth to make healthy food choices, increase physical activity and achieve healthy weights.

• *A Strong Local and State Collaborative:* While the Interagency Council established a framework and process for Las Cruces leaders to develop *Healthy Kids—Las Cruces*, the actual implementation plan was and continues to be locally driven. In December 2007, DOH convened a 2-day meeting with a diverse group of nearly 50 local and State leaders to develop an obesity prevention 5-year vision, goals, and action plan. On the first day local leaders developed a draft of a *Healthy Kids* implementation plan and on the second day presented the plan to State leaders. Together State and local leaders set priorities for the first year and committed their agencies or groups to work on specific parts of the action plan. As a result of the strong State-local collaborative, DOH Secretary Alfredo Vigil along with three other NM Cabinet Secretaries were joined by the Las Cruces Mayor Ken Miyagishima, the Las Cruces Public Schools Superintendent Stan Rounds, State legislators and numerous community leaders to launch the *Healthy Kid—Las Cruces* initiative in April, 2008.

• *A Coordinating Mechanism:* The success of implementation is in many ways due to the work of DOH's public health regional office in Las Cruces. Ray Stewart, the Las Cruces public health regional director dedicated resources and staff time to build, support and coordinate the community-led activities identified in the first-year action plan. The Health Promotion Team in the regional office has become the nerve center tracking the progress of activities, keeping groups on task, building cooperation and synergy across groups, and at times providing staff or resources to activities requiring additional support.

CONCLUSION

A roadmap to healthier futures remains largely uncharted and we in government may be missing a vital piece of the puzzle. We know the problem, we lack a clear solution. Part of the solution may lie in taking a social entrepreneurial approach. Governments tend to look at problems programmatically. Thus we tend to tackle obesity through agencies such as USDA and CDC. Even when we build collaborative efforts, we tend to frame solutions from traditional nutrition and health perspectives. But, obesity is only one part of a quality of life issue in a modern industrial society. If we step back and look at the larger picture we may find ways to connect fighting the rising tide of obesity with other efforts aimed at improving life. Take, for instance, the new Federal Government's efforts to increase the number of bicycle paths and pedestrian walkways. This has been viewed as a means of bettering the environment by reducing our carbon footprint. A social entrepreneur might further suggest adopting the model of some European cities which are providing free use of bicycles. These two ideas would not only be good for the environment but if more people have easy access to bicycling to work or school, they will become fitter and reduce our health care costs.

The road to reversing childhood obesity trends is long. We shouldn't expect changes over night. It took decades to reach this obesity epidemic. This insidious problem grows slowly, just like our personal weight gain, and it will take years to change the culture of our communities and our Nation so that physical activity and healthy eating is a social norm. A norm in which our children have an equal chance of making healthy choices as unhealthy choices.

Thank you.

APPENDIX A: THE NEW MEXICO INTERAGENCY FOR THE PREVENTION OF OBESITY

As part of Governor Richardson's priority to reverse the increasing rates of obesity in New Mexico, the State's Health and Human Services (HHS) Cabinet Secretaries established the New Mexico Interagency for the Prevention of Obesity. Created in the fall of 2006, the DOH-led Interagency is charged to (1) build greater alignment across State programs to create sustainable, consistent, and collaborative efforts and messages that increase physical activity, improve nutritional well-being, and treat and prevent obesity; (2) partner with the private sector to strengthen and support the Governor's obesity prevention priority; and (3) develop policies for obesity treatment and prevention.

Currently, Interagency voting members represent more than 40 State programs across 8 State departments. Members include:

• DOH: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), WIC Fit Families, Get Healthy Together, WIC Fit Kids = Happy Kids, WIC Farmers' Market Program, Commodity Supplemental Food Program, Coordinated Approach to Child Health (CATCH), Kitchen Creations, National Dance Institute—"Hip to be Fit," Fruits & Veggies: More Matters, Children's Medical Services, Public Health Clinics, School-based Health Centers, Community Health Councils, LEND, and Senior's Local Motion;

• PED: National School Lunch, National School Breakfast, Special Milk, Summer Seamless School Feeding, Fresh Fruit & Vegetable Program, Healthier U.S. Schools, Physical Education, before & after school physical and nutrition programs, School Districts Wellness Policy, Nutrition Competitive Foods Rule, and Health Education and Physical Activity Standards;
• HSD: Food Stamp Program, Food Stamp Nutrition Education Programs (ICAN, Kids Cook, and Cooking with Kids), Food Distribution Program, Food Banks, Medicaid, and NM Hunger Task Force;
• CYF: Child and Adult Care Food Program & Summer Service Food Program;
• ALT: Nutrition Services Incentive Program (NSIP), Senior Olympics and Farmers' Market Pilot;
• DA: Farmers' Markets, Farms to School Program, and Taste the Tradition Program;
• DOT: Safe Routes to School; and
• SP: New Mexico State Parks.

In recent months, the Interagency added five affiliate (non-voting) organizations: the New Mexico Healthier Weight Council, NMSU Cooperative Extension Services, NM Food and Agriculture Policy, Envision, and American Heart Association.

Healthy Kids, Las Cruces—Conlee Elementary Nutrition & Fitness Programs

[SY 2008–2009]

Nutrition and Fitness Programs	Pre-K	K	1st	2nd	3rd	4th	5th	Lead Agency
During School:								
* SAJAI Fitness Program		X	X	X	X	X	X	Conlee PE teachers
* PE 3 times/week								Conlee PE teachers
* Recess before lunch								Conlee teachers
* Color Me Healthy	X							CYFD train P–K teachers
* Cooking With Kids						X	X	Dona Ana Coop. Extension
* Eat Smart, Play Hard				X				Dona Ana Coop. Extension
* Organ Wise Guys		X	X	X	X			Extension train Conlee teachers
Fruit, Vegetable & Grains Tastings.		X	X	X	X	X	X	LCPS Student Nutrition Services
Breakfast in the Classroom		X	X	X	X	X	X	LCPS Student Nutrition Services
Out of School Time:								
* Safe Routes to School		X	X	X	X	X	X	DOH & Metropolitan Planning Org.
* School Edible Garden		X	X	X	X	X	X	Master Gardeners & School Council
* 4-H Activities		X	X	X	X	X	X	Dona Ana Coop. Extension
* Family Cooking & Fitness Program.	X	X	X	X	X	X	X	DOH & Dona Ana Coop. Extension
* Family Fitness & Fun Fiestas (2).	X	X	X	X	X	X	X	LC Rec. Dept. & DOH
* HEAL Program		X	X	X	X	X	X	DOH
Before & After School Program		X	X	X	X	X	X	LC Recreation Dept.
* Conlee Staff wellness program.								DOH
* Mayor's 5-2-1-0 Challenge	X	X	X	X	X	X	X	LC Mayor
* HealthyKidsNM Web Page		X	X	X	X	X	X	DOH
* Social Marketing Efforts	X	X	X	X	X	X	X	DOH & Interagency Members
* Program Evaluation:								
* Students' Eating & Fitness Behaviors.								DOH
* Students' BMI & Fitness Measures.								DOH
Conlee Neighborhood:								
* Nutrition Disclosure on Menus and menu boards in chain restaurants (pending).								

New programs established by Healthy Kids, Las Cruces initiative.

Senator BINGAMAN. Thank you very much.

Ms. Walters, why don't you go ahead and tell us about Cooking With Kids and similar programs and what they contribute to solving this problem?

STATEMENT OF LYNN WALTERS, EXECUTIVE DIRECTOR, COOKING WITH KIDS, SANTA FE, NM

Ms. WALTERS. Thank you, Senator Bingaman and Senator-elect Udall. Thank you for this opportunity. I appreciated seeing you both in our schools and for all your efforts on behalf of children over the years.

As you well know and has been really well said here, childhood obesity and nutritional deficiency is a serious public health issue. Last year in Santa Fe, actually due to the efforts of the Salazar Partnership for Healthy Schools, two schools did measure BMIs.

Actually, they have done it for 2 years now with private funding and found that of the 904 students attending Salazar and Agua Fria elementary schools, 28 percent were obese—not overweight or obese, but obese. That is rather startling. One of the schools actually was 34 percent.

I feel like it is my role here to really talk to you about one solution or one piece that can be the solution. Today, many children are no longer learning from their parents or grandparents how to cook or where food comes from, how to grow it. We have forgotten, in large part, the pleasure of preparing and eating healthy foods, the connection among families and community that comes from such pleasure.

We have observed today that children know that they are supposed to eat vegetables rather than candy. Almost every child knows that, right? Preferences and availability drive most of our food choices. Developing healthy preferences and cooking skills through direct experience with food is an important component of changing the culture of obesity.

As you mentioned, Cooking With Kids was initiated in 1995 as a volunteer program in two schools in Santa Fe with the intent to improve children's nutrition through hands-on food and nutrition education and to positively impact school meals.

Cooking With Kids' purpose is to motivate and empower children to make healthy choices by supporting their innate curiosity and enthusiasm for food. They learn directly about healthy eating through hands-on activities with fresh, affordable foods from many different cultures.

We currently work with over 4,400 children, prekindergarten now, some, through 6th grade in 12 low-income Santa Fe public schools. Last year, over 1,200 parents and grandparents volunteered during school day cooking classes, and we found that many parents who might be intimidated by coming to school when they were not successful in school are comfortable in participating in cooking classes.

The objectives of this program and other programs that work with hands-on food experience are for children to learn to accept a wide variety of healthy foods, that they will acquire practical food preparation skills, and to learn about people of other cultures while working cooperatively.

We have developed a bilingual interdisciplinary curriculum that meets many New Mexico public education standards in math, language, art, science, and social studies, which supports core curriculum. The heart of our program is the hands-on experience—touching, smelling, preparing, cooking, and tasting.

The classroom component consists of cooking classes taught by our staff, who partner with classroom teachers and parent volunteers, and fruit and vegetable tastings, to helping classroom teachers with materials and food provided by Cooking With Kids.

Patty Morris alluded to, in Las Cruces, actually those fruit and vegetable tasting classes are being implemented as well.

Some of the foods that children cook we might not think of as child foods. They are not macaroni and cheese that we have made children friendly. Children cook vegetable paella with green salad, minestrone soup with breadsticks, East Indian lentils with carrot rice pilaf, and vegetable tamales with red chili. Senator Bingaman years ago saw students preparing fresh green and white fettuccine with tomato basil sauce.

As the students prepare, share, and enjoy the fresh healthy foods together, they have multiple opportunities to learn, to exercise choice, and to enjoy eating together. In an effort also to link classroom learning with school meals, we continue to work with Santa Fe public schools to improve the appeal and quality of school lunches that children will eat.

We provide hands-on training for cafeteria managers using real food, although only once a year. Cooking With Kids-inspired school lunches are served about twice a month in all 21 Santa Fe public schools' elementary school cafeterias, and now in some of the middle and high schools.

The challenges really are our current eating and lifestyle patterns, which are a reflection of our societal values. As a result, cheap processed foods, conflicting messages, a dearth of cooking skills, lack of availability of affordable healthful foods in many areas are some of the barriers that we face.

In the realm of school meals, the status afforded to the women, mostly women, who cook for our children is very low, with accompanying low wages. Were we to give school food service workers the status and wages of high-powered chefs, were we to respect them and care that they are feeding our children, we would be making a meaningful statement about our priorities.

Lack of time for helping on this programming also is a growing challenge as the demands of No Child Left Behind are increasing. Cooking With Kids was initiated before No Child Left Behind, which I think has afforded it an advantage in the Santa Fe public schools.

However, were such a program to become an integral part of a school district rather than being implemented by a community partner, as we are, it could be swept away in a moment by any number of pressures that are facing schools, financial or academic.

Sustainability for social programs, as you know, is a continuing challenge. Funding, staffing, and community support must be ongoing. Facilities in schools also pose challenges, especially, for such a program as ours, the availability of dedicated classroom with adequate utilities. As computers are taking more energy in schools, we

have even found that circuits are not adequate for even electric appliances.

In addition, in Santa Fe, more schools would like to have Cooking With Kids than we are able to serve.

As I have said, the experience of cooking together is at the heart of what we do. It is a success when a child fishes around in his minestrone soup that he just helped make, pulls out a piece of kale, and says, "I like this." And that has happened.

A second grade student reported, "You know these recipes you give us? My grandma cooks all of them for dinner." A teacher commented, "We all benefit as a society when kids have skills, confidence, and a broader appreciation of many cultures."

We are currently fortunate to be involved in a research project that was funded by USDA/CSREES/NRI that is being directed by Colorado State University. It is entitled, "Cooking With Kids: Integrating Classroom, Cafeteria, and Family Experiences to Increase Fruit and Vegetable Preference and Intake."

The project is investigating the following—do the experiences provided by Cooking With Kids contribute to more healthful food choices and thus reduce children's risk for developing obesity and chronic disease?

We just have some preliminary results from the initial data collected last year from 700 fourth grade students in 11 Santa Fe public schools. These are preliminary. We will have full results next year.

We have found that in comparison with children that are not participating in Cooking With Kids, cooking and tasting classes, children enjoy cooking, whether it is in the classroom or at home. That might seem small, but perhaps it is a missing piece.

Confidence in cooking abilities, their self-efficacy increased significantly in children participating in Cooking With Kids compared with children from nontreatment schools. Preferences for fruits and vegetables were greater in children from Cooking With Kids schools than in children from nontreatment schools.

In conclusion, I appreciate your concern for the health of our children and applaud your efforts to make the world a better place. You can help by supporting sustained funding for nutrition education programming and, in addition to the SNAP ed or formerly Food Stamp Nutrition Education funding, which rightly serves children from low-income families, I believe that Government commitment to all children is needed.

This means support for children to have hands-on experience with healthy real foods as an integral part of their education. In addition, there is need to support new funding for school meals, which I know is a pipe dream at the moment. Also, though, continuing to support farm-to-school and local agricultural initiatives, which are really burgeoning across the country.

Convenience and indifference have brought us to this moment. Diligence, attention, and the commitment to work together is needed to make a positive difference in our communities.

Teaching nutrition using real food is not fast, cheap, or easy. There is value and satisfaction in self-reliance, and all children deserve to eat healthful, delicious foods and have the skills to take care of themselves. They are proud of these schools.

We must remember the child who remarked after eating delicious Greek food that they had just prepared, "There is joy in my mouth now."

Thank you.

[The prepared statement of Ms. Walters follows:]

PREPARED STATEMENT OF LYNN WALTERS

Senator Bingaman, guests, and distinguished leaders. Thank you for your work on the pressing issues of our time and for the opportunity to testify before you today. As a parent and as Founder and Executive Director of a small non-profit organization, I am deeply concerned with the health and well-being of children. We hope that the efforts of *Cooking with Kids* will not only benefit the children with whom we work, but will inspire others in their efforts to support a healthy future for all children. I appreciate your invitation to discuss *Cooking with Kids* purpose, challenges, and successes with this committee.

OBESITY IN NEW MEXICO CHILDREN

According to a recent study of New Mexico children 2–5 years old participating in Federal nutrition programs, 24 percent were considered overweight or obese. In a 2005 New Mexico survey of high school students, 26 percent were overweight or obese. As you are aware, the health risks of obesity are significant, including increased risk for the development of diabetes, hypertension, cardiovascular disease, and psychosocial problems. In Santa Fe, an evaluation summary of the Salazar Partnership Health Promotion Project reported in 2008 that 28 percent of the 904 students attending Salazar and Agua Fria Elementary Schools were considered obese. These two public schools have an average of 80 percent of students who qualify for free or reduced-price school meals.

COOKING WITH KIDS GETS CHILDREN EXCITED ABOUT EATING HEALTHY FOODS!

Cooking with Kids was initiated in 1995 as a volunteer program in two schools with the intent to improve children's nutrition through hands-on food and nutrition education and to positively impact school meals. Through *Cooking with Kids'* activities, elementary school students learn directly about healthy eating through hands-on activities with fresh, affordable foods from diverse cultures.

The objectives of *Cooking with Kids* are that children will:

(1) Learn to accept a wide variety of healthy foods;
(2) Acquire practical food preparation skills; and
(3) Learn about people of different cultures, while working together cooperatively.

Cooking with Kids serves 4,400 low-income children in 12 Santa Fe, NM schools; an average of 77 percent qualify for free or reduced-price school meals. During 2007–2008, the organization provided 2,043 hands-on food and nutrition education classes, including 868 fruit and vegetable tasting lessons taught by classroom teachers. *Cooking with Kids* delivers trained food educators, bilingual Spanish/English curriculum materials for teachers and students, equipment, food and supplies schoolwide.

The bilingual curriculum is a unique, interdisciplinary model of classroom food and nutrition education aligned with New Mexico Public Education Standards and Benchmarks in the areas of math, language arts, science, social studies, wellness, and art that is linked with school meals. *Cooking with Kids* develops and provides curriculum materials for teachers and students, with student materials and home recipes for families in Spanish and English. Activities are designed to correspond to developmental needs of the children, with student materials tailored for grades K–1, 2–3, and 4–6. Guided lessons with fresh healthy foods provide a quality experience that is not otherwise available to students, particularly students from low-income families. As students prepare, share, and enjoy fresh affordable foods from diverse cultures they have multiple opportunities to learn food preparation skills, to exercise choice (children are never forced to eat), and to enjoy healthy foods. Families are invited to participate as volunteers and family cooking classes in the evening offer unique opportunities for families to learn together.

Many families who might otherwise feel excluded and intimidated by the school environment feel welcome and valued in cooking classes. During the 2007–2008 school year, 1,200 parents and grandparents volunteered in cooking classes during the school day.

Cooking with Kids school lunches are served several times a month, connecting classroom learning to cafeteria meals. Examples of foods that students prepare in

cooking classes and are subsequently prepared by school food service to be served as school lunches are Llapingachos (Ecuadorian potato dish), Chinese-American Fried Rice, Vegetable Paella with Green Salad, East Indian Lentils with Carrot Rice Pilaf, Vegetable Tamales with Red Chile, and Minestrone with Bread sticks. *Cooking with Kids* provides hands-on training for the foodservice workers who prepare school meals, and collaborates with the Student Nutrition staff to serve *Cooking with Kids* school lunches. In collaboration with the New Mexico Department of Agriculture and Santa Fe Public Schools, we encourage and facilitate the use of New Mexico-grown produce in school meals as part of a Farm to School Program. *Cooking with Kids* produced large-scale posters that depict New Mexico farmers which are displayed in cafeteria dining rooms.

AWARDS

• 2005: *Cooking with Kids* received a national award recognizing Leadership, Innovation, and Nutrition Collaboration from USDA Food and Nutrition Services in the category of Partnerships and Collaborations. The award recognizes projects that use collaborative methods and integrated approaches in planning, developing, and delivering nutrition education involving multiple Food and Nutrition Services programs, which include Food Stamp and Child Nutrition programs.
• 2007: *Cooking with Kids, Inc.* was chosen as the non-profit to receive a national Innovation in Prevention Award by the U.S. Department of Health and Human Services for its efforts in promoting healthy lifestyles in communities.

Children's voices:

I love Cooking with Kids! I can make things I didn't think I'd like, but I do!
CWK helps us to learn to eat more healthy foods and less junk food.
Lentils have iron—that makes you strong.
We learned what India eats.
We learned how to cook and clean up after ourselves.
I learned to do the rice with my mom.
We know where the food is from.
We learned how to hold the knives.
We cleaned our hands and everything else.
Cooking with Kids makes us feel healthy and not tired.
Chinese Fried Rice has lots of vegetables.
I think we learned how to work better together.
Try new things because maybe you will like them.
The fruit salad is healthy because it has vitamins and minerals.
You have to be patient.
When you cook it's good and you're doing something for yourself.
There is joy in my mouth now!

CHALLENGES

Our current eating and lifestyle patterns are a reflection of societal values. As a result, the challenges are many, including cheap processed foods, conflicting messages, a dearth of cooking skills, and lack of availability of affordable, healthful foods in many areas. In the realm of school meals, status afforded to women who cook for our children is very low, with accompanying low salaries. Were we to give school foodservice workers the status and remuneration of high-powered chefs, we would be making a meaningful statement about our priorities.

Lack of time for health and wellness programming is a growing challenge, as the demands of No Child Left Behind (NCLB) are increasing. *Cooking with Kids* was initiated before NCLB, which has afforded it an advantage in Santa Fe Public Schools. However, were such a program to become an integral part of a school district, rather than being implemented by a community partner such as *Cooking with Kids*, it could be swept away in a moment by any number of the myriad pressures facing schools: financial or academic.

Sustainability for social programs is a continual challenge. Funding, staffing, and community support efforts must be ongoing. Teaching nutrition using real food is not fast, cheap, or easy!

SUCCESSES

The experience of cooking together is the heart of what we do. In this process, we observe that all of the children are enthusiastic participants and almost all children are excited to eat the foods that they have prepared.

A FEW STORIES

I consider it a success when a child fishes around in his Minestrone soup that he just helped make, pulls out a piece of kale and says, "I like this."

A second grade student reported, "You know those recipes you give us? My grandma cooks all of them for dinner."

A teacher noted that she was happy to have a (CWK) teacher that speaks Spanish because now the Spanish speaking moms who don't feel comfortable coming to other activities come to *Cooking with Kids* cooking classes.

Two classroom teachers noted that the autistic special needs boys in their classes were able to stay with the cooking activity for the entire 2 hours without disruption. The boys learned to enjoy the food preparation, enjoy social interaction, and especially enjoyed washing dishes. They were proud contributors to the class.

Two fifth grade classes had "salad parties" and brought in extra ingredients to make big salads to share.

As one teacher commented, "We all benefit as a society when kids have skills, confidence, and a broader appreciation for other cultures."

Cooking with Kids' innovative model of interdisciplinary education for Kindergarten through sixth grade students has inspired programs in several New Mexico communities. Las Cruces Public Schools now offers *Cooking with Kids* fruit and vegetable tasting classes in 14 schools and is currently piloting cooking classes in several schools. Inspired by the *Cooking with Kids* founders and curriculum, Albuquerque Public Schools has adapted the program and materials to meet the unique needs of a large urban school district. In an effort to offer the curriculum more widely, with support from the Robert Wood Johnson Foundation, *Cooking with Kids* developed a Web site that provides free access to fruit and vegetable tasting lessons for grades K–1, 2–3, and 4–6: *www.cookingwithkids.net*. Cooking curriculum, a program DVD, and *Cooking with Kids* school lunch recipes for institutional use are available for sale via the Web site. Over 1,500 individuals have downloaded free fruit and vegetable tasting lessons and individuals and institutions from over 20 States have purchased curriculum. Several colleges of Home Economics and Extension have procured curriculum for use through County Extension programs.

RESEARCH

Funded by USDA CSREES National Research Initiative, a 4-year research project is being conducted by Colorado State University. Entitled: *Cooking With Kids: Integrating Classroom, Cafeteria and Family Experiences to Increase Fruit and Vegetable Preference and Intake*, this project is under USDA Agreement No.: 2006–55215–18718; Proposal No.: 2007–05062. The Principal Investigator is Leslie Cunningham-Sabo, Ph.D., RD, Colorado State University; Co-PI Lynn Walters, *Cooking with Kids*, Inc.

This project is investigating the following questions: Does direct experience with fresh, affordable foods from diverse cultures, including cooking and tasting fruits and vegetables, increase children's preferences for and consumption of these foods? Will positive experiences with fruits and vegetables in the classroom plus cafeteria promotion improve students' acceptance of fruits and vegetables? Can family food preparation and eating practices be modified to support more healthful dietary patterns? Do these experiences contribute to more healthful food choices, and thus reduce children's risk for developing obesity and chronic diseases?

Results are promising from initial data collected from 700 4th grade students in 11 Santa Fe Public Schools. The preliminary results below are from the first year of a 2-year data collection in this evaluation of the *Cooking with Kids* program:

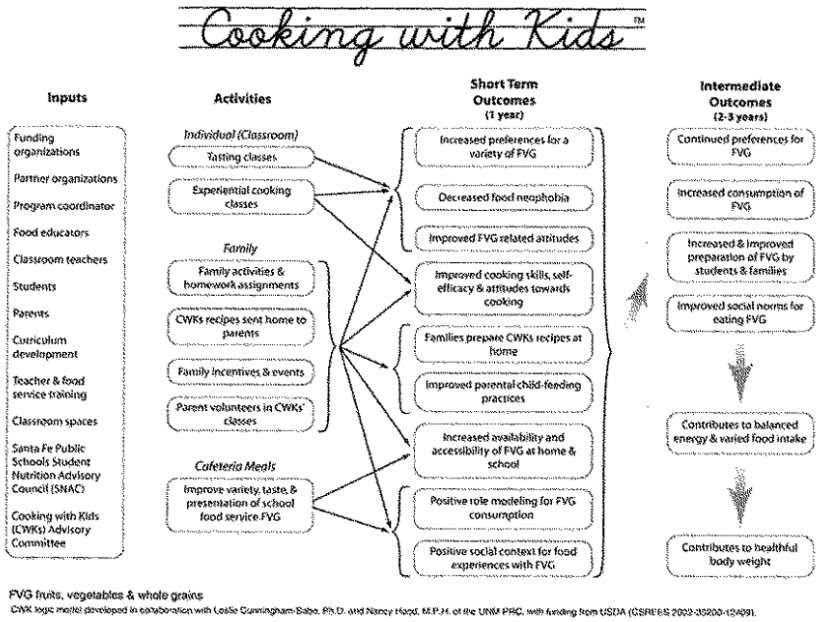
1. Children enjoy cooking, whether it is in the classroom or at home;
2. Confidence in cooking abilities (self-efficacy) increased significantly in children participating in *Cooking with Kids* compared with children from non-treatment schools;
3. Preferences toward fruits and vegetables were greater in children from *Cooking with Kids* schools than in children from non-treatment schools.

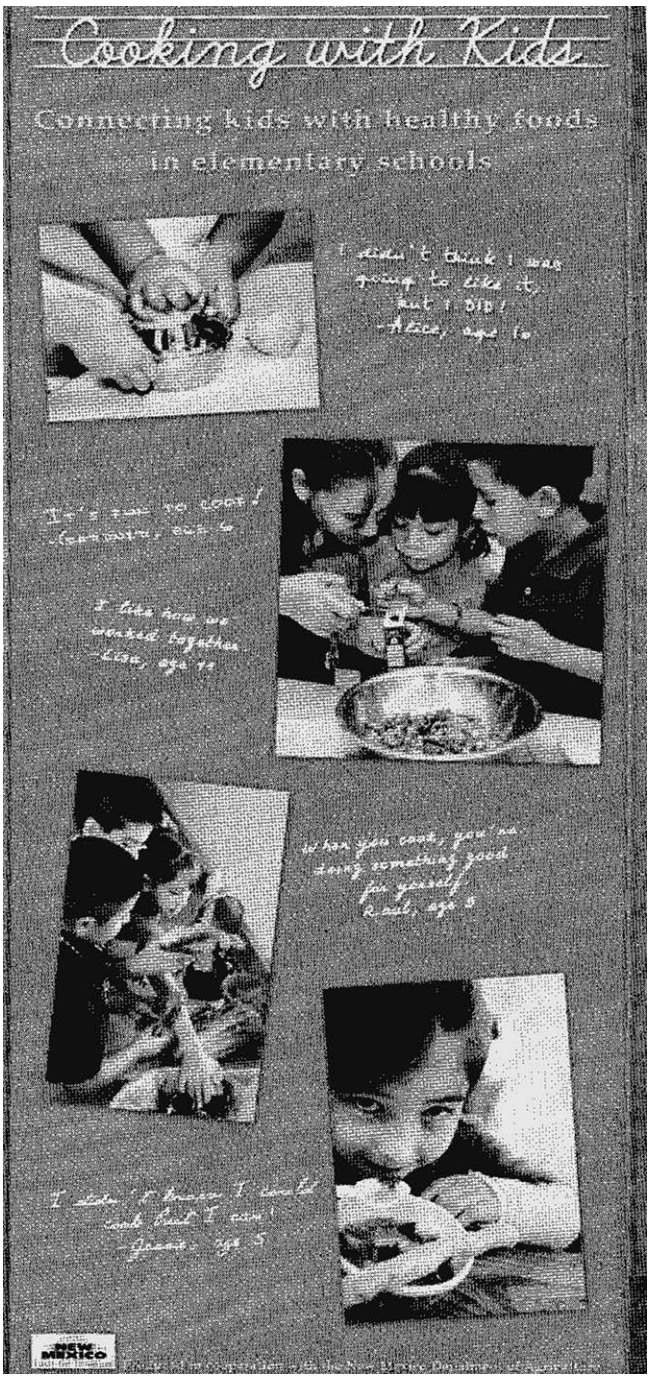
CONCLUSION

I appreciate your concern for the health of our children and applaud your efforts to make the world a better place. Congress can support increased and sustained funding for nutrition education programming and for fresh and healthy school meals. Convenience and indifference has brought us to this moment. Diligence, attention, and the commitment to work together is now needed to make a positive difference in our communities.

There is value and satisfaction in self-reliance. We must remember the child who remarked, after preparing and eating Greek Pastitsio, "There is joy in my mouth now."

Thank you for providing this opportunity to participate in the democratic process by testifying before this committee.




Cooking with Kids
Connecting kids with healthy foods in elementary schools
I didn't think I was going to like it, but I did!
-Alice, age 10
It's fun to cook!
-Samantha, age 9
I like how we worked together
-Lisa, age 11
When you cook, you're doing something good for yourself.
-Raul, age 8
I didn't know I could cook but I can!
-Jeanie, age 5
NEW MEXICO

Senator BINGAMAN. Thank you very much.

Let me ask, do you have any more information on this, you say that two of the schools are Acequia Madre and Salazar?

Ms. WALTERS. No, it was Agua Fria and Salazar.

Senator BINGAMAN. Agua Fria. There was for a 2-year period, where they did measure body mass?

Ms. WALTERS. Yes.

Senator BINGAMAN. How was that done? Was that funded?

Ms. WALTERS. Well, it was funded primarily by a private foundation that is actually in New York State who has a connection to community members here. It is really a project that was started by several people who started a reading program at Salazar, and then it expanded to Agua Fria. Now it is really a small consortium of people working on how to look at the health of the students in these schools.

There is more information that I can certainly send you, but the funding for—and there has been a lot of discussion, too, about the measuring of BMI or not. The school nurses in Santa Fe are part-time. Usually a school has a nurse 2 or 3 days a week. This funding, in addition to other things, has paid for the nurses at these two schools to be full time. They have had time to do the BMI measurements.

Senator BINGAMAN. Dr. Morris, what is your reaction to the thought that maybe we should just follow Arkansas's lead and go ahead and do this measurement of body mass throughout our elementary schools?

Ms. MORRIS. I think it is an excellent idea. If I could just add one barrier that I don't think I heard discussed around the BMI, which I have heard from a lot of nurses, school nurses in the State of New Mexico that they have difficulty—they don't want to measure kids.

The reason they don't is so many of their kids are uninsured. If they measure the child and if they determine the child is obese, what do they tell their parents if the children are uninsured? So that there is a link at least in the State of New Mexico that there is a concern around, where do I send them?

Now in our Healthy Kids Las Cruces, what we are trying to do is to initiate a BMI in at least our Conlee Elementary, if not in the entire Las Cruces public school district, where the Department of Health will take on the burden and hopefully work with some of the pediatricians, even if you are uninsured. If you come up with a BMI level that puts you at obese, that you will have the medical attention that you need.

That is one difficulty that we have, at least here in New Mexico. I think we absolutely have to measure BMI in order to get a handle on where the problem is, the extent of the problem, and whether or not we are making any progress. I think it is an excellent idea.

Senator BINGAMAN. Let me just ask for my own information here, Dr. Thompson, the actual measurement, collection, and all of this information on BMI was done through the Department of Education in Arkansas. Is that right?

Dr. THOMPSON. It is actually the responsibility of the local school districts and local schools. We had the same sets of issues with limited nursing personnel. We found an enormous wealth of interest.

Actually, we found in a few of our elementary schools, PE teachers who were already trying to do it with a hand calculator. The PE teachers in elementary schools were probably the strongest advocates because they took it as a professional affront that they were losing on the obesity side. We really brought in not just the school nurse personnel, but the physical education teachers.

We also found that many of our nurse training programs—the LPN schools, the others that were across the State—highly value the chance to get their students just hands-on contact on doing basic assessments. We got a lot of free labor, if you will, by connecting schools that needed help with nurse training programs at the LPN or at the bachelor-level training programs.

I might comment about that letter, if I could?

Senator BINGAMAN. Please.

Dr. THOMPSON. Our letter home to parents, we struggled with the same issue on the uninsured piece. I think there is a critical decision and a potential trap if we think that this obesity epidemic is a medical issue. It is a social issue.

What we did was give parents four things that had evidence bases underneath that they could do, that they could reduce the soft drinks, as your 5-2-1-0.

Ms. MORRIS. No, we are not——

Dr. THOMPSON. You are at zero. Eliminating sugared soft drinks, going to no-fat milk, 2 hours of screen time a day, and for the whole family to have a physical activity pattern where they were trying to do something because it is not going to work to tell the kid to go out if the dad is sitting on the couch. It is as big a problem as ever.

This we did take—we said it is a social issue, and then we worked with our healthcare system to be able to wrap around that. We didn't primarily say to parents of overweight children, you need to go see your doctor. I mean, that was not the approach that we took.

Dr. SANCHEZ. Can I jump in and say that is the right approach. However, one of the things that Dr. Thompson did mention is that some change in how we go about using Medicaid and SCHIP would allow for some of the concern about where one goes to be addressed.

I agree wholeheartedly that if we make this a medical issue, then what we start doing is sticking needles in children's arms and testing them for a whole host of things for which just the testing is going to cost more money than having a rational approach to a population-based social and population health issue.

I wholeheartedly agree with the issue of the uninsured, remember, I said I was initially opposed? That was why. The State of Texas has the dubious distinction of having the highest uninsurance rate not only for everyone, not only for adults, but also for children.

My concern was that the system might not be able to accommodate what we found and that parents would find themselves in a situation where they didn't know what to do. I think this approach of giving folks some solutions is an excellent approach that again says the solution lies within you, and the medical care system is

there if you need it for other things. At the end of the day, the solution lies within your home and within your community.

Senator BINGAMAN. Well, the changes in Medicare and SCHIP that you are talking about are, I think Dr. Thompson referred to it, we should change the definition of what is covered to include obesity. Is that the main change?

Dr. SANCHEZ. Not only diagnosis change, but what constitutes—I would add what constitutes a reimbursable intervention.

So that we have communities where if you see a nutritionist dietician, you may end up having to go to an endocrinologist's office, where there are equally qualified folks in communities, sometimes within school districts, who could provide the same service in a community setting as opposed to a medical care setting, and our reimbursement mechanisms aren't as friendly to that community-based setting or school-based setting as they might be.

If you have a school-based clinic, that is one thing. If you don't have a school-based clinic, and in Texas, there are many communities that don't, you still might be able to avail yourself of the services of a nutritionist, of a behavioralist, somebody to meet with the family and help begin thinking about change.

The one other thing about the behavioralist is sometimes the reimbursement is around the service provided to the child. We need to think about how we might have services that are provided to the family because it is a family change that has to take place ultimately.

What happens in the school provides the hub, but all the other places where a child lives his life is—it is all complementary and synergistic.

Dr. THOMPSON. If I could add something? In the SCHIP legislation explicitly, just including obesity as a reimbursable condition is a specific change that would be very beneficial for guidance to State programs.

Now I think the other issue, which we get into and I think State programs will have to work with the Center for Medicaid and Medicare Services, is our healthcare programs are pretty good at paying the doctor for doing something. The doctor is probably, as we learned with tobacco cessation, not the person you want teaching the parent or the family how to do better nutrition.

We want a nutritionist who is educated on how to engage families and support those changes. Right now, many of our Medicaid and SCHIP programs don't extend the reimbursement to that non-physician support, which frequently can be done in a group setting very efficiently and maybe more economically. I would be willing to bet much more successfully than having the physician do it, even though we will pay the physician to do it.

This is one of those places we can make the system better, make it more effective, and probably not cost that much.

Senator BINGAMAN. Dr. Morris, did you have a comment you wanted to make?

Ms. MORRIS. I did. I have two comments. One was back to the BMI. One of the things that we are struggling with to overcome this barrier around how do we actually measure it is actually use it as an empowerment tool or an education tool.

Why is it that we can't in our physical education classes have kids learn how to take their—some very simple fitness measures and then set goals for themselves, and then a month later, "I am going to get my resting heart rate down," or "I am going to know what my weight is and my height." So that they begin to take more ownership of it. You can collect the data as a monitoring piece, but it also can be used as an educative piece.

Now we have to sort of keep them separate at a State level in terms of monitoring, but one of the things we are hoping to do in the Conlee Elementary School is to really test that, and I think we are going to use the FITNESSGRAM that Dr. Cooper from Texas has really set up, which is five or six very simple measures around fitness and have the kids use those and measure themselves during their classes so that we can do that.

I think that is one way of sort of dealing with greater integration. The other piece is it is really important for the Federal Government to open up some of the—in the Medicaid issue. Also, at the State level, we have to get our State legislators to agree to open up those pieces as well.

We absolutely need it at the Federal level, first and foremost. Then, again, it comes up to how much is the State willing to pay to whether or not they are going to open it up.

Senator BINGAMAN. Congressman Udall, go ahead.

Mr. UDALL. Thank you, Senator Bingaman.

Just building on what all of you just exchanged back and forth there, which I think was a very, very good exchange in terms of saying that this, if you identify the problem, is a social problem rather than immediately turning it into a medical problem, when we were discussing the BMI, and having that kind of approach.

Now Dr. Morris mentioned in her testimony, and we know that this is true, these disproportionate rates of obesity and diabetes among minorities. In New Mexico, I believe you put in 32.4 percent of American Indians, 26 percent of Hispanic high school students—this is in 2007—were overweight or obese compared to 18.6 percent of white, non-Hispanic students.

My question for all of you is what are the particular challenges in reaching minority populations on these issues, and what particular approaches should we keep in mind as we attempt to craft legislation at the Federal level?

Ms. MORRIS. We struggle with this, and I think what I—sort of based on my experiences, I think we are balancing best practices versus innovation, experimentation, local determination of the kinds of programs we want.

One of the reasons we picked Las Cruces was because more than half of its student population is Hispanic. In order for us to reach hard-to-reach groups, it has to be done more from the local community and the local ethnic group taking charge in responsibility and leadership.

I see my role at the interagency of providing resources, providing advice, guidance, helping set frameworks. Ultimately, it has to be the Hispanics in Las Cruces saying these are the barriers I face. These problems are real to me today, and this is how I want to make those changes. Then it is for us to work together to set them up. It is very difficult.

Dr. SANCHEZ. I would say, to add on to that, we talked about cultural sensitivity and cultural competence, very important. At the end of the day, what we ought to be measuring is cultural effectiveness.

I would say to you the interesting thing about the CATCH program is that it was tested in what is a demographically very diverse population in El Paso, TX, and it had the desired effect.

While we need to be sensitive to cultural sensitivity and cultural competence, we ought to be measuring whether things are effective or not and how much they might be applicable in different subpopulations. Outreach is very, very important.

There are some subpopulations where our standard approaches to school-based activities or even community-based activities are not going to work the same way that they might in another subpopulation. We need to understand how we might do outreach differently.

I am somebody who believes very, very strongly in the community lay health worker model, the Promotores model. It is not only effective in Latino populations, the Southern States has been using those community lay health worker models to go out and engage at the home level and at the community level, rather than having the thought that you initiate gatherings at the school or some other independent setting.

I think also just the issue of poverty is one. If we think about the fact that one of the challenges that we have in our Nation is that when we look at graduation rates of our subpopulations, Latinos, African-Americans, and American Indians are not as high as they ought to be.

If we could think about approaches that, particularly in the school setting, was about not leaving any child behind even while we address this issue of childhood obesity, we could begin to convince ourselves that fit kids are smart kids, smart kids are fit kids. They go together. It is not one or the other.

As it relates to the nonwhite subpopulations, it might make sense to do these three things—cultural sensitivity, outreach in a different way, and then assuring that in the school setting, we are not only doing the right nutrition things and physical activity things, but actually thinking about and demonstrating what works in terms of graduating our young kids out of school.

Because at the end of the day, as we think about this and we look at the statistics—Dr. Thompson, I think everyone here would agree with me—is that if we could achieve graduation rates among Latinos and African-Americans that we have among whites and some of the subpopulations among Asians, some of what we are talking about begins to go away because it tracks with poverty and educational attainment as much as it tracks with race/ethnicity.

Dr. THOMPSON. I think the one thing, and I completely agree with the cultural issues. I would not want, because you are going to have actionable opportunities in the short run, to highlight the interrelationship to poverty. I have poor white communities. I just have more poor minority communities concentrated in our State.

On your economic stimulus package or on the decisions on reauthorization, to the extent that you can assure or ensure or require or incentivize or heighten awareness of the need for those invest-

ments to not just be sprinkled geographically evenly across the States that are going to receive that funding, but to be targeted to communities that have been economically disenfranchised. Because those are the communities that have the least capacity to use the information from a BMI report or from a local leader who wants to make something happen or from a change in the cultural perspective.

Those are the communities that need the most support. So that when the new road gets built, it actually doesn't divide where the kids live from where the school is. Because when the road gets built, it won't be decided by that local community.

Just incorporate some of those poverty-related issues into the thoughts on your economic stimulus package and targeting not just to States, because your States and your communities that are more affluent are going to get through this. The communities that are least affluent and least empowered are going to be set back farther and have more risk for their children on this issue.

Ms. MORRIS. If I could just add one other point? I think we have forgotten a very important group, which are our students. We are working right now, the interagency, with the Santa Fe Indian School. We are helping in their culinary arts program, teaching students basically how to prepare healthy traditional American Indian foods.

They are learning how to do nutritional analysis and reformulating. What they are going to do is go back, because the Santa Fe Indian School is owned by and run by the 19 pueblos in New Mexico, and so the students, part of their responsibility is then to go back and to teach the elders in their community and go to the senior centers in their community and teach them the healthy alternatives to traditional indigenous foods.

As part of that cultural sensitivity and cultural effectiveness and bridging the community and the schools and the students, students I think can play a very important role when they go back to their culture, especially in communities where culture, community, and families are still important, which tends to be in Native American and Hispanic cultures, more so I think than Anglo.

Dr. SANCHEZ. Can I add because we talked about food, it is I think important for us to have a sense of what the relationship between obesity and access to food is.

Food insecurity was mentioned, and one other area that has to do with USDA that is worth looking at is, how we think differently about what kinds of foods we subsidize production of so that we can make the availability and access to the healthy foods that we are talking about actually affordable to those folks who live in communities where they may not even have access to a supermarket where those kinds of foods are available.

Then, when they show up, and they look at the list of things that we have advised that they ought to be eating, they say, "You know what, we can't afford this. We need to buy the beans, and we need to buy what is in the can and pretty cheap."

We need to figure out how we make the healthy choices the easy choices, and I am not sure that we talked so much about that. Access to affordable healthy foods in communities that might other-

wise not have access is something that I think is really important to consider.

Mr. UDALL. Let me just thank you, all of you, again and say to Senator Bingaman that I have watched over the years in my work in the House how he has worked on healthy kids and moving New Mexico forward. I really look forward to joining him in the Senate and working with him on this issue in just a very short period of days.

Thank you, Senator Bingaman, for your invitation today.

Senator BINGAMAN. No, thank you very much for participating, and I know you are strongly committed to making progress on this. I am, too.

Thank all of you for coming, particularly our witnesses from out of State, and those of you from New Mexico as well. I thank you, all of you who attended. I think this was a useful hearing. We have got some good suggestions for actions we need to take in the next Congress, and we will try to do that.

That will conclude our hearing. Thank you very much.

[Whereupon, at 11:43 a.m., the hearing was adjourned.]

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