

PA13-173

HB6525

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2013**

**VOL.56
PART 15
4856 – 5209**

THE CLERK:

On page 42 of today's Calendar, House Calendar 170, favorable report on the joint standing committee on Public Health, Substitute House Bill 6525, AN ACT CONCERNING CHILDHOOD OBESITY AND PHYSICAL EXERCISE IN SCHOOLS.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Urban of the 43rd, you have the floor, madam.

REP. URBAN (43rd):

Thank you, Mr. Speaker.

I move acceptance of the joint committee's favorable report and passage of the bill.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

The question before the Chamber is acceptance and passage.

Please proceed, madam.

REP. URBAN (43rd):

Thank you, Mr. Speaker.

Mr. Speaker, the Clerk has in his possession an amendment, LCO 7387. I ask that he call it, and I be allowed to summarize.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Will the Clerk please call LCO 7387, it shall be

designated House Amendment Schedule "A."

THE CLERK:

House Amendment "A," LCO 7387, as introduced by
Representative Urban, et al.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Urban, you have the floor.

REP. URBAN (43rd):

Thank you, Mr. Speaker.

Mr. Speaker, this is a strike-all amendment and, therefore, does become the bill. I don't think that I need to spend a significant amount of time convincing this House that we have an obesity problem, not only in Connecticut but in our nation.

We have looked at studies that will show us that obesity will lead to Type 2 diabetes, obesity-related cancers, coronary heart disease and stroke, hypertension and arthritis. And one study showed a saving, if we could reduce the average body mass index in the state of Connecticut saving 7 billion dollars in 20 years.

What this strike-all amendment does, Mr. Speaker, is it sets up a task force of experts, as well as appointees, to examine all of the issues that are related to obesity and to report back to us.

It, also, Mr. Speaker, has some issues about exercise during the school day as a punishment or as the ability to, in after school hours, to use exercise in different ways, which I can relate to since I coached middle school boys in basketball. And I know that after school when they have all of that energy, you want to be free to let them run.

Mr. Speaker, I would like to thank Representative Carpino, who this bill was initially Public Health bill. I'd like to thank my ranking member, Representative Betts and Representative LeGeyt for his work on this -- LeGeyt, see, I knew I'd do it -- LeGeyt, for his work on this bill and my co-chair Senator Bartolommeo and, of course, my vice chair, Representative Fawcett.

Mr. Speaker, I move adoption.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

The question before the chamber is adoption of House "A."

Further on House "A"?

Representative Betts of the Mum City, 78th.

REP. BETTS (78th):

Thank you very much, sir.

Just very briefly, I just want to echo the

comments of the Chair of the Children's Committee.

This is a strike-all amendment and this really reflects a consensus-building, bipartisan-building effort to really begin the first step of addressing obesity and I'm very pleased with the help of a number of people that we were able to reach this point, and I'm hoping that this task force is going to move us forward in terms of trying to address this very serious problem so I would urge all of our colleagues to adopt this amendment, which is really going to be the bill. And again, I thank everybody for their efforts particularly Representative Carpino for bringing this forth and giving us a chance to really help people who are having problems with obesity.

So thank you very much, Mr. Speaker.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative Betts.

From the 32nd District, home of the Traveler's Championship, Representative Carpino, who I believe has discount tickets available for next month's tourney.

REP. CARPINO (32nd):

Thank you, Mr. Speaker.

A lot of people have done a lot of work on this,

and I'd like to thank all of them.

We make important policy decisions here every day, but the decisions we make most important in my mind are those that effect our youngest and our smallest citizens; 25 percent of children, in Connecticut alone, are obese; 17 percent of children from 2 to 19 across the United States. And in Connecticut alone, for anyone who's interested in dollars and cents, we spend over \$800 million on obesity-related issues alone, all of which can be avoided. Physical, mental, social, all problems that can be avoided through this. Again, this obesity task force is a large step in the right direction.

It will look at, in particular -- I'd like to ask everyone to pay attention to, increasing physical activity in children. Parents will tell you that children now are the most inactive generation but there are facts that support this so I thank everybody for their assistance and encourage my colleagues to support it.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative Carpino.

Representative LeGeyt of the 17th, you have the floor, sir.

REP. LEGEYT (17th):

Thank you, Mr. Speaker.

I rise to endorse the statements of my colleagues regarding this bill and say in a very generous way that I had concerns when this came out of Education regarding the sections about requiring or limiting physical exercise as a form of discipline. And when it came out of Education, it was reflected in the bill that the State would mandate how that was to be treated, and I proposed an amendment that turned it over the local boards and that amendment was deemed friendly and eventually wound up as part of this bill, and I very much appreciate those efforts and encourage my colleagues to support this bill. Thank you.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative.

Representative Candelora of the 86th, you have the floor, sir.

REP. CANDELORA (86th)

Thank you, Mr. Speaker.

If I may, just a couple of quick questions to the proponent of the amendment?

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Please proceed, sir.

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REP. CANDELORA (86th)

Thank you, Mr. Speaker.

As part of this task force, we're charging them in lines 32 through 33 with examining the nutrition standards for all food procured by the State. Do we mean in that language that we would be examining, in addition to this, items that are served in our local schools as well?

Through you, Mr. Speaker.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Urban.

REP. URBAN (43rd):

Through you, Mr. Speaker, first of all the word there is "examine" so we're not mandating anything at this point in time but, yes, I think the spirit of this and the legislative intent is because we do fund the schools through ECS money that we would be asking the schools to take a look at this, but we're probably already preempted because the schools are already doing this.

Through you, Mr. Speaker.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Candelora.

REP. CANDELORA (86th)

Thank you, Mr. Speaker.

I appreciate that. I do agree and I think the language should be construed as broadly as possible to look at these types of issues, and I wanted to make sure of that.

And then just my other question referring to the language that Representative LeGeyt has spoke to of physical exercise being used as a form of discipline and sort of leaving that up to the local boards of education to make that determination.

Being a parent of three children, I have one child, in particular, that taking away recess at times is the only way to motivate him on his classroom studies. He's a quite active healthy child that puts more emphasis in sports than he does in education. So once in a while the teacher will hold him in for recess in order to complete a homework assignment and things of that nature. I do see that we're leaving this up to local control to make the determination -- or -- excuse me -- in making the policy and, specifically, language 60 through 61, it says "as the board deems appropriate." So in my fact pattern, would the board of education still have the ability, if it is appropriate, to have a child be held for

recess for academic purposes so long as it doesn't
interfere with their overall health?

Through you, Mr. Speaker.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Urban.

REP. URBAN (43rd):

Through you, Mr. Speaker.

And I'm assuming the good representative would like this for legislative intent. It is absolutely true that legislative intent is to allow the teachers that flexibility but without the State telling them that but going down to our local school districts so that they can make that decision, and we had gotten a lot of feedback from our locals and from our teachers expressing exactly what you just expressed.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Candelora.

REP. CANDELORA (86th)

Thank you, Mr. Speaker.

I appreciate the answers. I do think this is a laudable issue that we need to address in the State of Connecticut and probably nationally, and I do support the amendment and am happy to see the bill much improved.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative Candelora.

Representative Ziobron. Happy anniversary. You have the floor, madam.

REP. ZIOBRON (34th):

Thank you, Mr. Speaker.

I am very happy to see the amendment language today. As a member of the Public Health Committee, I voted against this bill out of committee because I felt it was too much of the State dictating to a local board of education what they should do or shouldn't do with their children.

As a mother myself of two kids and a former board of education member, I saw firsthand why the teachers needed to have all of the tools of the tool box. And sometimes they motivated kids by keeping them inside from recess for five minutes or ten minutes and sometimes it was with a sticker, sometimes it was with a little toy. There's lots of different ways our teachers motivate our children. And I think it's a good idea when we don't prohibit those tools in the tool box. So for that reason I will be supporting the amendment today.

Thank you, Mr. Speaker.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative Ziobron.

Further on House "A"? Further on House "A"?

If not, I'll try your minds.

All those in favor, please signify by saying aye.

REPRESENTATIVES:

Aye.

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Opposed?

The amendment is adopted.

Further on the bill as amended? Further on the
bill as amended?

If not, staff and guests please retire to the
well of the House. Members take your seats. The
machine will be open.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll. Will
members please return to the chamber immediately?

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Have all the members voted? Have all the members
voted? Please check the board and make sure your vote
is properly cast.

If all members have voted, the machine will be

locked.

Would the Clerk please take a tally.

Will the Clerk please announce the tally.

THE CLERK:

Substitute House Bill 6525, as amended by House
"A"

Total Number Voting	139
Necessary for Passage	70
Those voting Yea	135
Those voting Nay	4
Those absent and not voting	11

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

The bill as amended passes.

Will the Clerk please call Calendar 92.

THE CLERK:

On page 41, House Calendar 92, favorable report of the joint standing committee on Labor and Public Employees. House Bill 6478, AN ACT CONCERNING THE CLAIMS DATA PROVIDED TO CERTAIN EMPLOYEES, as amended by House "A."

ASSISTANT DEPUTY SPEAKER ALTOBELLO:

Representative Megna of the 97th, you have the floor, sir.

REP. MEGNA (97th):

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SENATE**

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couple items first, Calendar page 21, Calendar 643, House Bill 6525, and then, Madam President, Calendar page 20, Calendar 635, House Bill 5926, and Calendar page 20, Calendar 639, House Bill 6379, and Calendar page 21, Calendar 642, House Bill 6478.

Thank you, Madam President.

THE CHAIR:

Thank you.

Mr. Clerk.

THE CLERK:

On page 21, Calendar 643, Substitute for House Bill Number 6525, AN AN ACT CONCERNING CHILDHOOD OBESITY AND PHYSICAL EXERCISE IN SCHOOLS, Favorable Report of the Select Committee on Children.

THE CHAIR:

Senator Bartolomeo.

SENATOR BARTOLOMEO:

Thank you, Madam President.

Madam President, I move acceptance of the Joint Committee's Joint Favorable Report and I urge passage of the bill in concurrence with the House of Representatives.

THE CHAIR:

The question is on acceptance and passage in concurrence.

Will you please remark.

SENATOR BARTOLOMEO:

Yes. Thank you, Madam President.

This bill, which originated from the Committee on Children, is a bill to address what's becoming, kind of, an epidemic in our -- our community. And that is obesity, not just in adults, but in children. So in just over the

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one generation, the U.S. rates of obesity have approximately tripled among preschoolers and adolescents and actually, quadrupled --

A VOICE:

(Inaudible.)

SENATOR BARTOLOMEO:

Okay.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes. Madam President, if this item might be passed temporarily where there's an issue for -- for review on this item. So if it might be passed temporarily, we will return to it in a while. And if the Clerk would proceed to the call of the -- the other items listed.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 20, Calendar 635, Substitute for House Bill Number 5926, AN ACT CONCERNING PERSONAL RISK INSURANCE RATE FILINGS, Favorable Report of the Committee on Insurance and Real Estate.

THE CHAIR:

Good afternoon, Senator Crisco.

SENATOR CRISCO:

Good afternoon, the lovely Lieutenant Governor.
Thank you.

Madam President, I move for acceptance of the Joint Committee's Favorable Report in concurrence with House Amendment "A."

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President.

THE CHAIR:

Mr. Clerk.

SENATOR LOONEY:

Calendar page 21, Calendar 643, House Bill 6525.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 21, Calendar 643, Substitute for House Bill Number 6525, AN ACT CONCERNING CHILDHOOD OBESITY AND PHYSICAL EXERCISE IN SCHOOLS, Favorable Report of the Select Committee on Children.

THE CHAIR:

Good afternoon, Senator Bartolomeo.

SENATOR BARTOLOMEO:

Hi, Madam President.

Madam President, I move acceptance of the Joint Committee's Joint Favorable Report and I urge passage of this bill in concurrence with the House of Representatives.

THE CHAIR:

Motion is on acceptance and passage in concurrence.

Will you remark, ma'am.

SENATOR BARTOLOMEO:

Yes, please. Thank you, Madam President.

This bill is in response to a growing concern regarding the increase in obesity amongst children and the negative impact that it has on our children's health.

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In just over one generation, the U.S rates of obesity have approximately tripled among our preschoolers and our adolescents, and actually quadrupled among our children from six to 11 years old, according to the Institute of Medicine.

And DPH has done a study with 8,000 children. And a third of kindergarteners through our third graders are actually overweight or obese. There also are some serious negative health effects based on children being overweight. Some of these include asthma, cardiovascular disease, orthopedic complications, type-2 diabetes, depression.

As a matter of fact, 60 percent of overweight children already exhibit at least one risk factor for heart disease, which is a a number one cause of death. And type-2 data -- type-2 diabetes, at one point in time, was actually referred to as adult onset diabetes, but now it represents 45 percent of new pediatric cases as compared to only 4 percent a decade ago.

This bill is -- has come to us as an amended version from the original bill. I'm happy to say this is a -- came to us as a bipartisan amended bill. And it was originated from a collaborative called the Connecticut Coalition Against Childhood Obesity.

There are three parts to this bill. The first part is a task force to study childhood obesity and its effects. A second part of this bill is addressing our policies for exercise in our elementary schools. One aspect of that is that the definition of our current laws addressing -- excuse me -- addressing exercise in school, we've now gone from saying grades kindergarten --

THE CHAIR:

Excuse me a minute.

Can we just lower the tone in the Chamber please. It's very hard to hear the Senator that's speaking.

SENATOR BARTOLOMEO:

Thank you very much, Madam President.

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We've now gone from having the statutes read grades kindergarten to five, and we're now saying elementary school because of the fact that many of our elementary schools differ in the grades that they cover. Some go to fourth, some go to fifth, and some go to sixth grade.

We also are -- have now in here -- one thing that's changed from the original version of the bill is we were looking to have a restriction on the -- how exercise was utilized in schools. We're now asking that our local and our regional boards of ed shall adopt a policy that the board deems appropriate in two things: One would be how employees address preventing a student from participating in their physical education -- physical exercise, I should say; and the second part is how they might not use this as a punishment -- physical exercise as a punishment.

So with that, Madam President, I do urge passage of this bill.

THE CHAIR:

Thank you.

Will you remark? Will you remark?

Senator Linares.

SENATOR LINARES:

Thank you, Madam President.

I, too, support this bill. I think it's a balanced piece of legislation. And I would like to thank the good Senator Bartolomeo for her work on this bill, and also, State Representative Carpino down in the House who put a lot of effort into this bill as well.

One thing I -- I like particularly about this is the task force that will -- the bill establishes a task force to study the effects of obesity on children's health. The task force must gather and maintain current information on child -- on childhood obesity, examine nutrition standards, and explore ways to increase children's physical activity, among other things.

As Senator Bartolomeo had highlighted, the percentage

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of -- of children age six to 11 in the United States who were obese increased from 7 percent in 1980 to nearly 18 percent and more than one-third of children and adolescents were overweight or obese in 2010. And 50 percent of children who are obese stay obese when they -- when they get older. So it is a huge problem. We have to solve it. It think this is a good step in the right direction.

I support this bill and ask my colleagues to do the same.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark?

Senator Ayala.

SENATOR AYALA:

Thank you, Madam President.

I, too, support this bill, but I think that using the other hat that I have as a teacher in the school system, I think that's it's important that we look at exactly how this physical education curriculum that we have.

Oftentimes, I see that a lot of our students don't like to participate in gym class because of the fact that gym class just isn't interesting. Not all of our students are basketball players, football players. They're not all athletes. And oftentimes what happens is the fact that physical education in our schools tends to be more of the athletic type of class.

So I think that going forward, and maybe even the task force might even want to consider looking into this as well, is really trying to transform what physical education is in our classroom. Why not include Zumba classes? Why not include dance? Why not include something that just gets kids moving around rather than having them sit on the bleachers?

I had the opportunity to be a substitute in one of our gym

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classes because the teacher was not there for that given period. And I went into the gym and it was surprising to see that over half the class was sitting on the bleachers because they just didn't want to participate. And I asked them why not, why wouldn't -- why didn't they want to participate, and essentially said I don't like basketball. And that's what they were doing. They were playing basketball.

So I think that if we really want to attack this situation and this problem, that we need to create other alternatives for students that might not necessarily be athletically inclined but might want to just move around. And essentially, the reason why we have obesity is because of the fact that people aren't moving around as much they should.

So as a possible suggestion going forward and getting involved with this task force, I really think that we ought to take a look at how we look at physical education curriculum in the state of Connecticut.

Thank you.

THE CHAIR:

Thank you.

Will you remark? Will you remark?

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

If I may, through you, a question or two to the proponent of the bill.

THE CHAIR:

Please proceed, sir.

SENATOR WELCH:

Thank you, Madam President.

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So as -- as I understand Section 2 and Section 3 of the bill, we are essentially requiring state boards of education to take a look at two situations. Situation 1 would be where members of the school, employees of the school deem it appropriate to exclude somebody from physical activity as a form of punishment. And Section 2 is where -- exactly the opposite, essentially, where a person might deem it appropriate to use physical activity as a punishment.

Is that a correct understanding?

Through you, Madam President.

THE CHAIR:

Senator Bartolomeo.

SENATOR BARTOLOMEO:

Thank you, Madam President, through you.

And thank you for the question.

Yes, because I did want the opportunity to clarify in addition, from Senator Ayala, that we're -- we're -- we are talking about not just gym class or physical education class. We're talking about every single day a child should have at least 20 minutes of physical exercise.

So typically, that ends up being recess, which leads me to Senator Welch's question. Yes, we are saying that a -- a teacher or any other staff member, any other person in that school cannot, in -- in Section 2(b), cannot take away as a punishment any of those 20 minutes allotted for every single day for the child to have physical exercise.

So a realistic example is a child is misbehaving or talking in class, and the teacher would have previously, as my son's teachers have done, said you just lost five minutes from your recess.

We -- the original bill said that you couldn't do that. This bill actually says that the local and regional boards of education establish a policy and -- about that specific issue. We may see that some establish a policy that allows it. Personally, I would hope that that doesn't happen.

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But we are acknowledging the fact that they do have the right to do that, but we want it addressed. We want a uniformity and a policy addressed for that.

Section 3, as you said, seems to be somewhat opposed. What it does is it -- it's saying that we want exercise to be a positive thing within our schools. And the idea of movement and exercise throughout school is a positive thing. So we don't want a -- for instance, you know, a teacher to say, well, you're misbehaving so now you've got a, you know, drop-and-do-twenty kind of thing. So we don't want it to be used as a form of discipline either. We want it to remain positive within the school systems.

Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

Thank you, Senator Bartolomeo, for that answer.

I think that kind of underscores one of my biggest concerns with this bill. I readily acknowledge that obesity is a problem that our country and our state faces. And I readily -- readily acknowledge that it is appearing in our school systems and in our society at younger and younger ages, and it's something we need to address.

I am somewhat concerned with the latter two sections and where -- where this might lead to. I can remember from my days in public school in Torrington, Connecticut, growing up as a kid, one of the things that I -- I never wanted to lose was recess. And frankly, it was very -- it was a motivating factor for me to behave. Not that that was a big issue back then, Madam President, but it was a consideration.

And the flip side of that, as I can remember in my days in -- in the military -- in fact, I can still hear my drill instructor at boot camp yelling my name, telling me to get down and drop and give him twenty, even though he seemed like he was 500, 600 yards away. That, too, was a very

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motivating factor for -- for me to stay in line and -- and behave.

And so, in a day when our public schools seem to have fewer and fewer tools to encourage good behavior, I am reluctant to take what I think might be two more away from them. So I will not be supporting the bill.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark? Will you remark?

If not, Mr. Clerk -- oops, sorry -- Senator Boucher.

SENATOR BOUCHER:

Thank you, Madam President.

Very briefly, indeed, the only question I have, through you to the proponent is, does this particular bill apply K-6 or kindergarten through eighth grade?

Through you, Madam President.

THE CHAIR:

Senator Bartolomeo.

SENATOR BARTOLOMEO:

Thank you, Madam President. Through you to Senator Boucher.

It is referred to as elementary school. And the reason that we have that is because in some towns elementary school might go through fourth grade, others through fifth and others through the sixth grade. So now we would have a consistent policy in one school in its entirety as opposed to a single class or two being sectioned out.

Through you, Madam President.

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Senator Boucher.

SENATOR BOUCHER:

Thank you very much, Madam President, for that clarification.

So I presume it is up to sixth grade but not beyond, if -- if that would be the case.

Through you, Madam President.

THE CHAIR:

Senator Bartolomeo.

SENATOR BARTOLOMEO:

Through you, Madam President.

It is this Legislator's intent that it would likely be the ending at sixth grade because I'm not aware of any school in the state of Connecticut that elementary is considered beyond -- even -- even one of my sons who goes to a school that goes up to eighth grade, within that school, they designate the lower school and the middle school. So the lower school only goes up to fifth grade. I'm not aware of anything in elementary school that goes beyond sixth grade.

Through you, Madam President.

THE CHAIR:

Senator Boucher.

SENATOR BOUCHER:

Thank you, Madam President.

I appreciate the answer for clarification for the record. It -- there is sometimes confusion with regards to certification for a teacher that might extend K through eighth grade and other times that might be considered secondary certification, and that was the reason for my confusion.

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Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark further? Will you remark further?

If not, Mr. Clerk, do you call for a roll -- please call for a roll call vote and I'll open the machine.

THE CLERK:

Immediate roll call has been ordered in the Senate.
Senators please return to the Chamber. Immediate roll call has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed.

Mr. Clerk, will you call the roll -- so call the tally.

THE CLERK:

House Bill Number 6525,

Total Number Voting	35
Necessary for Adoption	18
Those Voting Yea	31
Those Voting Nay	4
Those Absent and Not Voting	1

THE CHAIR:

The bill passes.

Mr. Clerk.

THE CLERK:

On page 5, Calendar 355 --

THE CHAIR:

**JOINT
STANDING
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HEARINGS**

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manuals and how this has evolved could be made available to the committee, that's something that we want to become very, very conversant and familiar with. And yet, again, I will have to again be on the same page as my cochair. It's been a tremendous experience, Commissioner, to work with you.

And I know you're talking it's a collaborative effort, but it takes a big person to collaborate. So we appreciate the fact that you're willing to collaborate and thank you so very much for your enlightening and disturbing testimony today.

COMMISSIONER JOETTE KATZ: Thank you and again thank you, Bill Rivera is here. Tammy Sneed, who is in charge of our girls services. It really does take a village and I've got some wonderful people at the department really have educated and brought me along. So I'd like to just publicly thank them again, and you, as well.

REP. URBAN: Thank you very much, Commissioner.

Next on our list to testified from the Commission on Children is Elaine Zimmerman on a slew of bills.

ELAINE ZIMMERMAN: Good afternoon, Senator Bartolomeo, Representative Urban and members of the committee. My name is Elaine Zimmerman. I'm the director of the Commission on Children. I'm here in support of an ACT CONCERNING CHILDREN AND BEHAVIORAL HEALTH, AN ACT ESTABLISHING A CHILDHOOD OBESITY TASK FORCE, the act on marketing of firearms and the parent engagement bill. I will however today just speak on the mental health bill, on behavior health. As some of you know, I helped create the station after the shootings in Newtown at the middle school. So when parents came to get

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rd/mb/ch/gbr CHILDREN COMMITTEE

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11:00 A.M.

You're getting good at this girl!

KACHINA WALSH-WEAVER: I've been testifying too long.

REP. URBAN: Are there any comments or questions?

Seeing none, I would merely say we always appreciate the dialogue that you bring to us and fully appreciate your position on the task force idea and, as I said, we -- we want to hear every voice and you have always been one very fair voice at the Capitol so thank you for your testimony.

KACHINA WALSH-WEAVER: Thank you, I appreciate that. Have a nice evening.

REP. URBAN: Thank you.

Next on our list is Dena Torino followed by Aimee Stupak.

So Dena, welcome.

DENA TORINO: Honorable Senators and Representatives of the Children's Committee, my name is Dena Torino. I am student at the University of Connecticut School of Social Work with a concentration in community organizing. I currently work at the Taft School where I live with my husband and two children.

HB 16525

Taft is an independent, co-educational boarding school for students in grades nine through post-graduate. I serve Taft as the Director of Student Activities and Director of Student Leadership Development and work collab -- collaboratively with our health team, a group made up of key community members coordinating, organizing and addressing issues including, but not limited to, student culture, residential

life and health and nutrition needs and trends.

I am here to testify in support of Raised Bill No. 6525, AN ACT ESTABLISHING A CHILDHOOD OBESITY TASK FORCE.

Our mission at Taft, to educate the whole student, means we work consciously and deliberately to help students gain knowledge, practice skills and create habits of mind pertaining to all aspects of their lives, helping them to become healthy productive citizens.

Nutrition and eating habits are one place we focus our efforts and within the context of today's obesity ep -- epidemic my hope is that Connecticut will lead the way in making the nutrition of its children a priority by creating the Childhood Obesity Task Force.

In a recent report entitled F As In Fat: How Obesity Threatens America's Future released by Trust for American's Health and the Robert Wood Johnson Foundation, a number of -- the number of obese adults, excuse me, along with related disease rates and healthcare costs are on course to increase dramatically in every state in the country over the next 20 years.

The report offered two pictures of the future of America's health and includes an analysis of state by state projections, one future if Connecticut stays on our current course and one if we reduce the average body mass index for our residents by just 5 percent.

If obesity rates continue on their current trajectories, the obesity rate in Connecticut could reach an astounding 46.5 percent, increasing our obesity related healthcare costs by 15.7 percent.

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rd/mb/ch/gbr CHILDREN COMMITTEE

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In contrast if average body mass indexes were lowered by 5 percent, Connecticut could save 7 percent in healthcare costs which would equate to a savings of \$7,370,000,000 by the year 2030.

I am mindful of the highly nuance and complex issues surrounding healthcare in our -- in our state, in our nation and while ongoing political and community debate over the state of our healthcare system and possible solutions have become increasingly heated, there are some concrete actions and solutions that should not be delayed and the creation of this task force is one step in that direction.

If you'd like to learn about the F As In Fat: How Obesity Threatens America's Future report, I've incl-- included the link in my testimony.

SENATOR BARTOLOMEO: Thank you, Dena, I'm sorry I have to ask you --

DENA TORINO: That's okay. Thank you for the opportunity.

SENATOR BARTOLOMEO: Questions from anyone on Committee?

Well thank you.

DENA TORINO: Thank you.

SENATOR BARTOLOMEO: We very much appreciate the information.

Next we have Aimee Stupak followed by Catherine -- I'm going to say Laccarino maybe.

AIMEE STUPAK: Senator Bartolomeo and distinguished members of the Committee on Children, my name is Aimee Stupak and I am a Master's degree

HB 6499
HR 11



State of Connecticut
GENERAL ASSEMBLY
Commission on Children



Testimony of Elaine Zimmerman
Executive Director
Connecticut Commission on Children

Children Committee
Connecticut General Assembly
Tuesday, March 05, 2013

Senator Bartolomeo, Representative Urban and Members of the Children Committee:

My name is Elaine Zimmerman. I am the Executive Director of the Connecticut Commission on Children and am here today in **support** of:

- SB 972 - An Act Concerning Children and Behavioral Health;
- HB 6525 - An Act Establishing a Childhood Obesity Task Force;
- HB 6497 - An Act Concerning the Marketing of Firearms to Young Children; and
- HB 6501 - An Act Concerning Parent Engagement.

I spent the weeks after the Newtown shootings in Newtown, co-directing the play space and art stations for children and youth at John Reed Middle School while their parents sought advice and counseling for their families. One first grader said to me, quite seriously, "We are moving my school to another school. My school has a mental illness. They want to be sure we do not catch it. So they are closing it down and moving us away."

On the one hand, someone must have told her that the children were killed by someone with an illness. But now she worries that it is contagious. In fact, she worries that she will catch it. So how do we help children not "catch" mental illness? Prevention, early intervention, assessment and a coordinated system of mental health care.

Connecticut's children and adolescents are experiencing a mental health crisis. There is a critical shortage of mental health and substance abuse prevention and treatment services. Twenty percent of all children and adolescents in Connecticut struggle with a diagnosable and treatable mental health problem. Only twenty-five

percent of all children and adolescents with emotional-behavioral problems currently access adequate mental health treatment services. Connecticut's suspension rate for black students with learning disabilities is the third highest among all 50 states. One in fifteen Connecticut high school students attempted suicide in the last year.

Focus on Prevention, Proven Practice and Start Early

If we start at the beginning, we have the best outcomes and the best return on investment. Our state needs an interconnected framework of supports in which schools, mental health, child and family services, and early childhood programs are organized in a continuum of intervention services to ensure that children with emotional-behavioral problems have access to good mental health services. Some of this is no cost or low cost and more about systems building than about new services.

Home visitation

For example, our state has been the recipient of over 27 million dollars in home visitation from the federal government, working with our most vulnerable families to ensure strength, minimize trauma and to buffer stressors.

In 2010, the Department of Public Health conducted a statewide needs assessment for Maternal, Infant and Early Childhood Home Visitation programs, referred to as the MIECHV Needs Assessment. Seventeen towns were identified as in 'very high need' of maternal and infant home visiting services and were targeted for the statewide MIECHV plan. They include New Haven, Hartford, Meriden, Bridgeport, New Britain, East Hartford, Waterbury, Windham, Bristol, Norwich, Bloomfield, Torrington, Winchester, Ansonia, Derby, New London, and Putnam.

There are approximately 40,000 births in CT each year. Roughly 10,000 births are to families with at least one significant risk factor. Of these births, 2400 babies are born to mothers, age 19 and younger. We have programs in towns and cities reaching out to pregnant moms and vulnerable parents helping the family with mental health issues, substance abuse challenges, trauma and other high level constraints on family functioning.

But we do not have a system of home visitation. It is program by program, town by town. Home visitation needs to be integrated with early care and education. It needs to be integrated across program model. It needs to be linked to mental health and our outreach workers who should all be trained in trauma-informed practice.

Home visitation is not the primary staircase to a mental health system. But it is a preventive strategy that could buttress numerous early and weak links from breaking apart and harming children. This includes attending to maternal depression, neglect, abuse and violence.

Home visitation is the earliest preventive strategy where mental health occurs in the home with new and particularly vulnerable parents. Better woven and coordinated with our early care and mental health systems, our Birth to Three system which works with infants and toddlers facing specified neurological and developmental challenges, this model could be a system of family strengthening, parent support and early infant toddler assessment.

Early Care and Education

We were, not long ago, expelling children in child care for behavior problems. The numbers made a mockery of us. Instead of tending to, we were throwing out, before children were four years old.

This challenge was addressed through mental health consultation with the early childhood field. Helping early care providers know how to deal with behavior challenges assisted the children in developmentally appropriate ways, helped parents know what they might do at home and assisted in early detection of delays, learning challenges and social emotional issues. We need to take this early childhood consultation model to scale and bring it also to the elementary schools.

Similarly, Enhanced Care Clinics, under the Behavioral Health Partnership, should have at least one clinician endorsed in infant mental health. Birth to Three, an excellent system of intervention and assessment of children with particular neurological difficulties and developmental delays, could be enhanced to better assess and address mental health needs in very young children.

Pediatricians similarly benefit from training. They may be skilled in stages of development, but this does not mean they are trained to pick up social emotional challenges. Of equal import, pediatricians are not trained in the nexus between learning disability and mental health. Learning disability, with emotional challenges, is often an explosion ready to happen. But this is rarely studied, shared with parents or prevented through intentional diagnostic care or planning. Some parents are not able to access professionals. Others do, but do not get the assessment or interventions necessary or accurately targeted to impede escalation

of symptoms, psychological distress and severe crisis. Often health care plans do not cover what is necessary and urgent.

There is no single problem facing the vulnerable families in our state. Rather there are a multitude of challenges which negatively affect parenting, maternal and child health, and social emotional development. Massachusetts supports universal screening for mental health concerns at all well-child pediatric visits. Our state should adapt this model. We would prevent and intervene earlier, with greater success and stability for the child and family. Similarly we need to ensure that all mental health and developmental screening is reimbursable for pediatric providers.

A Fragmented System

Our mental health programs are not coordinated or linked to systems, such as schools, in ways that would maximize referrals and alignment. More children see counselors in school than in most systems. 70 to 80 % of children who receive mental health services are seen by guidance counselors, school psychologists and psychiatric nurses in our educational system. We need to promote school-based early identification and screening efforts due to the access, use and normative context.

We need to ensure that these counselors are in our schools, with proper resources and parent information on how to access quality services. We also need a coordinated system of care with more attention to trauma- informed practice. Bringing research- based practice, prevention and families as partners into our medical home system will bolster our early interventions. This has truly not yet been done. Our neighbor, Vermont, is a strong model of this structure and its improved outcomes.

Community Mental Health

Only 36% of those with mental disorders receive treatment in a given year, according to the NIMH. There is a shortage of mental health specialists and child psychiatrists treating children and teens. There is a shortage of hospital beds for acute mental health and substance abuse treatment. We need to expand and ensure supply, quality and access for youth and young adults.

Timing and intervention are critical to mental illness. When a problem is not addressed, it grows and coils. There are often permeable lines between kinds of emotional disorders and mental illness. Crossing more and more streets with no intervention can lead to a growing emotional disorder with more challenges and

deeper obstacles to recovery. It is as if the expanse of time expands wounds to the core.

Children with mothers who are depressed face extreme challenges. Depression leads to isolation, lack of connection and, at its extreme, and an absence of nurturance. For a child, this lacuna is harmful to the heart of childhood growth, play and attachment. The core connection is clipped and the child can become troubled. Targeted programs that address maternal depression can help children avoid a stigmatized and lonely existence with outcomes that predict social emotional difficulties.

In early intervention, the right diagnosis and practice matters as in any science. But in this science we have a shortage of practitioners, a shortage of locations for healing, and a culture that says that emotional challenges are not to be discussed. The community needs to be supported in creating mental health programs that are as normal to the neighborhood as stop and go signs.

Substance Abuse

We need to enforce the health parity law which prohibits health plans from placing limits or costs on treatment for mental health and substance abuse that are more restrictive than those imposed on medical and surgical services. Too many youth and young adults suffer for lack of treatment options due to health plans that have stopped covering residential treatment and/or addiction services. Confounded requirements for a patient's stay let suicidal patients loose when they should be better stabilized and cocooned in care. Intermediate levels of care, such as intensive outpatient services are not included in some health plans.

Summary

One first grade Newtown student said to me, "There is nothing you can say or do that will convince me that this will not happen again." Let's prove him wrong.

I offer some language to the chairs that would create a home visitation system. I also offer language that would create a comprehensive mental health system over the next decade, phased in and attentive to our fiscal crisis.

The Commission also supports the bills before you today on firearms (HB 6497) on obesity (HB 6525) and on parental engagement (HB 6501).

Thank you for your time and consideration.

DRAFT HOME VISITATION BILL

Section 1. (NEW) (*Effective July 1, 2013*) (a) The State of CT shall establish a system of home visitation. Such as system shall include the development of: (1) a common referral process for families requesting home visitation and parenting education programs; (2) a common set of competencies and required training for all home visitors; (3) a common set of standards and outcomes for all program, to include requirements for model fidelity and a monitoring framework; (4) a family assessment to be used upon enrolment to determine the family and children needs, prioritizing the family's goals and intentions; (5) a system of universal, simple health and development screening for all young children; (6) a central location for all home visitors and their collaborators to find information on training, workshops, materials which would include a system for regular communication among models programs and staff; (7) collaborated, coordinated training for the home visitation and early care and education providers on issues such as child trauma, poverty and family supports, family stressors, mental health, special health care needs, early literacy and language acquisition; (8) a tracking system for common outcomes; and (9) a shared reporting system to the appropriations committee and the committees of cognizance for all home visitation programs, including a breakout of results from the various programs.

(b) The research-based home visitation models and the providers of home visiting services, in consultation with one or more research experts, shall: (1) jointly develop an outcome measurement plan to monitor outcomes for children and families receiving services through state and federally-funded home visiting programs; (2) develop indicators that measure each outcome area, which shall include, but not be limited to, father engagement, parental depression, violence reduction, early language/literacy, motor, cognitive, and social-emotional development, and poverty reduction; and (3) create a report that documents the collective impact of home visiting program outcomes across all indicators selected as well as data on cost per family served, number of families served, demographic data on families served and outcomes.

(c) Incentives shall be developed for community collaboratives that create a continuum of prenatal to age five services for young families with intentional integration of home visitation, family support programs, housing, health and early care and education.

(d) "Home visitation" means an effective early childhood service delivery strategy that promotes healthy child development, provides parenting support, and facilitates linkages to community resources.

DRAFT MENTAL HEALTH BILL**AN ACT CONCERNING A SYSTEM OF MENTAL HEALTH SERVICES AND ACCESS FOR CHILDREN.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) (a) The State of Connecticut shall design and implement a comprehensive prevention-focused child and youth mental health system. The system shall have an interconnected framework of supports in which schools, mental health services, child and family services, and early childhood programs are organized in a continuum of prevention and intervention services and systems to assure that every child with emotional-behavioral problems will have access to mental health services by 2023. Such plan shall include biennial benchmarks to track improvements in quality and access up to the ten year point.

(b) The child and youth mental health system in paragraph (a) of this section shall be: (1) Prevention-focused, with emphasize on early identification and intervention; (2) Age informed, ensuring access to developmentally appropriate services for early childhood, school aged children, adolescents and young adults; (3) Designed to offer a comprehensive continuum of care from prevention and early identification to intensive interventions addressing children with a range of mental health needs; (4) Family-driven, with parents and youth engaged in the planning, delivery and evaluation of services; (5) Culturally-competent, reflecting awareness of race, culture and language relevant to family identification and social health; (6) Community based, with access to services that are delivered in the home, school and community and with reduced reliance on the most costly and restrictive forms of congregate and residential care; (7) Evidence- based, expanding access to services and systems that are known to work; and (8) Informed by data, applying quality assurance strategies and the results-based accountability framework to ensure children and families have access to quality care.

Sec. 2 (NEW) (*Effective July 1, 2013*) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall develop within early childhood: (a) family strengthening through a system of proven home visitation programs as delineated in Sec. 13 of this act; (b) professional development for early childhood providers and pediatricians in the prevention and early identification of mental health problems utilizing Infant and Early Childhood Mental Health Competencies; (c) increased capacity for evidence-based mental health treatment that has been specifically developed for young children and their parents/caregivers including trauma-informed interventions, particularly for young children involved with the Department of Children and Families, with emphasis on protective relationships; (d) development of an early intervention mental health system including identification, assessment and treatment with full utilization of federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program requirements; (e) Revision of the Birth to Three system criteria for determining eligibility to include emotional/behavioral problems consistent with standard utilization of recognized mental health assessment tools; (f) Birth to Three referral to licensed early childhood mental health practitioners for any child needing psycho-social intervention; (g) coordinated training for child and family health practitioners in identification of maternal depression and its impact on child development; and (h) facilitation of home-based treatment with reimbursement for mothers of young children experiencing depression.

Sec. 3 (NEW) (*Effective July 1, 2013*) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall include within schools: (a) at least one school-based care coordinator for every school district; (b) a child psychiatry consultation network to support primary care physicians and school-

employed mental health staff; (c) tiered and proven responses to behavioral challenges in schools including positive behavioral intervention supports; (d) a memoranda of understanding between Emergency Mobile Psychiatric Service (EMPS) providers, community based mental health care agencies and all schools, within their respective catchment areas, to foster identification and referral of children with mental health needs and to foster on-going communication and collaboration; (e) school-based programs and staffing to assess and promptly intervene in mental health cases that include one social worker and one school psychologist in each school building, with minimum professional staffing ratios, and school based health centers; (f) mental health consultants who can assist schools, with quality and efficient interventions, modeled after the early childhood consultation partnership; and (g) training of school resource officers to assure proven and proper response with minimal over or under referrals based on demographics.

Sec. 4 (NEW) (Effective July 1, 2013) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall have systems improvements in access, coordination, professional development, family and customer service, services linkages and quality assurances to include: (a) training in and expansion of evidence-based trauma-informed interventions and practices; (b) access for pediatricians to child and adolescent psychiatry consultation or co-location of services between pediatricians and mental health providers; (c) increased family and consumer engagement in medical homes; (d) treatment of children with mental health needs involved in the judicial system provided with appropriate services and treatment setting within 7 days of referral; (e) expansion of a range of evidence-based practices to meet identified needs of the population; (f) incentives within the system of care to coordinate mental health services and communications between the family, school and community; (g) public information for parents on how to utilize 2-1-1 regarding stages of child development, and how the family can identify and help a child who may benefit from mental health intervention; (h) expansion of mental health screening programs, across the age spectrum, including pediatric primary care, early care settings, community agencies and schools to be accompanied by accessible and proven clinical services; (i) development of an enhanced statewide data network to facilitate improved utilization of data, data-driven planning and quality assurance across pertinent domains in child mental health through for quality assurance; and (j) a requirement that every program addressing mental health and behavioral needs is mandated to collect data on outcomes and that 10% of every mental health contract is directed to quality assurance services.

Sec. 5. (NEW) (Effective July 1, 2013) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall support financing that maximizes coordination, efficiencies, quality and consumer use in the best interest of the child, to include: (a) private and public reimbursement for mental health care services delivered in the home and in school settings; (b) private and public reimbursement for care coordination of services; (c) accountability and adherence to the Mental Health Parity and Addiction Equity Act of 2008; (d) reimbursement for mental health services through Early and Periodic Screening Diagnosis and Treatment (EPSDT) to prevent high risk children from developing mental health disorders, particularly when exposed to trauma or maternal depression; (e) reimbursement for treatment of maternal depression in the home; (f) a review of reimbursement policies and support networks in training and quality assurance for the statewide network of community based providers and child guidance clinics offering mental health services to families; and (g) allowances for cross-system funding, which may include co-location and braiding of resources to ensure that all children have access to mental health services based on child and family need, irrespective of insurance status, setting or system involvement, to eliminate barriers to quality care created by such silos.

Sec. 6. (NEW) (Effective July 1, 2013) The State of Connecticut shall (a) perform a study to determine whether youth and young adults whose primary need is mental health intervention are, instead, placed into the juvenile justice system and correction as a *de facto* mental health system, due to untreated behavioral or mental health challenges or learning disabilities; (b) study and determine the cost to youth and to the state for inappropriate referrals to the juvenile justice system and correction; and (c) analyze what programs need to be put in place to reduce inappropriate referrals, any disproportionality by race, and to ensure proper treatment within the mental health continuum of services described in Sec. 1 of this act.

Sec. 7. (NEW) (Effective July 1, 2013) (a) The Office of Early Childhood, in consultation with the Departments of Social Services, Children and Families, Developmental Services, Public Health, Mental Health and Addiction Services, the Commission on Children, the Office of the Child Advocate, the Office of the Healthcare Advocate, the Behavioral Health Partnership and selected non-profit institutions, shall implement the provisions of Sec. 2 of this act by June 2014.

(b) An implementation progress report shall be submitted to the Children Committee and other committees of cognizance by December 2013. Planning for improved early childhood mental health shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 8. (NEW) (Effective July 1, 2013) (a) The Department of Education, in consultation with the Departments of Higher Education, Children and Families, Public Health, Social Services, Developmental Services, Mental Health and Addiction Services, the Chief Court Administrator, the Office of the Child Advocate, the Office of the Health Care Advocate, the Commission on Children, the Behavioral Health Partnership and selected non-profit institutions, shall implement the provisions of Sec. 3 by January 2015.

(b) An implementation progress report shall be submitted to the Education Committee and other committees of cognizance by December 2014. Planning for improved child and youth mental health in schools shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 9. (NEW) (Effective July 1, 2013) (a) The Department of Children and Families, in consultation with the Departments of Social Services, Public Health, Mental Health and Addiction Services, the Office of the Health Care Advocate, the Office of the Child Advocate, the Behavioral Health Partnership and selected non-profit institutions, shall implement the provisions of Sec. 4 by January 2016.

(b) An implementation progress report shall be submitted to the Human Services Committee and other committees of cognizance by December 2015. Planning for an improved child and youth mental health system shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 10. (NEW) (*Effective July 1, 2013*) (a) The Department of Social Services, in consultation with the Departments of Children and Families, Insurance, and the Office of the Health Care Advocate, shall implement the provisions of Sec. 5 by January 2018.

(b) An implementation progress report shall be submitted to the Appropriations and Human Services Committee and other committees of cognizance by December 2017. Planning for improved child and youth mental health financing shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 11. (NEW) (*Effective July 1, 2013*) The study described in Section 7 shall be performed by PRI, in consultation with DCR and CSSD. Findings shall be reported to the Children's and Human Services Committees by September 2014.

Sec. 12. (NEW) (*Effective July 1, 2013*) The planning and implementation in Sections 8-11 may include support from philanthropy and shall be aligned with other federal and state opportunities.

Sec. 13. (NEW) (*Effective July 1, 2013*) (a) The home visitation system, as described in Sec. 2 of this act shall include the development of: (a) a common referral process for families requesting home visitation and parenting education programs; (b) a common set of competencies and required training for all home visitors; (c) a common set of standards and outcomes for all programs. Standards would include requirements for model fidelity and a monitoring framework; (d) a family assessment to be used upon enrollment to determine the family and children needs, prioritizing the family's goals and intentions; (e) a system of universal, simple health and development screening for all young children; (f) one site for all home visitors and their collaborators to find information on training, workshops, materials which would include a system for regular communication among models programs and staff; (g) coordinated training for the home visitation and early care and education providers on issues such as child trauma, poverty and family supports, family stressors, mental health, special health care needs, early literacy and language acquisition; (h) a tracking system for common outcomes; and (i) a shared reporting system to the Appropriations Committee and the committees of cognizance for all home visitation programs, including a breakout of results from the various programs.

(b) "Home visitation" means an effective early childhood service delivery strategy that promotes healthy child development, provides parenting support, and facilitates linkages to community resources.

**JOINT
STANDING
COMMITTEE
HEARINGS**

**CHILDREN
PART 5
1271 - 1562**

2013



Connecticut
Early Childhood
Alliance

Testimony before the Committee on Children
Raised Bill 6525 – An Act Establishing a Childhood Obesity Task Force
Submitted by Maggie Adair, Executive Director
Connecticut Early Childhood Alliance
Tuesday, March 5, 2013

The Connecticut Early Childhood Alliance thanks the Committee on Children for the opportunity to testify. I am Maggie Adair, Executive Director of the Connecticut Early Childhood Alliance. The Alliance is a statewide advocacy and membership organization committed to improving outcomes for all children, birth to age eight, in the areas of early learning, health, safety, and economic security.

The Alliance supports **Raised Bill 6525 – An Act Establishing a Childhood Obesity Task Force**. Childhood obesity is a national and state issue that sparks a call for action. A 2012 report conducted by the CT Department of Public Health (DPH) issued startling findings: nearly one in six Connecticut children in kindergarten and third grade is overweight, and one in seven children in kindergarten and one in six children in third grade is obese.

The DPH study found that obesity rates are significantly higher in low-income communities. It found that 40.8% of non-Hispanic Black and 43.3% of Hispanic children were overweight or obese compared to 26.8% of non-Hispanic White children. Children were more likely to be obese coming from schools where one-half of the population was eligible for free or reduced price school lunch compared to schools where less than a quarter were eligible (24% obese vs. 12% obese.)

This is clearly a call to action. Children who are overweight or obese in the very early years are more likely to face chronic illness later in life. Prevention and intervention strategies must begin in the earliest years of a child's life.

While poverty is not causally linked to obesity, we need to examine factors related to poverty, such as unsafe housing, poor air quality, lack of outdoor physical resources, lack of affordable health care and facilities, absence of supermarkets in urban areas, lack of transportation to sources of healthy foods, and unaffordability of healthy foods.

A Childhood Obesity Task Force presents an opportunity to convene experts, policy makers, and community leaders to identify practical, realistic, and evidence-based strategies to turn the curve.

Thank you for the opportunity to submit testimony.

Children Committee
March 5, 2013
John Bailey Government Relations Director
American Heart / Stroke Association



H.B. 6525 "An Act Establishing A Childhood Obesity Task Force"

Senator Bartolomeo and Representative Urban, and esteemed members of the Children Committee, thank you for allowing me the time to discuss a very serious health crisis confronting the state's most vulnerable.

My name is John Bailey, State Director of Government Relations for the American Heart Association.

The American Heart Association would like to comment on H.B. 6525 "An Act Establishing A Childhood Obesity Task Force."

There is a public health crisis facing the state of Connecticut. It is present wherever we look.

Obesity has gone prime time as an American health issue. It's everywhere: every neighborhood, every mall, every school and every workplace, but public policy is doing little to stem the tide of a crisis. If more is not done the cost to the state's taxpayers will be in the billions of dollars in health care costs, millions of hours of lost productivity and premature death due to health related diseases associated with obesity.

Consider these facts:

- The number of overweight children and adolescents ages 6-16 has nearly tripled since forty years ago.
- More than 10% of children between the ages of 2 and 5 are overweight, up from 7% in 1994
- Overweight adolescents have a 70% chance of becoming overweight or obese adults.
- Today, 65% of all American adults are overweight or obese, If current trends continue that percentage will rise even higher as generation reach adulthood.

As these facts show, obesity is a very serious health issue for our children and the long term impact will be felt by our state if nothing is done to curb the obesity trend. This crisis must be addressed sooner than later. The facts are startling. With nearly a quarter our young people in our state being defined as obese or overweight, it is our strong recommendation that the General Assembly take action and setting up a task force can be a step in the right direction in the battle to fight for our children's health.

In Connecticut, the adult obesity rate is nearly 22 percent with the overweight and obesity rates among adults rising. 3,000 of our friends, family, neighborhoods die each year from obesity-related complications. Even more distressing, these numbers do not reflect overweight and obesity trends for vulnerable populations, including children.

Most recently, the State Department of Education released a report that shed light on just how dire the state's childhood obesity crisis is in our schools. More than a quarter of our high school students are either obese or overweight. Males, Hispanics and African American's, are being recorded at the very troubling rate, 30% being obese or overweight.

Among children today, obesity is causing a broad range of health problems that previously weren't seen until adulthood.

Type 2 diabetes, which was once referred to as "adult onset" diabetes, is largely preventable with proper diet and physical activity. Until recently, most newly diagnosed cases of diabetes in children were for Type 1, which is mainly genetic in origin.

But today, as many as 45 percent of newly diagnosed diabetes cases in children are Type 2. At least 65 percent of people with diabetes die of some form of heart disease or stroke when the disease is left untreated.

Heart and cardiovascular health consequences of being overweight or obese is a major *preventable* cause of heart disease. Obesity has recently overtaken smoking as the leading cause of premature heart attack. A recent study found that children ages 7 to 13 who are overweight are at an increased risk of developing heart disease beginning at age 25. Teens who are obese and who have high triglyceride levels have arteries similar to those of 45-year-olds.

There are also psychological effects.

Obese children are more prone to low self-esteem, negative body image and depression.

And excess weight at young ages has been linked to higher and earlier death rates in adulthood.

Perhaps one of the most sobering statements regarding the severity of the childhood obesity epidemic came from former U.S. Surgeon General Richard Carmona, who characterized the threat as follows:

"Because of the increasing rates of obesity, unhealthy eating habits and physical inactivity, we may see the first generation that will be less healthy and have a shorter life expectancy than their parents."

The General Assembly must begin to develop realistic and far reaching public policy options to address a crisis that is putting our children in serious risk. Creating the Childhood Obesity Task Force and truly acting on its recommendations is an important first step.

The American Heart Association produced a report entitled "Understanding Childhood Obesity" that clearly lays out the current situation facing our children, outlines steps that can be taken to address this health epidemic, and examines the consequence if we do nothing to help our children.

I have submitted copies of this report to the clerk, and I hope you will take the time to review the material; The report is only 14 pages long.

Obesity can be stopped. And it doesn't take high-tech treatments or cutting-edge medications. Really, the solution begins and ends with the simple choices we make every day.

The AHA is committed to fighting childhood obesity and has established an aggressive health impact goal for the year 2020: to improve the cardiovascular health of all Americans by 20%, while reducing deaths from cardiovascular diseases and Stroke by 20% by the year 2020.

To measure the success of the 2020 impact goal, American Heart Association has created health impact measures for children over age two in the areas of: smoking, Body Mass Index (BMI), physical activity, diet score, total cholesterol, blood pressure and blood sugar.

The American Heart Association calls upon this committee to support HB 6525 and give our children a chance to live healthy life, risk free of obesity related life threatening diseases.



American Heart Association | American Stroke Association

Learn and Live.



Understanding Childhood Obesity

An Epidemic of Excess

Obesity has gone prime time as an American health issue. It's everywhere: in every neighborhood, every mall, every school and every workplace.

Obesity is more than a cosmetic concern. It doesn't just impact the way we look. It can change the course of our lives, and not for the better. It sets us on a fast track toward medical complications like heart disease, type 2 diabetes, high blood pressure and high cholesterol.

However, there's good news: Obesity can be stopped. And it doesn't take high-tech treatments or cutting-edge medications. Really, the solution begins and ends with the daily decisions we make.

The American Heart Association has developed this booklet to show how extensive the obesity problem — particularly in children — has become, why it is dangerous and how you can fight back.

How bad is it?

- *About one in three children and teens in the U.S. is overweight or obese.*
 - *Overweight kids have a 70–80 percent chance of staying overweight their entire lives.*
 - *Obese and overweight adults now outnumber those at a healthy weight; nearly seven in 10 U.S. adults are overweight or obese.*
-

Today, about one in three American kids and teens is overweight or obese, nearly triple the rate in 1963.¹

With good reason, childhood obesity is now the No. 1 health concern among parents in the United States, topping drug abuse and smoking.² Among children today, obesity is causing a broad range of health problems that previously weren't seen until adulthood. These include high blood pressure, type 2 diabetes and elevated blood cholesterol levels. There are also psychological effects: Obese children are more prone to low self-esteem, negative body image and depression.

Excess weight at young ages has been linked to higher and earlier death rates in adulthood.³ Perhaps one of the most sobering statements regarding the severity of the childhood obesity epidemic came from former Surgeon General Richard Carmona, who characterized the threat as follows.

"Because of the increasing rates of obesity, unhealthy eating habits and physical inactivity, we may see the first generation that will be less healthy and have a shorter life expectancy than their parents."⁴

Obesity has also risen dramatically in adults. Today over 144 million Americans, or 66 percent of adults age 20 and older, are overweight or obese (BMI at or above 25). That is nearly seven out of every 10 adults. Additionally, 33 percent (over 71 million) of adults are classified as obese (BMI at or above 30).⁵ Obese Americans now outnumber overweight Americans, which means that individuals who are above a healthy weight are significantly, not slightly, above a healthy weight.⁶ Some experts project that by 2015, 75 percent of adults will be overweight, with 41 percent obese.^{7,8}



What does it mean to be Obese or Overweight?

Overweight and obese are screening labels used for ranges of weight that are above what is generally considered healthy for a given height and may increase the risks for certain diseases or health problems. Overweight and obese are defined differently in children and adults because the amount of body fat changes with age. Also, BMI in children is age- and sex-specific because body fat differs based on growth rates and developmental differences in boys and girls.

Definitions for Adults

For adults over age 20, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI), which usually correlates with a person's body fat.

For adults, BMI is calculated by dividing body weight in pounds by height in inches squared, then multiplying that number by 703.

$$\text{BMI} = (\text{Weight in Pounds}) \div (\text{Height in inches}) \times (\text{Height in inches}) \times 703$$

For adults over age 20, BMI values of:

- Less than 18.5 are considered underweight.
- 18.5 to less than 24.9 are considered normal weight.
- 25.0 to less than 29.9 are considered overweight.
- 30.0 or greater are considered obese, or about 30 pounds or more overweight.
- Extreme obesity is defined as a BMI of 40 or greater.

Definitions for Children

Age- and sex-specific growth charts are used to calculate BMI in children and teens (ages 2–20) using a child's weight and height, then matching their BMI to the corresponding BMI-for-age percentile for their age and sex. The percentile shows how a child's weight compares to that of other children of the same age and gender. For example, a BMI-for-age percentile of 65 means that the child's weight is greater than that of 65 percent of other children of the same age and sex.

Children and teens whose BMI-for-age is:

- In the 95th percentile or higher are considered obese.
- Between the 85th and less than the 95th percentile are considered overweight.
- Between the 5th and less than the 85th percentile are considered normal weight.
- Below the 5th percentile are considered underweight.

Take Action!

Find out if you or your children are at risk for certain health problems. Visit the Centers for Disease Control's free online BMI calculators for adults and children at <http://www.cdc.gov/healthyweight/assessing/bmi/>. Knowing your risk is the first step!

It's important to remember that BMI is a tool. It may not always accurately describe weight classification for some individuals such as athletes, so a doctor or healthcare professional should make the final determination.



Causes of Obesity

There is no one cause of obesity. It can be influenced by lifestyle habits, environment and genetics. But, in the majority of cases, it boils down to a pretty simple equation: *We are taking in more calories than we are burning.*

Some common issues leading to this calorie imbalance include:

Portions Are Growing: Portion sizes have increased, especially when we eat away from home. "Value menu" items are all the rage. Although we consider these a bargain, they're a bad deal when it comes to good health.

Poor Nutrition: Our eating habits have led us to a kind of modern-day "malnutrition." Many of us fill up on "empty calories" or foods with no or minimal nutritional value. These choices are often high in fat, sodium, added sugars and calories but low in the nutrients we need to be healthy and strong. At the same time, we're ignoring healthy options like fruits, vegetables, whole grains and fat-free or low-fat (1%) dairy products.

Eating Out More: Unhealthy food and beverage choices can be found all around us, in places like fast-food restaurants and convenience stores. These options are ready-made and fit our on-the-go lifestyles.

Moving Less: Almost one in four children do not participate in any free-time physical activity. Additionally, the average American child spends four to five hours in front of the TV, computer or video games every day.

Bigger Portions

So what does it all mean?

- Americans are eating more.
- Portions have grown dramatically.
- People eat more when served bigger portions.

Portion Size Affects How Much People Consume

Today, food-service establishments are offering us a lot more for our money than they used to. And we're taking them up on it. For example, 20 years ago an average serving of fries was 2.4 ounces. Today it's 6.9 ounces. An average cheeseburger had 333 calories. Today it's 590. To put these calorie increases into perspective, between 1971 and 2000 the average American adult consumed 250 to 300 more calories every day. That adds up to an additional 26 to 31 pounds in just one year. Kids are also getting more calories than they need. Adolescents today eat on average 8 percent more than 30 years ago.⁹

The simple fact is that we eat what's in front of us. If larger portions are put on the plate, we eat more. This means we're getting more calories, which leads to increased body weight.^{10, 11}

Did you know a surplus of about 3,500 calories results in a one-pound weight gain? 110–165 calorie surplus daily can result in gaining 10+ pounds in a year.

Take Action!

Taking in fewer calories by controlling portions is a critical step in managing weight. Learn the proper serving sizes and pay attention to the Nutrition Facts panel on foods.

Teach kids to focus on their own fullness rather than rewarding them for eating whatever is set before them — i.e., cleaning their plates. Studies show that kids who learn to listen to their bodies will eat less than those taught to clean their plates.¹²

Portion Size vs. Serving Size¹³

Portion size is the amount of a single food item served in a single eating occasion, such as a meal or a snack. Many people confuse portion size with serving size, which is a standardized unit of measuring foods — for example, a cup or ounce — used in dietary guidance, such as the Dietary Guidelines for Americans. Portion size is the amount offered to a person in a restaurant, the amount offered in the packaging of prepared foods or the amount a person chooses to put on their plate. For example, bagels or muffins are often sold in sizes that constitute at least two servings, but consumers often eat the whole thing, thinking that they have eaten one serving. They don't realize that they have selected a portion size that was more than one serving.

Less Nutrition/Poor Choices

So what does it all mean?

- Americans are eating more and more foods that are high in calories but don't meet their nutritional needs.
- A majority of Americans are not getting enough vitamins and nutrients through healthy foods, such as fat-free or low-fat dairy, whole grains, fruits and vegetables.
- French fries are the most common vegetable consumed by children.

Americans aren't just overeating. The foods they're choosing often do not meet their nutritional needs. They are not getting the proper amount of fruits, vegetables and dairy products and are instead opting for "empty calorie" foods, i.e., foods high in calories but low in nutrients (vitamins, minerals, protein, carbohydrates, etc.). These empty-calorie foods are often high in saturated and *trans* fat, sodium and cholesterol.

Fruits and Vegetables

Most Americans do not eat enough fruits and vegetables. According to a 2007 national study, three out of four American adults are not getting at least five servings of fruits and vegetables every day. (The daily recommendation is eight to nine servings, based on a 2000 calorie diet).¹⁴

Children are not getting enough fruits and vegetables either. Fewer than one in 10 high school students get the recommended amounts of fruits and vegetables daily.¹⁵

French fries are the most common source of vegetable consumed by children and make up one-fourth of children's vegetable intake. Juice, which may lack important fiber found in whole fruits, accounts for 40 percent of children's daily fruit intake.¹⁶

Take Action!

Eat fruits and vegetables at **EVERY** meal. Skip the fried veggies — frying adds fat and calories.

Whole Grains

The American Heart Association recommends that at least half of your grain intake come from whole-grain foods, which are high in fiber and other beneficial nutrients. Dietary fiber helps you feel fuller longer and reduces the total number of calories you eat because fiber slows digestion in your stomach. Whole-grain foods may reduce your LDL or "bad" cholesterol levels and has been associated with a decreased risk of developing cardiovascular disease.¹⁷

Ninety-three percent of Americans failed to meet the recommendation to consume 3 ounces per day of whole grains (based on a 2,000-calorie diet).

Take Action!

Make sure to fit whole grains into your daily menu by keeping whole-grain foods (like bread, cereal, brown rice or whole-wheat pasta) in your house because restaurant meals tend to be very low in whole grains.¹⁸ When you do eat out, ask if wheat alternatives are available.

Milk and Dairy

Americans are not getting enough milk and dairy products, which are nutrient-rich and an essential part of a healthy diet. Consuming adequate amounts of dairy contributes to bone health, helps prevent osteoporosis and may lower the risk of high blood pressure and other cardiovascular risk factors by helping to control body weight and fat.¹⁹

In addition to not consuming enough dairy products overall, children may not be selecting low-fat (1%) or fat-free dairy products, resulting in higher calorie and fat intake. In a 2008 survey that asked middle school students what kind of milk they usually drank, the most common answers were whole milk (40%), chocolate milk (34%), and 2% milk (25.8%).²⁰

Take Action!

Teach kids to pick nonfat (skim) or low-fat (1%) dairy products and keep them on hand in your fridge.

Fats

The American Heart Association recommends keeping total fat intake to less than 35 percent of total calories (20 grams per day based on a 2,000-calorie diet) and limiting *trans* fat consumption to less than 1 percent (or about 2 grams based on a 2,000-calorie diet) and saturated fat consumption to less than 7 percent of total daily calories.

Many Americans are consuming more than the recommended amounts of the "bad fats" (saturated and *trans* fats).

Take Action!

The Nutrition Facts panel on food labels can help you make healthy food choices at the grocery store. Check the food label for *trans* fat content and the ingredient list for partially hydrogenated oils. Review both saturated fat and *trans* fat content on the Nutrition Facts panel to avoid substituting one unhealthful fat for another.

Many fried foods and baked goods are high in saturated fats and calories even if *trans* fat-free oils and fats are used. Use liquid vegetable oils instead of animal fats; choose foods that are steamed, broiled, baked, grilled or roasted; and ask restaurant servers about the oil used in food preparation and the nutrition information.

Added Sugars

In recent decades, Americans have increased their consumption of "added sugars," which are found in carbonated soft drinks, fruit drinks, sports drinks and many processed foods. Added sugars are a common source of "empty calories" because they have little or no nutritional value but contribute additional calories to a food or beverage.

Sugar-sweetened beverages are a major contributor of added sugars to American diets. It is estimated that soft drink consumption alone currently accounts for one-third of added sugar intake in the United States.²¹

Consumption of sweetened beverages has been linked to childhood obesity.²²

Based on a 2000 calorie diet, the American Heart Association recommends limiting sugar-sweetened beverages to 36 ounces per week or less.

Take Action!
 Limit the amount of beverages with added sugars your family drinks. Look for no-calorie alternatives to soda, such as water.
 Check food labels for added sugars in foods by scanning the ingredients list for sugar, syrups and sugar molecules ending in "ose," to name a few.

Breakfast

Breakfast really may be the most important meal of the day. Numerous studies have demonstrated that when both children and adults skip breakfast, the nutritional quality of their diets decreases.²³

Sodium

Most Americans consume more than double the amount of their daily recommended level of sodium (salt). The American Heart Association recommends adults eat less than 1,500 mg of sodium per day (and less for children under 14). A diet high in sodium increases the risk of having higher blood pressure, a major cause for heart disease and stroke.

Take Action!
 The majority of sodium we consume comes from salt added to the food supply (not from salt we add at the table). Look for "low-sodium" or "sodium-free" items at the grocery store (and skip the salt shaker at the table too).

American Heart Association Dietary Recommendations

The following table outlines the American Heart Association's recommendations for a healthy, nutritious diet for children and adults

For children²⁴

Age	1 year	2-3 years	4-8 years	9-13 years	14-18 years
Calories					
Female	900	1000	1200	1600	1800
Male	900	1000	1400	1800	2200
Fat	30-40% kcal	30-35% kcal	25-35% kcal	25-35% kcal	25-35% kcal
Milk/dairy	2 cups	2 cups	2 cups	3 cups	3 cups
Lean meat/beans					
Female	1.5 oz	2 oz	3 oz	5 oz	5 oz
Male	1.5 oz	2 oz	4 oz	5 oz	6 oz
Fruits					
Female	1 cup	1 cup	1.5 cups	1.5 cups	1.5 cups
Male	1 cup	1 cup	1.5 cups	1.5 cups	2 cups
Vegetables					
Female	3/4 cup	1 cup	1 cup	2 cups	2.5 cups
Male	3/4 cup	1 cup	1.5 cups	2.5 cups	3 cups
Grains⁴					
Female	2 oz	3 oz	4 oz	5 oz	6 oz
Male	2 oz	3 oz	5 oz	6 oz	7 oz

For Adults (ages 18 and older) based on 2000-calorie goal²⁵

Grains*	6 to 8 servings per day
Vegetables	4 to 5 servings per day
Fruits	4 to 5 servings per day
Fat-free or low-fat milk and dairy	2 to 3 servings per day
Lean meats, poultry and fish	less than 6 oz per day
Nuts, seeds and legumes	4 to 5 servings per week
Fats and oils	2 to 3 servings per day
Sweets and added sugars	Limit added sugars and limit sugar-sweetened beverages to 36 oz or less per week.

*At least half of the grains should be fiber-rich whole grains.

Eating Out

So what's the big deal?

- **People eat out more than ever before.**
- **When people eat out, they consume more calories than if they eat at home.**
- **Away-from-home meals contain fewer fruits, vegetables and whole grains than foods prepared at home.**

The more people eat out, particularly at fast-food restaurants, the more calories, fat and sodium they tend to consume. This is linked to higher BMIs both in children and adults.²⁶

Eating more fast-food meals is linked to consuming more calories, more saturated fat, fewer fruits and vegetables and less milk.²⁷⁻³¹ This is especially alarming if you consider how popular fast-food has become with kids. In the late 1970s American children ate 17 percent of their meals outside the home and fast food accounted for 2 percent of total energy intake. By the mid-to-late 1990s, 30 percent of meals were eaten outside the home and fast food contributed to 10 percent of overall energy intake.³²

By making more informed dietary choices away from home, Americans could help reduce calorie consumption and the risk of obesity and its associated health problems.³³

Visit www.heart.org/nutrition for more nutrition tips for your family.

Lack of Physical Activity

So what's the big deal?

- **Adults and children are not getting enough physical activity.**
- **Fitness and physical activity habits established in childhood are key indicators for health in adulthood.**

Physical activity brings lots of positive health benefits, including improved physical fitness, muscle endurance, aerobic (lung) capacity and mental health (including mood and cognitive function). It also helps prevent sudden heart attack, cardiovascular disease, stroke, some forms of cancer, type 2 diabetes and osteoporosis. Additionally, regular physical activity can reduce other risk factors like high blood pressure and cholesterol.

Despite its many benefits, children and adults are not getting as much physical activity as they should. The American Heart Association recommends that children and adolescents (up to age 18) get at least 60 minutes of moderate to vigorous physical activity every day. All adults ages 18–65 should avoid inactivity and get at least 150 minutes per week of moderate-intensity physical activity, which may be done with 30 minutes of moderate-intensity activity on five days of the week. There are additional guidelines for people age 65 and older, women who are pregnant and those ages 50–64 with chronic conditions or physical functional limitations (e.g., arthritis) that affect movement ability or physical fitness.³⁴

About one-third of students in grades 9–12 don't get recommended levels of physical activity. Furthermore, research suggests that extracurricular physical activity levels consistently decrease from elementary to high school, especially in girls. Research also indicates that most adolescents do not participate in moderate physical activity five or more times per week, and these patterns persist into adulthood.³⁵⁻³⁷

As children age, their physical activity levels tend to decline.^{38, 39} That's why it's important to establish good physical activity habits as early as possible. Kids who are physically fit are much less likely to be obese or have high blood pressure in their 20s and early 30s.⁴⁰

Recent estimates suggest that more than 50 percent of U.S. adults do not get enough physical activity to provide health benefits and 24 percent are not active at all in their leisure time. Physical activity decreases with age, and is less common among women than men and among those with lower incomes and less education.⁴¹

Take Action!

Get moving! Encourage activities that the entire family can do together. If you're currently not active at all, start slowly and build up.

Overweight kids may be discouraged about getting physically active if they feel their skill level is not up to par with their peers, so encourage activities that they can excel at like strength or resistance training.

Technology's Sedentary Seduction

So what's the big deal?

- **Screen time directly contributes to cardiovascular risk.**
- **Most children get more than the recommended limit of two hours of screen time per day.**
- **Limiting daily screen time to two hours or less has positive health effects.**

Americans are spending more free time than ever watching television, surfing online or playing video games.

In addition to being sedentary while sitting on the sofa, people tend to eat while watching TV. Each one-hour increase in television viewing is associated with an additional 167 calories, often through foods commonly advertised on television.⁴²

The American Heart Association and American Academy of Pediatrics recommend that children limit "screen time" (TV, video games and computer) to no more than two hours per day. The reality is that American kids are going well over this limit — and it is taking a toll on their health.

Sticking with the recommended two-hour daily TV limit can have a positive effect on children's health. One study of overweight children ages 4 to 7 found that limiting TV and computer time to less than two hours a day helped reduce caloric intake, sedentary behavior and body mass index over a two-year period.⁴³

Take Action!

Limit screen time to 2 hours a day — for children and adults! Adults set the example for kids.

Don't snack while watching TV. It's easy to get caught up in the show and not realize how much you're eating.

Take the TV and computer out of kids' bedrooms. Children and teens who have a TV or computer in their bedroom watch about an hour and a half more TV per day than those who don't, and they use the computer about 45 minutes more per day.⁴⁴

Parents' Perceptions and Roles

So what's the big deal?

- **Parents are important role models for their children. If parents are unhealthy, children are likely to be unhealthy too.**
- **Parents may not recognize when children have a weight problem.**

Parents are role models whose health attitudes and behaviors play a critical role in the development of their children.

Parents can help overweight children manage their weight; however, they aren't always aware when their children are at risk. In recent studies, parents have shown a high tendency to misperceive their children's weight and failed to identify them as overweight. This has been especially likely if parents themselves are overweight. If parents do not recognize their child as obese or overweight, they are less likely to support them in achieving a healthy weight.⁴⁵

Some parents of overweight children worry about labeling them or hurting their self-esteem. Nevertheless, parents play a critical role in the lifestyle habits of their children both through the habits they model and through the support and awareness they offer.

Take Action!

Calculate the BMI for each member of your family to find out if you are at risk.

Sleep

So what's the big deal?

- **Children need at least nine hours of sleep per night.**
- **Sleep plays an important role in the body's ability to grow, repair and stay well.**

Recent research points to a connection between poor sleep habits and health problems, including obesity. Despite recommendations that children and teens get at least nine hours of sleep every night, only 31 percent of high school students get eight or more hours of sleep on an average school night.⁴⁶ Although more research is needed to determine the exact connection between sleep and obesity, adequate sleep is beneficial to overall mental and physical health.

The Situation in Schools

Over recent decades the school environment has changed drastically. A generation ago schools fostered physical activity, but today many have been forced to deemphasize it to balance shrinking budgets and focus on standardized testing.

Physical Activity in Schools

A recent report revealed that physical education time has declined across many school districts since 2002.⁴⁷ In some areas, school-based physical activity programs have been completely eliminated.⁴⁸

Only 3.8 percent of elementary schools, 7.9 percent of middle schools and 2.1 percent of high schools provide daily physical education or its equivalent for the entire school year. Twenty-two percent of schools do not require students to take any physical education at all.⁴⁹ Physical education is an integral part of developing the "whole" child in social settings and the learning environment.

Nutrition in Schools

Schools offer a wide variety of meal and snack food options, but not always healthy ones. In a 2007 study, 61 percent of competitive foods (foods sold outside of the School Meals program including in vending machines, a la carte items, school store/canteen items, etc.) offered in high schools were fried and high in fat. These calorie-dense, nutrition-poor foods accounted for 83 percent of all food sold.⁵⁰

Schools can be part of the solution, comprehensive nutrition education has proven to be effective in combating obesity, especially among low-income students.⁵¹ Additionally, improving nutrition standards of foods sold in schools can have a positive impact on students' diets.

Early Childhood Programs

Child care settings are also important environments for forming good health habits around children's health habits. Poor diet and physical inactivity at an early age increases the chance for developing serious health problems. Preschool children are consuming too many high calorie, sweetened beverages and foods with low in nutrients.^{52,53} A recent study of children in the Women, Infants and Children (WIC) Feeding Program found that on average, children spent more than twice as much time watching television and using computers than being physically active.⁵⁴

Quality school health programs have a proven return on investment

Despite economic pressure and a focus on test scores, it is possible and productive for schools to foster healthy lifestyle skills for students and staff. In fact, schools that do so often see improved test scores, fewer behavioral problems, increased financial benefits and happier and healthier students and staff. Studies have shown that normal-weight children have higher scholastic achievement, less absenteeism and higher physical fitness levels than their obese counterparts.^{55,56}

Healthcare Settings

So what's the big deal?

- **Healthcare providers are not consistently diagnosing weight problems in children.**
- **Healthcare providers may not feel equipped to talk about nutrition and physical activity with patients.**

Dealing with obesity at the earliest possible stage is optimal for a child's long-term health. However, far too few doctors are adequately addressing the problem in their young patients.

One recent estimate suggests that pediatricians accurately identified and diagnosed only 34 percent of overweight or obese children. Specifically, pediatricians correctly diagnosed 10 percent of overweight children, 54 percent of obese children and 76 percent of severely obese children.⁵⁷

Take Action!

Make it a point to talk to your healthcare provider about your weight (or your child's) at your next visit.

Marketing Food to Kids

So what's the big deal?

- Advertising does affect consumer behavior — in adults and children.
- A dramatic majority of ads targeted at children are for unhealthy products.
- Almost no advertising dollars are spent marketing healthy products to children.

Advertising on television and other forms of electronic media has a massive influence on our lifestyle decisions, particularly young people. It impacts the food preferences, purchase requests and diets of many children and is associated with the increased rates of obesity in this age group.⁵⁸

Young people see more than 40,000 advertisements per year on television alone, and half (50 percent) of all ad time on children's television shows is for food.⁵⁹ Children ages 8–12 see over 50 hours of food advertising a year.

Research shows that exposure to food advertisements produces significant increases in calorie intake in all children and the increase is largest in obese children.⁶⁰

The overarching conclusions are that, along with many other intersecting factors, food and beverage marketing does influence the diet of children and youth. Current food and beverage marketing practices for children do not promote healthy dietary habits.

Take Action!

Turning off the TV is a great way to limit the number of advertisements your family sees.

Market healthy foods to you family. Companies spend almost no ad dollars on fruits and vegetables, so make a pitch for the healthier foods yourself!



Consequences of Obesity

Overall Health Consequences

So what's the big deal?

- **Obesity negatively impacts every organ system in the body.**
- **Obesity is now regarded as more damaging to the body than smoking or excessive drinking.**
- **Obese children have the arteries of a 45-year-old person.**

Obesity and overweight have a negative impact on almost every organ system in the body. In addition to taking a toll on the physical health of children, obesity influences children's quality of life, impacting their physical, social and psychological functioning.⁶¹

There is a direct correlation between increases in body mass index (BMI) and increased risk for numerous other diseases and chronic conditions including diabetes, high blood pressure, asthma, liver problems, sleep apnea and some cancers.⁶²

Heart and Cardiovascular Health Consequences

Being overweight or obese is a major preventable cause of heart disease. Obesity has recently overtaken smoking as the leading cause of premature heart attack.⁶³

A recent study found that children ages 7 to 13 who are overweight are at an increased risk of developing heart disease beginning at age 25.⁶⁰ Teens who are obese and who have high triglyceride levels have arteries similar to those of 45-year-olds.⁶⁴

Type 2 diabetes, which was once referred to as "adult onset" diabetes, is largely preventable with proper diet and physical activity. Until recently, most newly diagnosed cases of diabetes in children were for Type 1, which is mainly genetic in origin. But today, as many as 45 percent of newly diagnosed diabetes cases in children are Type 2. At least 65 percent of people with diabetes die of some form of heart disease or stroke when the disease is left untreated.⁶⁴

Social

Being overweight can have a negative impact on a child's self esteem, behavior, friendships and academic performance.⁶⁵⁻⁷¹

Financial Costs

So what does it all mean?

- **The more overweight an individual becomes, the more expensive they become to the healthcare system.**
- **Obesity is more expensive to the healthcare system than smoking and problem drinking.**
- **9.1 percent of adult medical expenditures can be attributed to obesity.**

While obesity is a major health problem for children and adults, it is a major financial problem for our healthcare system. That's why tackling obesity is the right thing to do, for our health and the bottom line.

Obesity costs doubled in past decade The cost of treating obesity-related illnesses nearly doubled in the past decade, from \$78 billion in 1998 to \$147 billion in 2008.⁷²

Additionally, indirect costs associated with obesity include lower productivity, increased absenteeism and higher life and disability insurance premiums.⁷³



Out of Balance: Disparities and Racial, Ethnic and Low-Income Groups

So what does it all mean?

- Certain racial and ethnic groups are more at risk to be obese or overweight.
- The prevalence of obesity is rising fastest among African-American and Hispanic populations, making these groups especially at risk.
- Low-income families have a greater prevalence of overweight in some populations.
- The highest regional prevalence of obesity is consistently in the South.

Throughout the United States, overweight and obesity have increased in people of all ethnic groups, all ages and both genders. This is not an isolated threat to health, nor one limited to a particular population group.

However, among some racial, ethnic and socioeconomic groups, and within certain geographic regions, the prevalence of obesity and many obesity-related risk factors is especially high

While personal choices play a role in the rise of obesity, they alone are not responsible for the epidemic we face today. Many children grow up surrounded by unhealthy foods at home and in school. Others lack access to safe places where they can play and be active. Some low-income neighborhoods have many fast-food restaurants, but few stores or markets that sell nutritious foods. And many Americans with limited economic resources simply can't afford to buy healthy foods, join health clubs or participate in organized sports or physical activity programs.

The obesity epidemic threatens everyone, but not everyone is equally at risk. For example, among children and adolescents, obesity is more common in African Americans and Hispanics and the numbers of overweight African-American and Hispanic children are growing faster than the number of overweight Caucasian children.^{74, 75}

Geographic Disparities

The highest regional prevalence of obesity is consistently in the South. Since 1990 every state in the United States has seen an increase in the prevalence of obesity.⁷⁶

2008 State Obesity Rates

State	%	State	%	State	%	State	%
Alabama	31.4	Illinois	26.4	Montana	23.9	Rhode Island	21.5
Alaska	26.1	Indiana	26.3	Nebraska	26.6	South Carolina	30.1
Arizona	24.8	Iowa	26.0	Nevada	25.0	South Dakota	27.5
Arkansas	28.7	Kansas	27.4	New Hampshire	24.0	Tennessee	30.6
California	23.7	Kentucky	29.8	New Jersey	22.9	Texas	28.3
Colorado	18.5	Louisiana	28.3	New Mexico	25.2	Utah	22.5
Connecticut	21.0	Maine	25.2	New York	24.4	Vermont	22.7
Delaware	27.0	Maryland	26.0	North Carolina	29.0	Virginia	25.0
Washington DC	21.8	Massachusetts	20.9	North Dakota	27.1	Washington	25.4
Florida	24.4	Michigan	28.9	Ohio	28.7	West Virginia	31.2
Georgia	27.3	Minnesota	24.3	Oklahoma	30.3	Wisconsin	25.4
Hawaii	22.6	Mississippi	32.8	Oregon	24.2	Wyoming	24.6
Idaho	24.5	Missouri	28.5	Pennsylvania	27.7		

Economic Disparities

Childhood obesity is having a greater impact on children from low-income families. The higher cost of fresh produce and other nutritious foods is cited as one barrier to healthy eating for poorer families. Also, as income increases, adults tend to eat healthier foods and exercise more frequently.⁷⁷

Many poorer families have less access to health clubs, sports facilities or organized sports leagues for children.⁷⁸ Also, the communities where they live tend to offer fewer opportunities to stay healthy such as access to a supermarket.

Disparities in Access to Healthy Foods

People in some communities have limited opportunities to make healthy food choices. In general, poorer and non-white areas tended to have fewer fruit and vegetable markets, bakeries, specialty stores and natural food stores. Predominantly minority and racially mixed neighborhoods had half as many supermarkets as predominantly white neighborhoods.⁷⁹

Access to supermarkets and other food stores is significant because a higher density of healthy food outlets is associated with a lower mean BMI, a lower prevalence of overweight adults, and a lower prevalence of obesity.

Disparities in Physical Activity and Access to Facilities and a Look at the 'Built' Environment

Children's physical activity levels may be influenced — positively or negatively — by the environment in which they live.^{80,81} Access to parks is a key environmental factor that may impact physical activity levels.^{82,83} Children who live near parks and other green spaces are more physically active.

Minority adolescents and those from families with lower socioeconomic status have less access to facilities for physical activity (parks, playgrounds, walking paths, etc.).⁸⁴



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Connecticut Academy of Family Physicians
One Regency Drive
P.O. Box 30
Bloomfield, CT 06002
860-243-3977

Statement concerning

Raised Bill 6525 – An Act Concerning a Childhood Obesity Task Force

Committee on Children

March 5, 2013

This statement is being submitted on behalf of the Connecticut Academy of Family Physicians in support of Raised Bill 6525 – An Act Concerning a Childhood Obesity Task Force. Childhood obesity is quickly becoming a health care epidemic and there is no better time for Connecticut policy makers and health care providers to take on the task of determining the best way to help children suffering from obesity and preventing other children from becoming obese.

Ongoing medical research continues to prove that obese children are more likely to suffer from numerous diseases and health problems than are healthy-weight children. Diabetes, asthma, hypertension, and liver disease are just a few of the diseases that obese children are at an increased risk of developing. According to Walt Larimore, a Colorado Family Physician, an 8-year old who is obese and hypertensive has a vascular age of a 38 year old and will die 10 to 20 years sooner than children of a healthy weight. As adulthood approaches obese children are at an increased risk of cardiovascular disease, several types of cancer and other diseases in addition to the health problems that they have already been living with.

The problems for obese children are not just physical. The psychological effects of obesity cannot be understated. Children suffering from obesity are often teased or treated as outcasts by their peers, they are often isolated and prone to low self-esteem. This in turn leads to a decreased desire to participate in physical activity which helps the vicious obesity cycle to continue.

Healthy lifestyle habits begin in childhood. It needs to a priority of this legislature to determine how we can help provide our children with the foundation for health living. We encourage this Committee to pass this bill and to include a family physician who treats children on the task force.

Strengthening local public health.



Connecticut Association
of Directors of Health

Testimony of the Connecticut Association of Directors of Health
Comments on Raised Bill No. 6525: An Act Establishing a Childhood Obesity Task Force

To the Distinguished Co-Chairs and Members of the Children Committee
March 5, 2013

Good afternoon, distinguished Co-Chairs and Members of the Children Committee. My name is Karen Spargo, President of the Connecticut Association of Directors of Health (CADH) and Director of Health of the Naugatuck Valley Health District, serving the towns of Ansonia, Beacon Falls, Derby, Naugatuck, Seymour and Shelton.

CADH supports *Raised Bill No. 6525: An Act Establishing a Childhood Obesity Task Force*, subject to amended language that incorporates public health representation on such a task force. State and local public health professionals have long been at the forefront of battling obesity in Connecticut. Among many examples of the important work of local health departments specifically:

- The Northeast District Department of Health (serving Brooklyn, Canterbury, Eastford, Hampton, Killingly, Plainfield, Pomfret, Putnam, Sterling, Thompson, Union and Woodstock) and other partners in a regional collaborative launched the *WriteSteps School Walking Initiative* pilot project to add a daily walk at school in the Plainfield School System. During walks, students discussed an assigned topic each day and wrote about it upon returning to the classroom. The no-cost program has decreased reports of disciplinary problems, improved test scores, and enhanced physical activity for both students and staff.
- The Eastern Highlands Health District (serving Andover, Ashford, Bolton, Chaplin, Columbia, Coventry, Mansfield, Scotland, Tolland and Willington) helped implement *Safe Routes to Schools* programs, which examine conditions around schools and conduct projects and activities that work to improve safety and accessibility and reduce traffic and air pollution in the vicinity of schools. As a result, these programs help make bicycling and walking to school safer and more appealing transportation choices, thus encouraging a healthy and active lifestyle from an early age.
- The Norwalk Department of Health, in collaboration with the Norwalk Department of Recreation and Parks, secured an obesity prevention grant to transform an overgrown and unused property into Fodor Farm Community Garden. Each year, families and community groups register for use of 220 garden plots. Fodor Farm also offers educational sessions on cooking and nutrition and a seasonal farmers' market. Healthy food access can significantly combat obesity.

We applaud Raised Bill 6525's multi-sector approach in creating a task force to address this important topic. But any such task force should leverage the substantial expertise and experience of the public health community in combatting childhood obesity. In particular, any newly created task force should capitalize on the institutional memory of those who served on the now-dormant Connecticut Childhood Obesity Council, which included an epidemiologist, health education experts, and other public health professionals. Please amend bill language to include state and local governmental public health representation on the proposed task force.

Thank you for your consideration. CADH is a nonprofit organization comprised of Connecticut's 71 local health departments and districts. Local health directors are the statutory agents of the Commissioner of Public Health and are critical providers of essential public health services at the local level in Connecticut.

State of Connecticut
GENERAL ASSEMBLY



COMMISSION ON CHILDREN

Senator Bartolomeo, Representative Urban and members of the Committee on Children:

My name is Mary Kate Lowndes. I am the Director of Special Initiatives & Development for the Connecticut Commission on Children and core member of the CT Coalition Against Childhood Obesity steering committee. Both support HB 6525, *An Act Establishing a Childhood Obesity Task Force*.

As you know childhood obesity is an increasing health challenge across our nation and in our state. Today, about one in three American kids and teens is overweight or obese, nearly triple the rate in 1963. Overweight kids have a 70-80 percent chance of staying overweight their entire lives.¹ Obese and overweight adults now outnumber those at a healthy weight; nearly seven in 10 U.S. adults are overweight or obese.²

Among children today, obesity is causing a broad range of health problems that previously weren't seen until adulthood. Sixty percent of overweight children already exhibit at least one risk factor for heart disease, the #1 cause of death.³ Type 2 diabetes – once referred to as adult-onset diabetes – represents up to 45% of new pediatric cases, compared with only 4% a decade ago.⁴

Obesity kills more Americans each year than AIDS, cancer and injuries combined. At this rate, the current generation of children will be the first in our history to have a shorter life expectancy than their parents.⁵

There are also psychological effects: Obese children are more prone to low self-esteem, negative body image and depression, and are often targets of bullying.

Statistics for our state are also alarming. Over one-quarter (26.6%) of Connecticut high school students are either overweight (14.1%) or obese (12.5%). Racial and gender disparities prevail. Male students are significantly more likely to be overweight or obese (33.0%; 16.5% overweight, 16.5% obese) than female students (20.1%; 11.7% overweight, 8.4% obese). Hispanic (31.2%; 16.0% overweight, 15.2% obese) and non-Hispanic black teens (43.9%; 19.9% overweight, 24.0%

¹ American Heart Association, http://www.heart.org/HEARTORG/GettingHealthy/WeightManagement/Obesity/Childhood-Obesity_UCM_304347_Article.jsp?gclid=CMC1h7O01LUCFYje4AodJgQAKA

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⁴ *Childhood obesity: What it means for physicians. Commentary* JAMA, August 22/29, 2007. Vol. 298, No. 8. 3pp.

⁵ *Childhood Obesity in Connecticut fact sheet*, CT Department of Public Health, fall 2012.

obese) are more likely to be overweight or obese, compared to non-Hispanic white teens (22.1%; 12.3% overweight, 9.8% obese).⁶

A recent study by the CT Department of Public Health (DPH) of over 8,000 students in 74 elementary schools across the state found that about one-third of Connecticut kindergarten and third-grade students are overweight or obese.⁷

Moreover, obesity is costly. National health care spending on obesity approximates \$150 billion annually. Taxpayers fund about \$60 billion of these costs through Medicare and Medicaid. Recent research indicates that if obesity rates are reduced by as little as 5 percent, health care savings could exceed \$29 billion.⁸

An estimated \$856 million of adult medical expenditures in Connecticut are attributable to obesity each year.⁹

The societal consequences of childhood obesity also include impacts on worker productivity and national security. Obesity has become one of the most common disqualifiers for military service.¹⁰

Numerous programs and initiatives have been implemented in Connecticut over the past several years to address prevention and prevalence of childhood obesity. Local efforts in Bridgeport, Windham, Stamford, Hartford, Danbury, Middlesex County and other locales strive to address this epidemic. Numerous state agencies are also involved in the fight.

A statewide Task Force on childhood obesity would enable policymakers and stakeholders to explore in one common venue best practices, cutting edge research, challenges and gaps, and potential solutions. It would also allow the state to bring parents to the discussion as the key constituent to make change at the dinner table and in the community. The National Academy of Sciences, just this past week, convened parents and parent leaders to see how they as a constituency could improve outcomes.

The Coalition Against Childhood Obesity fully supports the idea of a Childhood Obesity Task Force. We would suggest the membership include those noted in HB 6525 as well as a representative from: DPH, Commission on Children, End Hunger CT!, the Rudd Center, the CT Food Policy Council, the American Academy of Pediatrics, CT Academy of Nutrition and Dietetics and the American Heart Association; and from local childhood obesity coalitions in each county including the Hartford Childhood Wellness Alliance, the Stamford Obesity Task Force, and the

⁶ Connecticut Department of Public Health, 2011 Connecticut School Health Survey Youth Behavior Component. Hartford, CT, June 2012.

http://www.ct.gov/dph/lib/dph/hisr/pdf/cshsresults_2011ybcreport_web.pdf

⁷ Preventing Childhood Obesity presentation, DPH Commissioner Jewel Mullen, November 2012.

http://www.cga.ct.gov/coc/PDFs/obesity/2012_forum_ppts/mullen.pdf

⁸ NCSL, Childhood Obesity-2011 Update. <http://www.ncsl.org/issues-research/health/childhood-obesity-2011.aspx>

⁹ Finkelstein, EA, et al. 2004. *State-level estimates of annual medical expenditures attributable to obesity* Obesity Research 12:18-24.

¹⁰ Ibid.

Windham County Healthcare Consortium; a school superintendent, school physical education teacher, a child nutritionist, a parent, and a teen.

We would also suggest the roles of the task force include those listed in HB 6525 as well as researching effective national and state efforts on childhood obesity reduction and prevention, and coordinating grant applications for federal and private dollars available to address childhood obesity reduction and prevention.

Kentucky and North Carolina are two states that recently created legislative task forces on childhood obesity. They explored strategies for addressing childhood obesity through the following:

- (1) Early childhood intervention.
- (2) Childcare facilities.
- (3) Before- and after-school programs.
- (4) Physical education and physical activity in schools.
- (5) Higher nutrition standards in schools.
- (6) Comprehensive nutrition education in schools.
- (7) Increased access to recreational activities for children.
- (8) Community initiatives and public awareness.
- (9) Other means.

Given the current budget challenges and the cry for a response to the Newtown tragedy, a statewide childhood obesity task force may seem extraneous. However, Connecticut has a history of studying an issue, taking leadership, and moving to create efficiencies and strengthen outcomes. School readiness and bullying are two such examples. A time-limited Task Force with the goal of specific policy recommendations could bolster CT's leadership on obesity reduction for children, saving millions of dollars and improving the quality of life for the next generation.

Thank you.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TESTIMONY PRESENTED BEFORE THE COMMITTEE ON CHILDREN March 5, 2013

Jewel Mullen, MD, MPH, MPA, Commissioner (860) 509-7730

House Bill 6525 - An Act Establishing a Childhood Obesity Task Force

House Bill 6515 would establish a task force that will address childhood obesity in Connecticut. The proposed task force would guide Connecticut in establishing priority, evidence-based strategies aimed at decreasing childhood obesity rates in the state. The Department of Public Health respectfully requests being included as part of the membership of this task force. The Department can offer data and provide policy recommendations.

A recent study by the Department found that about one third of Connecticut children in kindergarten and third grade are overweight or obese and about one out of every seven are obese. The study was conducted with a sample of over 8,000 students in 74 elementary schools across the state from 2010 – 2011, and found that about 41% of non-Hispanic black and 43% of Hispanic children were overweight or obese, compared to 27% of non-Hispanic white children. The rates of overweight or obesity were similar among boys and girls. Obesity rates are significantly higher in lower income community schools.

The results of this study illustrate the alarming rate of childhood obesity, especially among high risk groups such as low-income, black and Hispanic children. Obesity is a major risk factor for chronic diseases such as cancer, diabetes, heart disease, and stroke. Children who are overweight or obese are more likely to develop these serious chronic diseases at earlier ages that lead to premature disability, early death, loss of productivity and decreased quality of life.

Over the past 30 years, the childhood obesity rate in America has almost tripled. According to the Centers for Disease Control and Prevention, in 2010, approximately 17 percent of children and adolescents aged 2-19 years were already obese.

Thank you for your consideration of the Department's views on this bill.

*Phone: (860) 509-7269, Fax: (860) 509-7100
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 13GRE
P.O. Box 340308 Hartford, CT 06134
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**TESTIMONY OF THE CONNECTICUT PUBLIC HEALTH ASSOCIATION
H.B. 6525: AN ACT ESTABLISHING A CHILDHOOD OBESITY TASK FORCE
JOINT COMMITTEE ON CHILDREN
MARCH 6, 2013**

Senator Bartolomeo, Representative Urban, and members of the Children's Committee, my name is Colleen O'Connor and I serve as Advocacy Chair and as a member of the Board of Directors of the Connecticut Public Health Association (CPHA). The Connecticut Public Health Association (CPHA) represents over 300 public health professionals, committed to improving the health of all Connecticut residents through evidence-based policy and programs. *CPHA offers our support for H.B. 6525: An Act Establishing a Childhood Obesity Task Force*, which would establish a task force to study and make statewide policy recommendations on childhood obesity.

CPHA believes that Public Health has a vital role to play in childhood obesity prevention in Connecticut. The mission of Public Health is to "promote physical and mental health and prevent disease, injury, and disability" in populations and communities.¹ Public Health differs from clinical professions such as medicine and nursing as we try to prevent diseases and injuries from happening (primary prevention) versus treating individuals after they become unhealthy. The public health field has been integral to addressing obesity in Connecticut and nationally, through health education and evidence-based prevention programs and policy measures. A few examples include: the Nutrition, Physical Activity and Obesity Prevention Program of the Connecticut Department of Public Health (DPH), the Connecticut Childhood Obesity Advisory Council, a joint venture between the DPH and the Connecticut Commission on Children, as well as the Healthy People 2010² and 2020^{3,4} initiatives. In fact, childhood obesity is considered one of the most serious public health challenges of the 21st century.⁵

Public health practitioners can play an integral role on the proposed Childhood Obesity Task Force as they are skilled at translating best practices from the field and evidence from scientific literature into evidence-based programs and policies. Furthermore, public health practitioners consider the societal factors and systems problems that encourage childhood obesity and which contribute to the racial and ethnic disparities in childhood obesity rates and related outcomes. We understand that without addressing these factors, public health policies and programs can have limited success for disadvantaged populations. While CPHA recognizes that public health is only one aspect of the environment that shapes health within a state or community, we understand public health as having a critical role to play in this important policy arena.

H.B. 6525 is both timely and imperative, given the rising incidence of this disease and its related health and economic costs in the state of Connecticut. Over the past three decades, the prevalence of childhood obesity has quadrupled among 6 – 11 year olds and tripled among preschool age children and adolescents in the United States.⁶ It is currently estimated that 25.7% of all Connecticut children are overweight or obese.⁷ The prevalence is especially high among certain sub-groups of children; 31.2% of low-income children, age 2-5, are overweight or obese, as well as 43.9% of African American teenagers (24% obese) and 31.2% of Hispanic teenagers (15.2% obese).^{7,8}

The consequences of obesity are significant for children, adults and society as a whole. Overweight and obese children face greater risk of developing chronic diseases previously considered adult illnesses, such as cardiovascular disease, diabetes, high cholesterol, sleep apnea and certain kinds of cancer.⁹ It is also very concerning that overweight or obese children continue to face an elevated and continued risk of chronic disease and premature death into adulthood.⁹ This contributes to the high costs of treating obesity related conditions—costs which exceed \$856 million a year in Connecticut alone. A significant portion of this cost (\$665 million) is paid for through Medicaid and Medicare.¹⁰

The Institute of Medicine (IOM) has outlined the importance of government involvement in reducing the prevalence of childhood obesity, recommending that federal, state and local governments: “establish a high-level task force on childhood obesity prevention to identify priorities for action, coordinate public-sector efforts and establish effective interdepartmental collaborations.”⁶ CPHA urges the Connecticut legislature to join the White House and other states, such as North Carolina, California, Hawaii, Mississippi and Kentucky, in following the IOM’s recommendation to establish Childhood Obesity Task Forces.

CPHA supports developing a statewide, comprehensive plan to address childhood obesity and believes a centralized task force with legislative leadership, comprising a broad representation of experts including public health, is an important step towards this goal. Therefore, CPHA respectfully requests that the Task Force include representation from the Public Health community. CPHA enthusiastically supports the overarching goal of H.B. 5746: *An Act Concerning a Task Force on Childhood Obesity* as it seeks to systematically address one of the most pressing public health problems faced by our youngest, and often times, most vulnerable, Connecticut residents.

Thank you for your time.

Sincerely,
Colleen O’Connor, MPH
Chair of Advocacy and Board of Directors
Connecticut Public Health Association

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**Public testimony before the Children's Committee in support of the creation of a
Childhood Obesity Task Force submitted by Dena Torino
March 5, 2013**

Good afternoon, Senator Bartolomeo, Representative Urban and members of the
Children's Committee:

My name is Dena Torino. I am a student at the University of Connecticut's School of
Social Work with a concentration in Community Organizing. I currently work at The
Taft School, an independent coeducational boarding school for students in grades nine
through post graduate. I serve Taft as the Director of Student Activities and Director of
Student Leadership Development and work collaboratively with our Health Team—a
group made up of key community members coordinating, organizing and addressing
issues, including but not limited to, student culture, residential life, and health and
nutrition trends.

I am here to testify in support of raised House Bill No. 6525 - AN ACT ESTABLISHING
A CHILDHOOD OBESITY TASK FORCE.

Our mission at Taft—to educate the whole student—means we work consciously and
deliberately to help students gain knowledge, practice skills, and create habits of mind
pertaining to all aspects of their lives, helping them to become healthy productive
citizens. Nutrition and eating habits are one place we focus our efforts. And within the
context of today's obesity epidemic, my hope is that Connecticut will lead the way in
making the nutrition of its children a priority by creating the Childhood Obesity Task
Force.

In a recent report entitled "*F as in Fat: How Obesity Threatens America's Future 2012*,
released by Trust for America's Health (TFAH) and the Robert Wood Johnson
Foundation (RWJF), the number of obese adults, along with related disease rates and
health care costs, are on course to increase dramatically in every state in the country over
the next 20 years (See more at: <http://healthyamericans.org/report/100/#sthash.4wX57BaB.dpuf>).

The report offered two pictures of the future of America's health and includes an analysis
of state by state projections. One future, if Connecticut and America stay on our current
course and one if we reduce the average body mass index (BMI) of our residents by just 5
percent.

If obesity rates continue on their current trajectories, the obesity rate in Connecticut could
reach an astounding 46.5 percent, increasing our obesity related health care costs by 15.7
percent.

In contrast, if average body mass indexes were lowered by 5 percent, Connecticut could
save 7 percent in health care costs, which would equate to a savings of 7 billion 370
million dollars (\$7,370,000,000) by the year 2030.