Approved: February 2, 2005
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on January 12, 2005 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Norm Furse, Office of Revisor of Statutes
Whitney Nordstrom, Committee Secretary

Conferees appearing before the committee: Billie Hall, President and CEO of Sunflower Foundation
Jodi Mackey, Director of Child Nutrition and Wellness, Kansas State Department of Educations

Recognitions

Upon calling the meeting to order, Chairperson Barnett welcomed Committee Members and introduced staff members, Norm Furse, Revisor of Statutes; Emalene Correll and Terri Weber, both of the Kansas Legislative Research Department; Whitney Nordstrom, Committee Secretary; and Morgan Dreyer, Intern.

Presentation on "Kansas Update on Obesity and Childhood Nutrition"

The Chair then introduced guest speaker Billie Hall, President and CEO of Sunflower Foundation. Ms. Hall began by thanking the Committee, then stated she would be focusing her presentation on Childhood Obesity in Kansas. A copy of her presentation is (Attachment 1) and (Attachment 2) attached hereto and incorporated into the Minutes as referenced. Highlights of her presentation included:

1) The Sunflower Foundation: *Health Care for Kansans* was created in 2000 with a mission to serve as a catalyst for improving the health of Kansans.

2) Overview of Obesity.

3) Responding to Obesity-What's Happening in Kansas.

4) The Sunflower Approach.

5) Opportunities for Action.

6) Taking a Public Policy Approach. As a policy approaches are evaluated in Kansas, there are opportunities in several sectors that may be worthy of consideration:

a) School-based
b) Worksite-based
c) Built Environment
d) Other

7) Concluding Remarks.

Chairperson Barnett thanked Ms. Hall for her presentation and asked Committee for questions and/or comments.

A range of questions and comments came from both Senators Barnett and Journey including what policies the Sunflower Foundation supports and what the breakdown of the $657 million obesity-attributable medical expenditures in Kansas would be.

Chairperson Barnett then introduced guest speaker Jodi Mackey, Director of Child Nutrition and Wellness, Kansas State Department of Education. Ms. Mackey began by thanking the Committee, then stated she would

be focusing her presentation on School Meals and Childhood Obesity in Kansas. A copy of her presentation is (Attachment 3) attached hereto and incorporated into the Minutes as referenced. Highlights of her presentation included:

1) An estimated 15% of American children and adolescents ages 6-19 are overweight. The childhood obesity crisis is the result of widespread changes in American culture including:

- -Less physical activity
- -Increased consumption of sweetened beverages
- -Confusion over portion sizes
- -Highly processed foods

2) School meals are part of the solution to the childhood obesity crisis because:

- -Calories and portion sizes are controlled
- -Fat in school meals is restricted
- -School meals include a variety of foods

3) Current Nutrition and Health Education Opportunities.

4) Local Wellness Policy.

Chairperson Barnett thanked Ms. Mackey for her presentation and asked Committee for questions and/or comments.

A range of questions and comments came from Senators Brungardt, Barnett, and Emalene Correll including what other states have done to develop policy, if smaller portions of food throughout the school day is being implemented, if there are standards on how subsidies are used, are foods with no/low nutritional value hard to define and regulate, and are we placing another responsibility on schools.

Adjournment

Chairperson Barnett reviewed next weeks agenda. As there were no bill introductions and with no further business, the meeting was adjourned. The time was 2:15.

The next meeting is scheduled for January 18, 2005.

Atachment 1

Sunflower Foundation
HEALTH CARE FOR KANSANS

Presentation to the

Senate Public Health and Welfare Committee

Billie G. Hall
President & CEO, Sunflower Foundation
January 12, 2005

I. Introduction

Mr. Chairman, members of the committee and guests...my name is Billie Hall. I am President and CEO of the Sunflower Foundation: Health Care for Kansans. I sincerely appreciate this opportunity to visit with you briefly today regarding issues of common interest and concern...and I thank you, Senator Barnett, for your invitation.

The Sunflower Foundation: *Health Care for Kansans* was created in 2000 with $75 million in proceeds from a settlement between the Kansas Attorney General, the Kansas Insurance Department and Blue Cross and Blue Shield of Kansas to resolve Blue Cross' charitable obligations to the state.

The foundation's mission is *to serve as a catalyst for improving the health of Kansans*, which we support through a program of grantmaking and related activities. Since June 2002 (when we began our program work), the foundation has awarded over $6 million in grants to nearly 200 organizations throughout the state.

Senate Public Health and Welfare
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The foundation currently has two major priority areas. The first is **promoting access to affordable and quality health care, especially for the underserved populations of our state.** While I'm not here to talk about access issues today, I will say that we are interested in supporting pubic and private initiatives that reduce barriers to care for the uninsured and underinsured.

Our **second** priority centers around promoting healthy behaviors and preventing disease. In this context, our efforts are focused on tobacco control and prevention and **the growing public health issue of obesity and the burden of disease and death that it causes**. I am here today to talk about obesity, with an emphasis on obesity in children and youth.

II. Overview of Obesity

In the United States, obesity has risen at an epidemic rate during the past 20 years. According to a report published in the June 16, 2004, issue of the *Journal of the American Medical Association*, nearly one-third of all adults are classified as obese.

Since the 1970s, the prevalence (or percentage) of obesity has more than doubled for preschool children aged 2-5 years and adolescents aged 12-19 years, and it has more than tripled for children aged 6-11 years.

Obesity is a risk factor for serious and life threatening chronic diseases and other major health problems. Childhood obesity involves significant risks to physical and emotional health that often continue into adulthood. In 2000, it was estimated that **one in three children born in the United States are at risk for being diagnosed with type 2 diabetes at some point in their lives.**

In addition to the health consequences, obesity has a negative impact on the self-esteem of children and adolescents.

The latest data from the 1999-2002 National Health and Nutrition Examination Survey show that the percent of children who are overweight continues to increase. Among children and teens age 6-19, 16 percent (over 9 million) are overweight according, **or triple what the proportion was in 1980.**
These data also point out the alarming disparities among population groups:

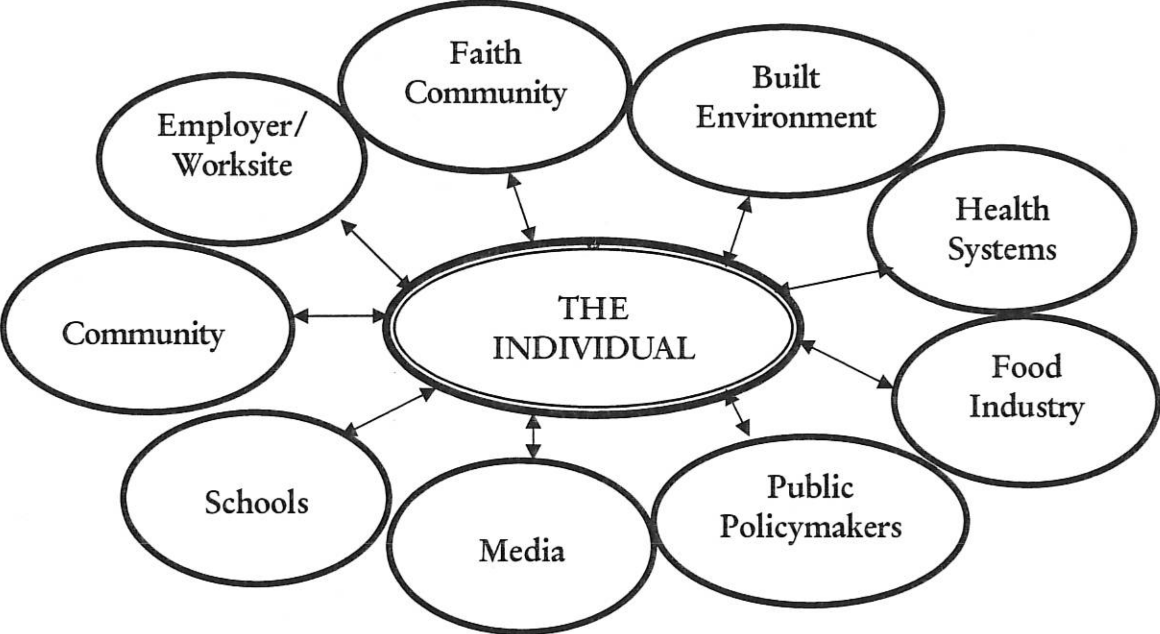
- Non-Hispanic black (21 percent) and Mexican-American adolescents (23 percent) ages 12-19 were more likely to be overweight than non-Hispanic white adolescents (14 percent).
- Mexican-American children ages 6-11 were more likely to be overweight (22 percent) than non-Hispanic black children (20 percent) and non-Hispanic white children (14 percent).

The economic costs of obesity are also high. For example, according to the Centers for Disease Control and Prevention, the annual cost of obesity-attributable medical expenditures in Kansas totals $657 million, at least $143 million of which is paid by the Medicaid program.

III. Responding to Obesity – What's Happening in Kansas

The Sunflower Foundation has spent the last three years learning what we can about the extent and impact of obesity in Kansas. One of the most positive findings of the Sunflower Foundation's research is the overwhelming interest in obesity and the multitude of Kansas organizations that are responding or want to

respond. The concern, however, is the limited evidence on effective prevention strategies across all sectors and the complexity of the social, cultural and environmental contexts that exist. It is clear that changing the trends in obesity will require more than just implementing the "right" program – it will take the collective efforts from diverse segments of society working together to create social, cultural and environmental changes that encourage and promote healthy decisions and lifestyles as the following diagram demonstrates.



IV. The Sunflower Approach

The Sunflower Foundation is contributing its resources to this issue through a three-fold approach:

First – We continue to seek out innovative programs in all sectors through our competitive grants process. To date, we have awarded over $ 3 million dollars

in obesity-related grants and initiatives to schools, neighborhood programs, work sites, health care providers and local and state health agencies.

Second – We are supporting current research that will help our state understand the prevalence of obesity among children and minority populations and better inform our efforts for developing prevention programs for these groups.

Third –We are convening experts from around the state to explore promising practices and model programs that offer real potential for solutions. As a result of this convening, the Sunflower Foundation, in coordination with a major public health initiative – Shaping America's Youth, will be launching in late February a Web-based resource and tool to help public and private organizations develop effective strategies and programs and to continue to raise the level of understanding and awareness about obesity in Kansas.

V. Opportunities for Action

While the issue of obesity affects all ages and populations, we believe it is especially important to focus on children and youth, where there is great opportunity to establish sustainable, life-long patterns of healthy behaviors. Because of the increasing health risks associated with childhood obesity, it is imperative that we develop prevention programs that engage families, schools and communities with the goal to create healthy environments in which children live and learn lifelong healthy behaviors.

This fall, the Institute of Medicine released the report "Preventing Childhood Obesity: Health in the Balance," which takes a more global perspective and offers recommendations in all sectors:

1. *National Priority*: Government at all levels should provide coordinated leadership for the prevention of obesity in children and youth. An increased level and sustained commitment of federal and state funds and resources are needed.
2. *Industry*: Industry should make obesity prevention in children and youth a priority by developing and promoting products, opportunities, and information that will encourage healthy eating behaviors and regular physical activity.
3. *Nutrition Labeling*: Nutrition labeling should be clear and useful so that parents and youth can make informed product comparisons and decisions to achieve and maintain energy balance at a healthy weight.
4. *Advertising and Marketing*: Industry should develop and strictly adhere to marketing and advertising guidelines that minimize the risk of obesity in children and youth.
5. *Multi-Media and Public Relations Campaign*: The Department of Health and Human Services should develop and evaluate a long-term national multimedia and public relations campaign focused on obesity prevention in children and youth.
6. *Community Programs*: Local governments, public health agencies, and community organizations should actively develop and promote programs that encourage healthy eating behaviors and regular physical activity, particularly for populations at high risk for childhood obesity.
7. *Built Environment*: Local governments, developers, and community groups should expand opportunities for physical activity that include recreational facilities, parks, playgrounds, sidewalks, bike paths, routes for walking or biking to school, and safe streets and neighborhoods, especially for populations at risk for childhood obesity.
8. *Health Care*: Pediatricians, family physicians, nurses, and other clinicians should engage in the prevention of childhood obesity.
9. *Schools*: Schools should provide a consistent environment that is conducive to healthy eating behaviors and regular physical activity.
10. *Home*: Parents should promote healthy eating behaviors and regular physical activity for their children.

Koplan, JP., Liverman, CT., Kraak, VA. "Preventing Childhood Obesity: Health in the Balance." Committee on Prevention of Obesity in Children and Youth. National Academies Press. Washington DC, 2004.

VI. Taking a Public Policy Approach

The increasing number of obese children and youth throughout the United States is leading policymakers to rank it as a critical public health threat. Policymakers are asking what responses, if any, they should take to address this issue.

To date, those responses have been varied, but considerable. For example, a study conducted by the Kansas Health Institute indicated that, between 1999 and 2003, thirty state legislatures adopted policies that target obesity or attempt to increase physical activity. Seventy-nine obesity-related policy issues were passed by state legislatures during the period. However, at this time we do not have data on the impact or effectiveness of these policies.

Attached to my remarks is an excerpt from *Obesity and Public Policy: A Framework for Intervention*, developed by the Kansas Health Institute, providing examples of public policy-related strategies that address obesity in a variety of sectors. In addition, I have copies of the complete report for each of you, thanks to Tony Wellever from the Kansas Health Institute.

As policy approaches are evaluated in Kansas, there are opportunities in several sectors that may be worthy of consideration:

School-based:

1. Competitive foods in Kansas schools
    - Availability
    - Nutritional Standards
    - Restrictions

2. Physical activity in Kansas schools
   - Review of physical activity requirements in Kansas schools, including frequency and duration of the physical activity
   - Baseline study of physical education (PE) requirements, including definition of a physical education unit (e.g. does a unit constitute activity, classroom teaching or both?)
   - Review and study of physical activity through other opportunities, such as recess, before/after school programs, etc.
3. Annual BMI measurements (height/weight) for Kansas students
4. Efforts to identify model programs for schools

Worksite-based:

1. Incentives for worksites to provide safe, convenient and affordable venues for employees to engage in physical activity.
2. Incentives for businesses that have health promotion and wellness programs
3. Encourage and support efforts to identify model worksite programs

Built Environment:

1. Incentives to improve the built environment for communities – for safe, walk-able communities and neighborhoods
2. Incentives to promote public/private partnerships to enhance built environment

Other:

1. Councils or Commissions on Physical Fitness and Nutrition
2. Research and data to enhance our understanding of the issue

These ideas are not intended to give you a comprehensive list of the many policy related approaches that are being tested across the country, but rather an introduction to the possibilities. It is clear, however, that these approaches need to be evaluated for effectiveness along with implementation issues and costs. The Sunflower Foundation is committed to identifying and evaluating

approaches to obesity from both a program and policy perspective and will share our work with policymakers and others.

VII. Concluding Remarks

In summary, finding effective and sustainable solutions to the complex problem of obesity is as challenging in Kansas as it is nationwide. But we are inspired and encouraged by the commitment of so many in our state to this issue – and by existing and emerging opportunities to work together on this front. The Sunflower Foundation is also committed to this work and to finding the most effective ways to apply our resources in support of efforts to reduce the prevalence of obesity in Kansas.

Thank you Mr. Chairman and members of the committee for inviting me to share information with you today about the Sunflower Foundation's interests and work related to obesity. I would be happy to address any questions or comments you may have.

Excerpt:

Wellever, Anthony. "**Obesity and Public Policy: A Framework for Intervention.**" Kansas Health Institute July 2004: 30.

Schools and youth-serving organizations

- Offer incentives for schools to adopt healthy school nutrition policies
- Mandate daily physical activity for all grades K-12
- Provide physical education with resources on a par with the academic curriculum
- Incorporate nutritional and physical activity standards in before- and after-school programs
- Establish nutritional and physical activity standards for preschools

Work sites and employer programs

- Develop a HEDIS measure on BMI measurement
- Contract with health plans that offer weight management services, tools and resources
- Sponsor health risk appraisals for employees
- Encourage and facilitate programs like "Weight Watchers at Work"
- Encourage work-site food vendors to provide healthy food choices

Community support programs, services and policies

- Establish food standards for public venues and buildings
- Conduct special events to educate and involve community members and groups in nutrition and physical activity efforts
- Create alternatives to sedentary behaviors
- Offer community-based exercise, nutrition and cooking classes, with an emphasis on cultural competence

Community design for healthy eating and active living

- Mandate "health impact" studies for new construction projects
- Increase access to healthy food, active recreation and neighborhood resources through incentives, regulations and public sector involvement
- Encourage strategic revitalization of neighborhoods
- Conduct community needs assessments to help set priorities and target resources

The food industry and food marketing

- Provide funding for research to gain an in-depth understanding of the behavioral factors that influence food consumption patterns
- Use marketing expertise to 1) promote concepts of balance, variety, moderation and physical activity; 2) teach portion control; and 3) eliminate confusion about nutrition requirements and goals
- Encourage restaurants to provide healthy, low-calorie choices, appropriate portion sizes and nutritional information
- Encourage development of shops and restaurants that are more accessible by walking or bicycling
- Increase federal funding for research on nutrition messaging and techniques (e.g. food labels and food pyramid information)

Health care system

- Provide funding for research and demonstration projects to determine the effectiveness of prevention and treatment interventions
- Provide adequate reimbursement for effective services, including incentives to encourage positive outcomes and good performance
- Establish support structures and tools to enable providers to deliver weight management services, such as information systems, training and access to community resources

Communication and public advocacy

- Provide funding for a coordinated national media campaign
- Link media campaigns to the work of coalitions conducting community programs
- Link media campaigns to public policy advocacy
- Focus messages on the science base, the need for prevention (particularly among children) and collaboration
- Priority areas for public advocacy include: 1) reduce soda consumption in schools; 2) reduce advertising of unhealthy food for children; 3) increase availability and quality of physical education in schools; and 4) improved community infrastructure

Source: Raymond and Moon, 2003

Atach #2

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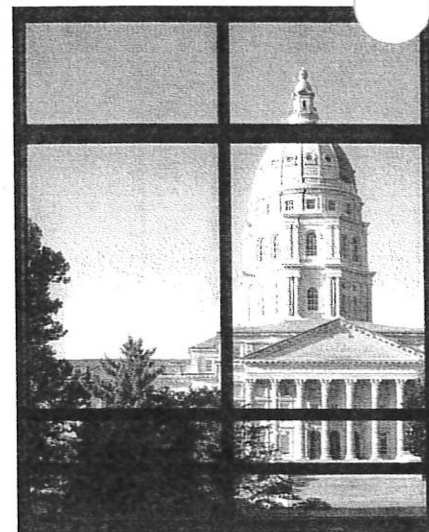

Issue Brief

KANSAS
HEALTH
INSTITUTE

Is Obesity a Public Policy Problem?

Anthony Wellever

Results in Brief

- In Kansas, the cost of obesity-attributable medical expenditures totals $657 million per year, at least $143 million of which is paid by the Medicaid program.
- Obesity is a public policy issue because its health costs are born by society at large and because weight bias affects the ability of obese people to participate equally in the political, social and economic life of their society.
- Between 1999 and 2003, thirty state legislatures adopted 79 separate policy initiatives that target obesity and physical inactivity.
- The greatest number of state bills had to do with improving school-based physical education. Sixteen bills instructed the state department of health or a newly created commission to study the topic of obesity and to make recommendations.

More information

For more information on this topic, visit www.khi.org to read two reports on obesity and public policy. The first report is *Obesity and Public Policy: Legislation Passed by States, 1999 to 2003,* and the second report is *Obesity and Public Policy: A Framework for Intervention.*

Research for this project was funded by the Sunflower Foundation: Health Care for Kansans.

The Centers for Disease Control and Prevention (CDC) announced in February that obesity will overtake tobacco use as the leading cause of preventable death by 2005. Next year, obesity will be responsible for the deaths of an estimated 500,000 Americans. These deaths will come from a variety of diseases resulting from obesity, such as heart disease, diabetes and some forms of cancer.

The direct physiological causes of obesity are known and simple. People gain weight when they consume more calories in the form of food and drink than they expend in their physical activities. But an individual's weight also is determined by a combination of genetic, metabolic, behavioral, environmental, cultural and socioeconomic influences.

Obesity is certainly a public health problem, but is it also a public policy problem that demands attention? Some argue that public health problems, by definition, are public policy problems because they affect the welfare of the entire population. Others claim that the aggregate of individual behavior that does not affect the health of others is not sufficient

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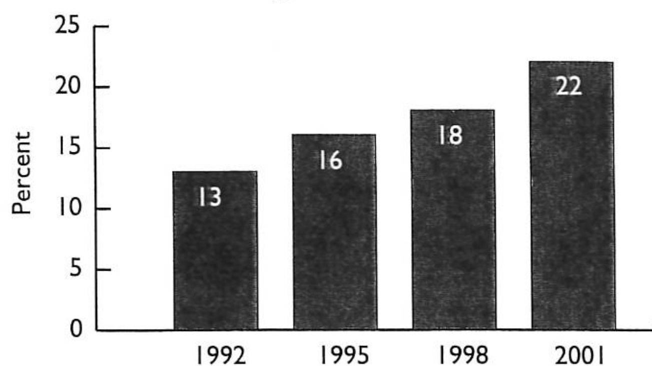

Source: Kansas Department of Health and Environment, 2003

to raise a public health problem to the level of a public policy problem.

On the other hand, certain health issues such as sexually transmitted diseases and diseases caused or exacerbated by secondhand smoke may become public policy issues if policymakers perceive that the prevalence of the behaviors is a danger to the public. Because obesity is not a communicable disease and its direct impact on the health of others is limited, many policymakers claim that the "obesity epidemic" requires no public policy intervention.

Personal behavior rises to the level of public policy, some claim, when it negatively affects a group or class of individuals. Such may be the case in regard to obesity. Consider the social consequences of obesity in the following circumstances:

Obesity-related social costs

On average, annual health care expenditures of non-elderly obese people are more than one-third greater than people of normal weight. In Kansas, the cost of obesity-attributable medical expenditures totals $657 million per year, at least $143 million of which is paid by the Medicaid program. If current trends continue, one dollar out of every five spent on health care in the year 2020 will be spent on obesity-related conditions.

While many economic and non-economic costs of obesity are born by overweight individuals, some of the economic costs of obesity related to health care are shifted to others. Just as healthier people subsidize the care of those who are less healthy and who consume more health care services, people who are not obese pay higher health insurance premiums to subsidize care provided to obese members in their health plan and those without health insurance. Medicaid expenditures, financed by tax revenues, are greater than they would be if the obesity rate of beneficiaries was lower. Obesity lowers profitability of businesses and may lower productivity, employee pay raises and benefit expansions.

Bias and discrimination

Clear evidence exists of pervasive bias against overweight people across key sectors including employment, education, health care and housing. The power of negative attitudes (bias), in some cases, may produce unreasonable actions (discrimination) against overweight people.

No federal laws exist currently to protect obese individuals from discrimination. Michigan is alone among states in prohibiting employment discrimination on the basis of weight. A handful of cities have adopted ordinances that include weight in their definitions of unlawful discrimination.

Overweight and obesity are associated with lower incomes and lower levels of educational attainment, but association is not the same as causation. How much of the association results from overweight people being unfairly denied opportunities at school, at work and in the medical system? To what extent is overweight a cause of lower income and lower education? Certainly, other explanations exist for the relationship between obesity and income

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education, but we may be mistaken to think that the explanations flow in one direction only.

Racial and ethnic disparities

African Americans and people of Hispanic origin living in the U.S. have a higher prevalence of overweight and obesity than White Americans. One possible explanation is that low-income minorities are subject to environments in which low-cost, energy-dense foods composed of refined grains, added sugars and certain fats are more readily available than more nutritious foods. Unequal access to health education and treatment services may exacerbate obesity and its accompanying health conditions in some minority groups.

Certainly, not all members of a particular minority group are overweight. Because obesity has a tendency to aggregate in families, however, there may be a genetic component to obesity susceptibility. Recent research concludes that genetics play a "large part" in susceptibility to obesity. This stream of research suggests that a number of genes, each with a small effect, contribute to an individual's susceptibility to obesity. Obesity, like many other health conditions, is caused by the interaction of genetics and environmental conditions.

Some argue that indigenous people in pre-modern societies developed a biological adaptation that allowed them to cope with alternating periods of feast and famine. The so-called "thrifty genome model" allowed them to store fat when food was plentiful as a hedge against starvation in times of famine. The genes, which were once important to survival, now no longer serve a function. In fact, they have become harmful, because fat, originally stored for famine situations, is not used up. Additionally, many have traded a more active lifestyle for one that is more sedentary.

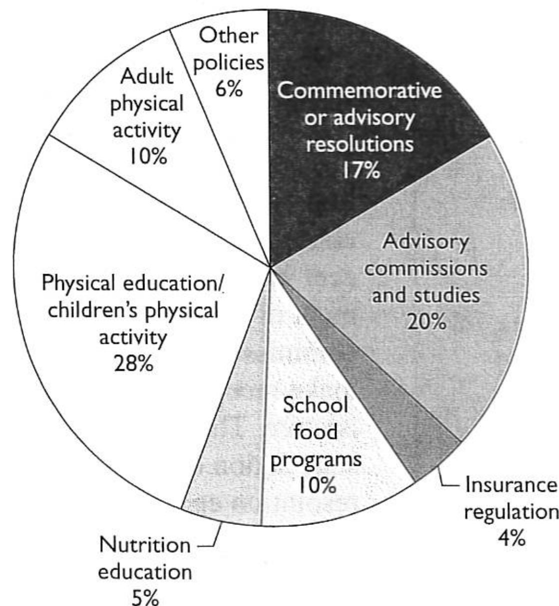
Ultimately body weight is determined by individual behavior, but the same behaviors can affect individuals differently. Many minorities may be disadvantaged by their genetic predisposition, poverty and the environments in which they live.

The role of public schools

One approach for reversing the epidemic of obesity is to concentrate on obesity prevention in children. Learning healthy behaviors at a young age will accrue benefits throughout the life-course of an individual.

As quasi-governmental organizations, public schools have a duty to protect the health and safety of the children in their charge. As learning institutions, schools should attempt to remove barriers to performance within their control that allow children to optimize their potential. Offering instruction in good health habits (bal-

Obesity-Related Bills Passed in State Legislatures, 1999–2003*



** 79 bills were passed in 30 states during the period.*

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On average, annual health care expenditures of non-elderly obese people are more than one-third greater than people of normal weight.

anced nutrition and physical fitness) and reinforcing the lesson by providing an environment that supports healthy eating and physical activity fulfills both duties.

Legislative efforts

Because obesity is influenced by multiple factors, policy solutions to reduce its prevalence are not immediately evident. To find out what policymakers in other states are doing about obesity prevention and treatment, policies recently passed by state legislatures were examined.

Between 1999 and 2003, thirty state legislatures adopted policies that target obesity or attempt to increase physical activity. Seventy-nine separate policy initiatives passed by state legislatures were identified during the period. In 2001, Surgeon General David Satcher issued a report, *Call to Action to Prevent and Decrease Overweight and Obesity,* calling for increased recognition of obesity as a major public health problem. Since that time, the number of obesity-related laws has increased substantially. Sixty-three percent of the bills passed during the five-year period related to obesity were passed in 2002 and 2003.

The greatest proportion of bills (28 percent) had to do with improving school-based physical education. Approximately 20 percent instructed the state department of health or a newly created commission to study obesity and make recommendations to the legislature. The third most frequent state action (17 percent) was a resolution encouraging citizens to lose weight and become more active, urging state agencies to undertake obesity-related programming, or proclaiming an obesity prevention-related day, week or month. Fewer bills targeted general physical activity and school food programs. Insurance regulations, generally mandating that surgical procedures endorsed by the National Institutes of Medicine for the treatment of morbid obesity be offered, were passed in three states.

Obesity is a clear threat to the public's health. Some environments, such as schools, may unwittingly promote the consumption of empty calories by their competitive food policies. In inner cities and isolated rural areas, food stores that sell fresh fruits and vegetables may not be accessible. In suburbs and rural areas, there may be no sidewalks, walking trails or bike paths that encourage physical activity. The environment and some of the other factors that influence obesity may be altered positively by public policies that target the population as a whole rather than individuals. Legislatures in thirty states have recognized the importance of this issue and have begun to take action.

State legislation is not the only avenue of public policy open to those who want to reduce the prevalence of obesity in Kansas. State government administrators, communities, school boards and employers around the nation have also focused their attention on population-based initiatives to limit and control the obesity epidemic. The actions they have taken to date do not represent the full spectrum of possibilities. But they are a start.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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Attachment 3

Child Nutrition & Wellness, Kansas State Department of Education
785-296-2276 – www.kn-eat.org

School Meals & Childhood Obesity

Lately, the prevalence of obesity among Americans has received widespread media attention. An estimated 15% of American children and adolescents ages 6-19 are overweight. The childhood obesity crisis is the result of widespread changes in American culture including:

- **Less physical activity** - Nearly half of young people ages 12-21 do not engage in physical activity on a regular basis. Today, children are more likely to spend their free time sitting in front of a screen. The average American child spends five hours in front of a screen each day.

- **Increased consumption of sweetened beverages** - Consumption of carbonated beverages has skyrocketed, while consumption of milk has declined. Fifty-one percent (51%) of the average American child's daily liquid intake is made up of sweetened beverages. Many of these beverages provide calories, but no nutrients.

- **Confusion over portion sizes** - Super-sizing of portions greatly increases calorie intake and presents the wrong message about how much food should be consumed.

- **Highly processed foods** - Many commercially produced fast foods and processed foods are high in both calories and fats, but low in other essential nutrients. This can result in people being overfed but undernourished.

School Meals are Part of the Solution!

School nutrition programs serve education everyday by providing healthful school breakfasts, lunches and after school snacks to students in 1,671 schools. On a typical school day, more than 300,000 school lunches and almost 60,000 school breakfasts are served to Kansas students. School nutrition programs employ approximately 7,000 Kansans and bring more than $108 million annually in federal funds into the Kansas economy.

School meals are part of the solution to the childhood obesity crisis because:

- **Calories and portion sizes are controlled.** School breakfasts are planned to provide approximately one-fourth of the Recommended Daily Allowance (RDA) for calories, while school lunches provide about one-third of the RDA for calories. Calories are varied to meet the needs of different age or grade groups of students. For example, meals for elementary students provide fewer calories than those for secondary students.

- **Fat in school meals is restricted** to the amounts recommended in the Dietary Guidelines for Americans (DGA): No more than 30% of total calories from fat and no more than 10% of total calories from saturated fat.

- **School meals include a variety of foods** that provide essential nutrients for growth and well-being. School meals must meet nutrient targets for vitamins A and C, protein, calcium and iron.

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Child Nutrition & Wellness, Kansas State Department of Education
785-296-2276 – www.kn-eat.org

Current Nutrition & Health Education Opportunities

Kids a Cookin' provides fun educational nutrition activities to promote fruit and vegetable consumption for students in grades K-6.

For more information go to www.kn-eat.org.
Click on General Program Information, What's New, Kids a Cookin'

Body Walk is a unique educational walk-through exhibit for K-6 students to help them learn to EAT SMART and PLAY HARD. The exhibit travels to Kansas schools.

For more information go to www.bodywalk.org.

Power Panther Pals

Power Panther Pals helps 4th, 5th and 6th graders learn to enjoy fruits and vegetables and to incorporate physical activity into their daily lives.

For more information go to: www.powerpanther.org.

Coordinated School Health Program

This powerful approach recognizes and addresses the close relationship between health and learning.

For more information go to www.kshealthykids.org.

Coming Soon…..

Power Panther Preschool – A program for child care centers and day care homes

Power Panther Professionals – Inservice training for school and child care center personnel

Local Wellness Policy

What? A local wellness policy is required by the public law (P.L. 108-265) that reauthorized Child Nutrition Programs and went into effect on June 30, 2004. The policy must include:

- Assurance that local nutrition guidelines for school meals will not be less restrictive than Federal policy
- Nutrition guidelines for all food sold on campus
- Goals for nutrition education and physical activity
- A plan for measuring effectiveness

Who?

- School districts and private schools participating in the National School Lunch Program are required to implement a local wellness policy.
- Parents, school nutrition professionals, school board members and other stakeholders must be involved in developing the policy.

When?

- The local wellness policy must be in place by July 2006.

How?

- During school year 2004-2005, KSDE will develop a prototype wellness policy in collaboration with a variety of stakeholders from across Kansas.
- School districts will be able to adopt the prototype policy as provided or modify it to suit local needs.
- During school year 2005-2006, KSDE will provide training and technical assistance on modifying and using the prototype wellness policy.