

CDC *Vital Signs* Town Hall Teleconference

Progress on Childhood Obesity: Many States Show Declines

August 13, 2013  
2:00–3:00 pm EDT

Coordinator: Thank you all parties for standing by. All lines have been placed on listen-only until the question and answer session of conference.

Today's call is being recorded. If you have any objections you may disconnect at this time. I will now turn the call over to the facilitator Dr. Dan Baden. And you may begin.

Dan Baden: Thank you Lori. Good afternoon everyone. I'm Dr. Dan Baden. I'm the Associate Director for External Partner Outreach and Connectivity in CDC's Office for State, Tribal, Local and Territorial Support. Welcome. I'm glad you could join us today.

Today we'll be discussing the latest File Finds Report on progress on childhood obesity many states show declines.

Before I get started I wanted to go over some housekeeping details.

You can go online and download today's PowerPoint presentation so you can follow along with the presenters.

The web address is [www.cdc.gov/stltpublichealth](http://www.cdc.gov/stltpublichealth). Again, that's S-T-L-T public health. There's a link directly to the *Vital Signs* Town Hall website under Highlighted Products and Resources on the lower right side of the page.

On this Town Hall page you can also view bios for each of the presenters. This is where we'll add the audio recording and transcript from today's teleconference as well. They should be available next week.

Obesity rates and low income preschoolers after decades of rising began to level off from 2003 through 2008 and we're now showing small declines in many states. However, too many preschoolers are still obese.

Twelve percent or one in eight preschoolers is obese in the United States. Children who are overweight or obese as preschoolers are five times as likely as normal weight children to be overweight or obese as adults.

Our STLT partners are critical to continuing the downward trend of childhood obesity.

On today's call we're going to hear from three colleagues. First we'll hear from Lieutenant Commander Ashleigh May, PhD, an epidemiologist in the Obesity Prevention and Control Branch in the Division of Nutrition, Physical Activity, and Obesity of the National Center for Chronic Disease Prevention and Health Promotion at CDC. She'll provide a summary of this month's *Vital Signs* report.

Dr. May will had the call over to Ms. Lonias Gilmore, a public health consultant and physical activity and obesity training coordinator in the Cardiovascular Health, Nutrition, and Physical Activity section of the Michigan Department of Community Health.

Ms. Gilmore will share how Michigan is reducing barriers to eating smart and moving more in low income families within the state.

Ms. Gilmore will then turn the call over to Ms. Loretta Santilli, director of the Division of Nutrition at the New York State Department of Health.

Ms. Santilli will discuss how New York State has coordinated their efforts with various partners to reduce the prevalence of childhood obesity and increase the over health - overall health of the youth in the state.

Please note there will be a time for questions and answers after our presentations today. But you can get in queue whenever you like to ask a question by pressing star 1. You'll be asked to record your name and we'll put you in queue.

And now I turn the call over to Dr. May.

Dr. Ashleigh May: Thank you. So again today I'll be sharing some of the findings, the key findings from the *Vital Signs* Report released on last Tuesday focusing on obesity among low income preschoolers.

So, you should be on slide 5 now which is titled Key Findings.

So we've run through our report that after decades of rising obesity rates among low income preschoolers are showing small but significant decline in many states and territories.

We found that there were small declines in 19 of the 43 states and territories that we studied between 2008 and 2011.

There were also small increases in three of the 43 states and territories included in there - in this study and no change in 21 of the 43 states and territories.

Figure 1 shows you just an overview of which states increased, decreased, or had no change in their obesity prevalence between 2000-2003 through 2008.

Next slide, Figure 2 shows the prevalence of obesity among low income preschool-aged children in 2011.

And what we found was that although there's been declines across many states the obesity rates remain high.

In 2011 the obesity rate in the US ranged from 9.2% in Hawaii to 17.9% in Puerto Rico.

Next slide, so the public health importance of childhood obesity, we know that one in eight US preschoolers is obese. And we also know that obesity tracks into adulthood.

Children who are overweight or obese as preschoolers are about five times as likely to be overweight or obese as adults as compared to their normal weight peers.

Obesity also carries with it negative health consequences, including high cholesterol, high blood sugar, asthma, mental health problems, and a host of other negative health consequences.

And obesity's also costly. Among adults obesity was associated with nearly \$150 billion in medical costs in 2008 dollars.

Next slide, so our *Vital Signs* report also provided recommendations for what various stakeholders in the obesity epidemic or childhood obesity epidemic could do to help prevent obesity or reduce obesity among young children.

And certainly there are a number of key stakeholders, parents, child care providers, doctors, and nurses.

But we chose to really focus a lot of our efforts around what state and local health officials could do to engage community members in preventing childhood obesity.

And some of the things that were suggested were for creating partnerships with committee members to make changes that promote healthy eating and active living.

And those partners may include a number of individuals, including civic leaders, child care providers, and other nontraditional partners who may not view community health as a part of their mission, but through their work may be able to impact the health of young children.

Another recommendation was to make it easier for families with children to buy healthy and affordable foods and beverages in the neighborhoods in which they live, and also to provide access to safe and free drinking water in places such as community parks and recreation areas, child care centers and to also provide or help schools, local schools to open their gyms, playgrounds, sports fields during non-school hours to provide places for children to actively to play safely.

And finally to help childcare providers in the use of best practices for improving nutrition and also increasing physical activity and limiting screen time.

Next slide, so on this slide we share with you some additional resources that are related to this release and childhood obesity in general. The link for the *Vital Signs* Report is listed here, as well as additional information on the CDC website regarding childhood obesity.

And finally, we've also shared the CDC's State Indicator Report which provides state-based metrics for behavioral, environmental, and policy indicators that are related to nutrition, physical activity and breast-feeding among other areas.

And with that I will turn the call over to Lonias.

Lonias Gilmore: Thank you Dr. May. This is Lonias Gilmore. I'm a public health consultant with the Michigan Department of Community Health.

We are really excited here in Michigan about this modest although significant progress that we're making on trying to reduce obesity rates in young children, specifically those from low income families.

And I'm honored to be able to share some of the activities and programs that we've been engaged in that we believe are making an impact on these families. Next slide, slide 13.

Officially what I'm going to be talking about is the concept that a lot of us have been working on, which is environmental support.

We understand and know that environmental support increases opportunities for low income families in particular, but families in general with children to eat healthy and move more.

And as Dr. May presented eating smart and moving more have a great impact on maintaining healthy weight.

Next slide, the childcare setting is definitely a critical one for addressing healthy eating and physical activity for young children preschool age.

And it is specifically supported by data here in Michigan. Nearly 400,000 Michigan children under the age of 6 need care while their parents work. So the work that we're doing is definitely supported by information that we have coming out of our state in particular.

And the program I'd like to talk to guys about is how we've been implementing the Nutrition Physical Activity Self-Assessment for Child Care.

Michigan began implementing this intervention in 2009. This particular intervention, also known as NAP SACC is designed to encourage childcare providers to assess their current practices and policies and relationship to national best practices to see how they measure up and then to use those results to make changes and meet goals that they may have.

In 2011 the Michigan Nutrition, Physical Activity, and Obesity Program that was funded by CDC partnered with the Early Childhood Investment Corporation here in Michigan.

The Early Childhood Investment Corporation (ECIC) is the implementing agency for the state's quality rating and improvement system as charged by the Michigan Office of Great Start.

So their position in early childhood development and in infrastructure for early childhood development made them a really ideal partner for the work we were doing.

And we believe that partnering with them will help us to spread the NAP SACC initiative to more children statewide.

Specifically the NAP SACC process has several steps. And you'll see that on slide 14 how these steps kind of work together.

With permission from the University of North Carolina Center for Health Promotion and Disease Prevention, the Michigan Department of Community Health updated and automated the original NAP SACC toolkit.

Now our online tool is based on NAP SACC and the *Let's Move* Childcare Checklist. However, we did go ahead and keep the process in place because the process is what really makes things work.

So the childcare provider begins with a self-assessment again with the purpose of taking a snapshot of their current practices and policies and measuring them up against national best practices to see how they measure up.

Now that we have the process online, the self-assessment results automatically feed into the action planning template and give the provider a list of actions for them to consider and take action on.

They can choose however, many they would like. Some childcare providers have chosen everything on the list. Others have been really, really strategic. Either way it works really well and it's paced by the provider.

All the way through the process providers in Michigan that are participating in NAP SACC have access to a trained NAP SACC consultant for targeted technical assistance. They get the technical assistance they need. Those that need more get more. Those that just need to touch base occasionally they can go ahead and do that. It's customizable.

The third step also includes training by way of NAP SACC workshops that work to engage staff and educate childcare staff on improving nutrition and increasing physical activity.

Last but not least, at the end of the process which usually doesn't last more than six months at a time the provider will repeat the self-assessment to see how they've made progress and in many cases to build a new action plan for additional goals.

Here in Michigan we have been able to engage and work with nearly 100 licensed child care centers impacting more than 7,000 low income children aged 5 years and younger so we're pretty excited about that.

Each participating center since 2009 has set and/or accomplished at least one goal to improve nutritional and physical activity. And examples of those goals may be self-serve drinking water throughout the day or limiting screen time.

Next slide, another critical setting has been in communities where Michigan has worked. Over eight years, the Michigan Department of Community Health funded 37 of 45 local health departments across the state to develop and

implement a strategic vision for each target community that they identified or that they were going to work with.

The goal of the Healthy Communities Project was to build communities where families have access to affordable fresh fruits and vegetables, opportunities for active transportation, tobacco free areas, and adequate and safe parks and trails.

This project was made possible through funding from the CDC Fund of Michigan, Nutrition and Physical Activity and Obesity Prevention Program, the Federal Recovery Act, and the Federal Nutrition Assistance Program.

This particular site demonstrates how we believe that community park improvements through healthy communities are impacting children from low income families.

There were many park improvements that took place over the eight years including a park upgraded with equipment to accommodate children with disabilities.

And we believe that these parks based on where they are located, have the potential to increase access to physical activity for approximately 4,800 children from low income families.

On the next slide I'll build a little bit on how this project improved access to affordable fruits and vegetables.

Nineteen farmers markets throughout the state of Michigan were enhanced with electronic benefit transfer machines and capabilities. And by doing so,

these farmers markets are able to accept nutrition assistance cards or SNAP for food stamp cards therefore attracting low-income families.

In addition to that local health departments through this project are now able to reach nearly 7,000 low income individuals every year across Michigan through cooking demonstrations, taste tests, and other nutrition education activities at farmers markets, but also at food pantries.

And this is a sustained low income families with children to make healthier lifestyle choices by these encounters.

On the next slide I'll talk a little bit about some of the things Michigan has learned through these projects.

Number one, partnerships are key. Dr. May actually alluded to this. In order to maximize impact state, nutrition and physical activity programs must form diverse partnerships across various sectors.

That's going to be education, early childhood development as I expounded on, transportation, local governments, community organizers, even faith-based organizations—very important partnerships.

An example of an important partnership is actually related to early childhood development. We have found that when partnering with experts and decision-makers in that field it's critical to actually find out where obesity prevention goals intersect with early childhood development priorities rather than trying to push obesity prevention as a new priority.

Second, building capacity in local jurisdictions does actually work. The Building Healthy Communities project here in Michigan created momentum for change.

Work continues in communities throughout the state implement the strategic visions that were developed in the project.

And last but not least policies make it stick. This is actually a quote from one of our NAP SACC participants at one of the childcare centers here in the state.

This particular provider was kind of trying to discuss and share what she experienced in her center. Centers that develop formal policies stand the best chance to meet or exceed best practices.

An example comes from some of our Head Start grantees that works with us. These grantees have been able to develop and implement agency-wide nutrition and physical activity policies, reaching nearly 4,000 children aged 3 to 5.

Examples of policies include commitments to age appropriate physical activity and breastfeeding support.

If you go to the end at the end of the day Michigan is working to make the healthy choice the easy choice for low income families with young children. And our work continues.

I'll now turn it over to Loretta Santilli from the New York State Department of Health.

Loretta Santilli: Great. Thank you Lonias. Good afternoon everybody and good morning those that are west coast participants as well. Thank you all for taking some time out of your day to listen in.

I'm here as the director of the Division of Nutrition here in the New York State Department of Health.

But I'm just one voice behind really a larger group of staff, both in our Division of Nutrition as well as our Division of Chronic Disease Prevention and the other state and local partners who have worked side by side with us for many years on these coordinated efforts. So I'm grateful to be the one voice sharing this great work with you this afternoon.

So I'm going to be talking about the New York State efforts. And my present station starts at slide number 25 on the coordinated CDC slide stuff.

And then flipping to our first content slide, why do we care? We're preaching to the choir here. You wouldn't be on this call if you didn't understand already that children really are a precious resource. And we have to make sure that we maintain their ability to grow into healthy adults.

As the data are showing, you know, the trend is finally starting to reverse. If we were not able to reverse this trend for the first time we may see our children facing a shorter lifespan than their parents.

You know, as a mom with two kids myself, that's very concerning. We want our kids to do better than we did. And having a shorter lifespan is just not acceptable.

When you talk about the economic costs Dr. May in the opening presentation talked about the health care costs.

In New York State we're looking at \$11.8 billion each year. So, childhood obesity, it turns into, you know, healthcare costs that are really exorbitant.

And we really can't manage a population where 1/3 of our children here in New York State are overweight or obese. We need to do something about it.

So what are we doing about it? Turning to the next slide 27, we've been responding to these rising obesity rates with a coordinated effort for years, since the mid-90s. It's been a team effort starting really at the state level.

We're really looking at the system and policy changes that can be implemented. But then we have to then push those down to the local level. That's where the rubber meets the road, those local, multifaceted interventions that are implemented are really where the action occurs.

It also needs to be cross sector coordination and partnerships. You've heard that a couple a times already. Partnerships are absolutely key.

With many of the agencies whether it be early child care, education, the schools, home, working with our families, and the community where we work, where we play, where the healthcare environment and the hospitals and our prevention, health care providers as well.

And we can't forget about evaluation of performance improvement. We're so busy doing all of these great things, but we have to stop also and evaluate what we're doing, look at what we can do better, build our evidence base.

We want to invest in the things that we know are working and we want to make sure we then keep those going, making them sustainable for the future.

Next slide 28 is a public health practitioner at the core. Prevention is the best cure for anything. So when we talk about some of the New York State obesity prevention strategies we look at some specifics like supporting those healthy food and beverages choices in particular the consumption of the low-fat nonfat milks, fruits and vegetables, and whole grains.

From a clinician perspective it's all about ins and outs. What do your eyes and nose? So you want healthy in and you want lots out.

So on the inside we also want to look at supporting or breast-feeding. That's the earliest food for our littlest people and supporting breast-feeding initiation and exclusivity and duration is critical.

On the outs we're looking at the physical activity. We want to get the kids moving more and limiting those sedentary activities. The electronics definitely rule our children's world so we have to limit that screen viewing and go from there.

And it really needs to be both that coordinated systems as well as that human behavior change perspective across all those environments.

Next slide number 29, you guys all have the slide sets and if not I encourage you to retrieve those. I'm going to go through some examples but given the limited time I'm not going to cover everything on the slides. But I do want to do some of the highlights.

So the next few slides I'll do in rapid fashion and you can always follow-up later if you would like more detail about any of the initiatives that I mention here.

First is our CACFP program. This is our federal meal reimbursement program, \$213 million here in New York State serving 14,000 day care centers sites, 330,000 nutritious meals and snacks to our low income children.

One of the key interventions here is in 2010 we implemented a healthier meal pattern that went above and beyond the national CACFP standard. So we continue to raise the bar above where some of the national standards are.

Next slide number 30, also in our child care environment is our well play hard and childcare settings initiative.

This is a nationally recognized practice tested intervention that looks at improving the nutrition and the physical activity practices in the places where these low-income children are cared for.

We did a very robust evaluation of this program and we found significant increases in the amount of consumption of vegetables by children.

And it crossed over into homes. So not only were they consuming it in their place where their childcare but at home as well.

And because it involved the families and the parents they were reporting child initiated vegetable snacking and parents offering vegetables to the children at home was also increased.

So we've taken what we've learned with the childcare settings and we've modeled a day care home initiative after that success so that again we can continue to expand and sustain these efforts.

Slide number 31 is on the NAP SACC program and I know Lonias has covered that in great depth. Just to give you an idea of impact here in New York we've implemented it in 254 childcare centers reaching more than 11,000 children and 2,200 plus staff.

And again as she mentioned about those policies the policies that were written, that's where we were that's where we showed two to three years later those practices were still sustained in those childcare environments.

The next slide 32 focuses on our WIC program. This is also a federal program in New York State \$550 million program.

This provides the supplemental nutritious food information on the healthy eating and referrals to healthcare to more than a half 1 million low income women infants and children here in New York.

In fact 50% of all of the infants born in New York State are participating in WIC, so we have quite the catchment there.

The next slide, slide 33 I want to highlight two WIC interventions in particular. One was in 2009 New York was the first state in the nation to revamp its food packages.

And what it really did was reflect the latest science on what a healthy diet looks like according to those dietary guidelines for Americans.

We also implemented a WIC Healthy Lifestyle Initiative which is we call it Thick WIC, Fit WIC here in New York State—that's a mouthful, which is really a fun low-cost education approach to increase physical activity through our local agencies, our local WIC agencies so those two are just to highlight some of the WIC interventions.

Slide number 34 we would be remiss to talk about comprehensive obesity prevention without focusing a little bit on those breast feeding support activities.

Again all of our activities are designed to increase the initiation duration and exclusivity of breast-feeding.

And again we look at this from all of our programs whether it be WIC, or CACFP or in our hospitals or in the community or in the working population. We really need to focus this and support those new mothers in every way possible.

From the WIC side we designed the breast-feeding specific food packages. We support through peer counseling programs so mother to mother.

We have breast-feeding coordinators in each of our local agencies. We provide breast pumps as needed and we really support that working mom with the Making it Work Toolkit.

We also have child care friendly designations for some of our CSCS CACFP participants and we have breast-feeding quality improvements in hospitals including the breast-feeding friendly hospital designation as well.

So there's a tremendous amount of effort on this particular topic area.

All of the things that we're talking about would not be possible when done in isolation. Slide 35 hones in again on that partnership.

In particular one of the examples that we like to highlight about our partnerships is in that early child care environment. The Obesity Prevention and Childcare Partnership was affiliated with our New York State Early Childhood Advisory Council.

And it really provided us the ability to advance the adoption of the obesity prevention practices in childcare settings.

So we were able to see and move the childcare regulations to include higher standards in the nutrition physical activities, screen time, breast-feeding and in New York State's childcare quality rating improvement system.

This work is not done. There's a lot more we can continue to do but without those partnerships we would not have gone as far as we have for now.

Slide number 36. So how are we doing? We have all of these activities going around - going on around the state from all different sectors. Is it making a difference?

For those of you looking at the slides this is a great graphic that really show the trends in obese children ages 2 to 4 participating in our WIC program.

And I really like this graphic because it highlights the differences between some of our racial and ethnic groups.

This particular graphic shows that children of Hispanic origin really have the highest percentages followed by black children and then white children.

But their patterns and their trends are very similar with from 1990 to 2010 the graphic shows the increase and some stabilization right around 2003.

And then finally we're starting to see the reversal of the trend kind of turning that corner.

But we can't really look at all of our kids in one lump. We really have to think about them and approach it differently based on those racial disparities.

Slide 37 we are reversing the trend. We are starting to see the fruits of our labor. Some data points to share with you for New York State. Children 2 to 5 years participating in WIC we saw the percentage of children that were obese decrease about 14% from 2003 to 2011.

So to count kids when we look at our low-fat consumption of milk in 2009 66.4% it went up to to 69.4%. So that's almost 7,000 more kids drinking better milk. You start counting heads. I think that helps put it into perspective.

Looking at it from the breast-feeding initiation range we've gone up from 72% in 2008 to 79% in 2012. So again these are just, you know, picking and choosing some of the data points. There are many others that we can use.

What are our lessons learned? First and foremost we cannot again work in isolation. Those isolated initiatives although they may be great conceptually and they may have an impact, you know, in their small local area they are not sufficient in and of themselves to really tackle the widespread issue of childhood obesity.

What we really need to do is engage the state agencies in establishing those obesity prevention practices and standards and then we that also have to monitor the performance. We have to make sure it's working.

We have to implement those strategies at the local level, so nutrition, physical activity screen time and breast-feeding interventions we know will promote and support those practice improvements across all types of settings.

And we have to support those partnerships, okay? By building those partnerships we can make sure that they are sustained best practices over time.

One of the quotes that I like is alone we can go fast but together we can go farther. And I think when we're talking about childhood obesity prevention we need to go farther.

So that's the pieces that I want to share with you formally. I think at this point I'll pass it back over to Dan for our Q&A session.