

Bill as Introduced

HB 1479-FN - AS INTRODUCED

2010 SESSION

10-2319

04/01

HOUSE BILL **1479-FN**

AN ACT requiring that body mass index be assessed in all pupils in grades one, 4, 7, and 10.

SPONSORS: Rep. Schulze, Hills 26; Rep. Stiles, Rock 15; Rep. French, Merr 5; Rep. Hogan, Hills 25; Rep. Pilliod, Belk 5; Sen. Hassan, Dist 23

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill requires body mass index be assessed in all pupils in grades one, 4, 7, and 10 who have not opted out for religious reasons.

This bill is a request of the commission on the prevention of childhood obesity established by 2008, 219.

Explanation: Matter added to current law appears in ***bold italics***.
 Matter removed from current law appears [~~in brackets and struckthrough.~~]
 Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT requiring that body mass index be assessed in all pupils in grades one, 4, 7, and 10.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 New Section; School Health Services; Body Mass Index Assessment. Amend RSA 200 by
2 inserting after section 32 the following new section:

3 200:32-a Body Mass Index Assessment.

4 I. In addition to the requirements of RSA 200:32, the school nurse of every school shall
5 conduct a body mass index assessment for all pupils in grades one, 4, 7, and 10 who have not opted
6 out pursuant to paragraph II. The assessment shall not include the pupil's name, address, phone
7 number, date of birth, social security number, or any other personally identifiable information about
8 the pupil. The results of the assessment shall be provided to the school board, the school
9 administrative unit superintendent, and to the department of education. The school shall retain the
10 assessment results as part of the pupil's school health record. The school shall furnish a copy of the
11 assessment results to the parents or legal guardians of the pupil.

12 II. No body mass index assessment shall be required of a child whose parent or guardian
13 objects thereto in writing on the grounds that such assessment is contrary to the child's religious
14 tenets and teachings. The school shall develop a form allowing a parent or legal guardian to opt out
15 of the body mass index assessment for religious reasons.

16 2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
10-2319
Revised 10/30/09

HB 1479-FN - FISCAL NOTE

AN ACT requiring that body mass index be assessed in all pupils in grades one, 4, 7, and 10.

FISCAL IMPACT:

The Department of Education states this bill may increase local expenditures by \$86,261 in FY 2010, \$90,574 in FY 2011, \$95,103 in FY 2012, \$99,858 in FY 2013, and \$104,851 in FY 2014. There will be no fiscal impact on state, county, and local revenue or state and county expenditures.

METHODOLOGY:

The Department of Education states this bill requires school nurses to annually assess the body mass index of every student in grades one, four, seven, and ten who have not opted out for religious reasons. The Department states a survey of school nurses in 2009 indicates approximately 50% of school nurses annually record height and weight for certain grades, and 21% of those recorded are converted to body mass index. The Department assumes 50% of students in the grades identified will be impacted by this bill. There are currently 60,534 students in the grades identified; therefore, an estimated 30,267 will be impacted. The Department assumes 5 minutes per student will be required to record height and weight, calculate body mass index, and communicate with parents. The Department states the average school nurse salary is \$47,000, or \$0.57 per minute. The Department estimates the cost to local school districts to implement the requirements contained in this bill will be \$86,261 in FY 2010 (30,267 students X 5 minutes per student X \$0.57 per minute). The Department estimates the annual cost to local school districts will increase by 5% in subsequent school years, for estimated costs of \$90,574 in FY 2011, \$95,103 in FY 2012, \$99,858 in FY 2013, and \$104,851 in FY 2014.

Amendments

Amendment to HB 1479-FN

1 Amend the title of the bill by replacing it with the following:

2

3 AN ACT requiring that body mass index be assessed for pupils in grades one, 4, 7, and 10.

4

5 Amend the bill by replacing all after the enacting clause with the following:

6

7 1 Statement of Purpose. The general court recognizes that childhood obesity is increasing at
8 exponential rates and that there are physical, educational, and financial costs to society. Before any
9 recommendations for community action are suggested, the general court finds that it is important to
10 have actual baseline data to better understand the extent of the problem in New Hampshire.

11 2 New Section; School Health Services; Body Mass Index Assessment. Amend RSA 200 by
12 inserting after section 32 the following new section:

13 200:32-a Body Mass Index Assessment.

14 I. In addition to the requirements of RSA 200:32, each school district shall take the height
15 and weight measurements for all pupils in grades one, 4, 7, and 10 and shall calculate the pupil's
16 body mass index (BMI) score using age appropriate BMI-for-age weight status categories as
17 determined by the Centers for Disease Control and Prevention. The school district shall group the
18 aggregate BMI data as follows and shall forward such data to the department of education not later
19 than the school district's end of year reporting date:

20 (a) The number of pupils that are below the 5th percentile.

21 (b) The number of pupils that are between the 5th percentile but less than the 85th
22 percentile.

23 (c) The number of pupils that are between the 85th percentile but less than the 95th
24 percentile.

25 (d) The number of pupils that are equal to or greater than the 95th percentile.

26 II. The pupil's name, unique pupil identifier, or other personally identifiable information
27 shall not be attached to the BMI data forwarded to the department of education.

28 III. The parent or legal guardian of a pupil may request an exception from participation in
29 the BMI assessment in accordance with school district policy.

30 IV. Any individual pupil information recording or reporting process shall be at the discretion
31 of the school district.

32 3 Effective Date. This act shall take effect 60 days after its passage.

2010-0671h

AMENDED ANALYSIS

This bill requires body mass index be assessed for pupils in grades one, 4, 7, and 10.

This bill is a request of the commission on the prevention of childhood obesity established by 2008, 219.

Rep. Stiles, Rock. 15
February 12, 2010
2010-0671h
04/10

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8 exponential rates and that there are physical, educational, and financial costs to society. Before any
9 recommendations for community action are suggested, the general court finds that it is important to
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Amendment to HB 1479-FN
- Page 2 -

2010-0671h

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This bill is a request of the commission on the prevention of childhood obesity established by 2008, 219.

Speakers

Hearing Minutes

HOUSE COMMITTEE ON EDUCATION

PUBLIC HEARING ON HB 1479-FN

BILL TITLE: requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.

DATE: January 27, 2010

LOB ROOM: 207 **Time Public Hearing Called to Order:** 11:00 AM

Time Adjourned: 12:50 PM

(please circle if present)

Committee Members: Reps. Rous, Reever, Veaton, Clarke, B. Shaw, K. Shaw, J. Day, O'Neil, Burke, P. Harvey, P. Price, Ingretson, Stiles, K. Hutchinson, Boehm, Laurent, B. Ward, Fleck and Ladd. Casey

Bill Sponsors: Reps. Schulze, Hills 26; Stiles, Rock 15; French, Merr 5; Hogan, Hills 25; Pilliod, Belk 5, Sen. Hassan, Dist 23

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

***Representative Joan Schulze, prime sponsor – supports.** See written testimony. This bill is the result of the Commission to Prevent Childhood Obesity.

***Representative Nancy Stiles, co-sponsor – supports.** See written testimony. She is the Vice Chair of the Obesity Commission.

Representative Barbara French, co-sponsor – supports. She was a school nurse. The information is already entered on the students' record. Obesity has become a bigger and bigger problem. As a nurse she dealt with personal image. Nurses can help work with their students. Rarely was the concern from the parents. Could a teacher look at the health records?

Mark Joyce, NHSBA – opposes. Opposes on behalf of NHSBA. Suggestion:

1. Thinks the cost impact is even more than indicated on the FN.
2. Parents and students have more than religious concerns about this, it could be an invasion of personal rights – it's different than vision and hearing – vision and hearing are crucial to learning. It is a privacy matter.
3. Concerns about privacy and use of records. FERPA has to have good reason for keeping records. What will historic record keeping be? Maybe it could be sampling statistics from physicians.

***Katherine Rannie, NHDOE – supports.** See written testimony. The DOE already recommends this.

Elyse Alkaly, Nashua, NH – opposes. She said the BMI number is wrong in terms of her child. She feels that while it says the child is “fat” he is not. Age may skew the figures. It will follow the child forever if in the file. His has objections to that. Should look at food and drink at elementary schools and water should be available.

Mary McGowan, M.D., Foundation for Healthy Communities – supports. BMI is a validated assessment and is adjusted for age and gender. Physicians need to be educated. We need to do this because kids who are truly obese will miss school, so this test is necessary for educational purposes of being in school. We need to educate our communities about this. She does recommend family physicians get BMI but might be harder for them to input data. Sampling data might not be reasonable. She said it is good for looking at groups – not necessarily for individuals.

Beth Corwind, Keene School District SAU 29 – supports. There is a success story from the wellness policy at SAU #29. A fitness gram assessment is used. BMI is one part of fitness gram. Fitness gram is positive. Schools feel they have role and responsibility in community health.

Susan Carr, NHAHPERD and teachers at Souhegan High School – supports. She is in favor of the bill because it will help with overall education. She doesn't think records are shared. There would not be an additional fee.

***Nancy Pederzini, American Heart Association – supports.** See written testimony. BMI is a good surveillance tool. We need the data to determine the trends. It is a great first step. Cardiovascular deaths are linked to obesity.

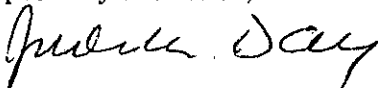
Lisa Kent, NHAHPERD – supports. She has no belief that this will relieve the problem but it will help. It allows for intervention if necessary – not meant to be a way to label children.

Lisa Morris, Lakes Region Partnership for Public Health – supports. They are looking for data by town, county and state. This will help engage schools.

***Shawn LaFrance, Executive Director, Foundation for Healthy Communities – supports.** See written testimony. Many children in the welfare program are obese.

***Peter Ames, American Cancer Society – supports.** See written testimony. We have to attack the obesity problem. One third of cancers are associated with obesity.

Respectfully submitted,



Representative Judy Day, Acting Clerk

HOUSE COMMITTEE ON EDUCATION

PUBLIC HEARING ON HB 1479-FN

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DATE: 1/27/2010

LOB ROOM: 207

Time Public Hearing Called to Order: 11:00

in audience Time Adjourned: 12:50

(please circle if present)

Committee Members: Reps. Rous, Reeve, Yeaton, Clarke, B. Shaw, K. Shaw, J. Day, O'Neil, Burke, P. Harvey, P. Price, Ingretson, Stiles, K. Hutchinson, Boehm, Laurent, B. Ward, Fleck and Ladd.

Casey

Bill Sponsors: Reps. Schulze, Hills 26; Stiles, Rock 15; French, Merr 5; Hogan, Hills 25; Pilliod, Belk 5, Sen. Hassan, Dist 23

Judy Day

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

- * ① ^{Rep} Joan Schultz - prime sponsor supports Result of Commission to Prevent Childhood Obesity. (written testimony)
- * ② Rep Nancy Stiles supports (written testimony) vice chair of Obesity Commission
- ③ Rep Barbara Freund (supports) School Nurse 1963 ... Info already entered on students record - Obesity became a bigger & bigger problem - ~~Nurse~~ As a nurse she dealt with personal info. Nurses can help work with these students Rarely was the concern from parent - Could a teacher look at the health records?

④ - Mark Joyce - Opposes bill on behalf of NHSBA -

Suggestion - ① Thinks is cost impact even more than indicated in FN

② Parents + students have more than religious concerns about this could be an invasion of personal rights -- different than vision + hearing - vision + hearing are crucial to learning (privacy matter)

③ Concerns about privacy + use of records FERPA has ^{to have} good reason for keeping records. What will historic ~~be~~ record keeping be? maybe could be sampling statistics from physicians

*
⑤ Katherine Rannie - DOE - supports bill. DOE already recommends this (written testimony)

⑥ ~~Alice~~ Elyse Alkaly - Opposes on behalf of self - said BMI Number is wrong in terms of her child - She feels that while it says the child is "fat" he is not Age may screw figures. Will follow child forever if in file. His objection to that. ~~No~~ should look at food + drink at elementary school should be water available

⑦ Dr. Mary McGowan - supports - BMI is validated assessment & is adjusted for age + gender Physicians need to be educated

HB 1479 - FN

(3)

Represents NHAH PoRD and teachers
Souhegan High School

(7) (Continued) Need to do this because kids who are truly obese will miss school, so this test is necessary for educational purposes of being in school. We need to educate our communities about this. She does recommend family physicians get BMI but might be harder for them to input data. Sampling data might not be reasonable.

She said good for looking at groups - Not necessarily for individuals

(8) Beth Corwin - supports bill - Success story from wellness policy in SAU #29. Fitness gram assessment is used. BMI is one part of fitness gram. ~~Positive~~ Fitness gram is positive. Schools feel they have role + responsibility in community health.

(9) Susan Carr - supports - in favor of bill because will help with overall education. Doesn't think needs are shared. Would not be an additional fee - 1

* Written testimony

~~10~~ (10) Nancy Pederzini - Heart Asso.
in support of bill. BMI is a
good surveillance tool - Need
data to determine trends

(11) Great first ~~step~~ Step
Cardiovascular deaths linked
to obesity

NH AAPERS (11) Lisa Kent ^{supports} has no belief this
relieves problem but it will
help. Allows for intervention
if necessary - Not meant to be
a way to label children.

(12) Lisa Morris Lakes Region
Partnership for Public
Health. Supports bill.
Looking for data by town,
~~City~~ County + state - This will
help engage schools

* (13) Shawn LaFrance - Foundation
for Healthy Communities
Supports. ~~Leaves~~ many
children in welfare program
are obese (see written testimony)

(14) Peter Arnes - American Cancer Society
Supports - we have to attack obesity
problem 1/3 ~~new~~ of cancer asso. with obesity.

Sub-Committee Actions

HOUSE COMMITTEE ON EDUCATION
SUBCOMMITTEE WORK SESSION ON HB 1479-FN

BILL TITLE: requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.

DATE: February 9, 2010

Subcommittee Members: Reps. K. Shaw, C. Clarke, N. Stiles, R. Ladd, K. Casey

Comments and Recommendations:

Amendments:

Sponsor: Rep.	OLS Document #:
Sponsor: Rep.	OLS Document #:
Sponsor: Rep.	OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. R. Ladd

Seconded by Rep. C. Clarke


Vote: 3-2

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Kim Shaw
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON EDUCATION
SUBCOMMITTEE WORK SESSION ON HB 1479-FN

BILL TITLE: requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.

DATE: 2/9/2010

Subcommittee Members: Reps. Kim Shaw, Claire Clark, Nancy Stiles, Rick Ladd, Kim Casey

Comments and Recommendations:

Amendments:

Sponsor: Rep.	OLS Document #:
Sponsor: Rep.	OLS Document #:
Sponsor: Rep.	OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Ladd

Seconded by Rep. Clarke

Vote: 3-2

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep.
Subcommittee Chairman/Clerk

Kim Shaw

sub comm 2/9/10

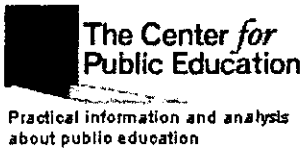
February 08, 2010

EMAIL PAGE PRINT PAGE TEXT SIZE + -

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- Corporate Partners



States weigh idea of BMI reports as they tackle obesity epidemic

By Carol Chmelynski

3/15/05 -- As school and health officials become increasingly concerned with tackling the obesity epidemic, a growing number are turning to the idea of reporting children's body mass index to parents. A handful of states have even flirted with the idea of adding the BMI on report cards.

In 2003, Arkansas -- where 38 percent of children are overweight or at risk of becoming overweight -- became the first state in the nation to make school weigh-ins a state law and mandated that parents be sent an annual report stating their child's BMI. The reports also explain what the BMI means, the health effects associated with obesity, and ways to combat the problem.

Similar proposals have surfaced in Georgia, Texas, and other states.

BMI is a measure of body fat based on height and weight. It is calculated by dividing weight (in kilograms) by height (in meters) squared. For children, appropriate BMI ranges change by age and gender.

These ranges are plotted on a standard growth curve to obtain a percentile ranking for each child. Children whose BMI is between the 85th and 94th percentile are considered to be at risk of being overweight. Children whose BMI is above the 95th percentile are considered overweight. (The term obese is not generally used for children.)

In Arkansas, the original law called for schools to include BMI information on school report cards, but in a special session in 2004, legislators modified the law to require that the information be mailed to parents separately in letters.

The Arkansas Center for Health Improvement -- a health policy research center sponsored by the Arkansas Department of Health, the University of Arkansas for Medical Sciences, and Arkansas Blue Cross Blue Shield -- coordinates and funds the effort to calculate the BMI of the state's 450,000 students.

Joy Rothenbach, director of the center's BMI initiative, says schools send students' height and weight information, and the center calculates the BMI and sends reports to parents.

In Georgia, state Rep. Stephanie Stuckey Benfield introduced a bill last month to require schools to calculate students' BMI and list it on report cards. But she dropped plans to pursue the measure after receiving angry e-mails and phone calls.

The most legitimate complaints concerned potential harm to students' self-esteem, Benfield says. "That was certainly never my intent, but I'm sensitive to that." She plans to continue to work on childhood obesity in Georgia, where an estimated 37 percent of the state's schoolchildren are overweight.

Previously, Georgia legislators have tried and failed to ban soft drink machines in schools, require recess, and add physical education classes.

In Texas, state Sen. Leticia Van de Putte filed a bill in January that would require schools to measure children's BMI and send the information home to parents. She considered but rejected the idea of having BMI added to report cards.

In recent years, Texas lawmakers restricted student access to vending machines, banned deep-frying of food and candy sales in schools, and made daily physical education mandatory for elementary students.

Legislation also has been introduced in Connecticut, Iowa, New Jersey, New York, Oregon, and Tennessee to require or encourage schools to measure students' BMI, says Amy Winterfeld, spokesperson for the National Conference of State Legislatures

Some school administrators balk at the extra burden and expense of mandated health procedures. For example, the cost of postage alone to send separate first-class letters to the homes of all Arkansas students is \$166,500.

The entire Arkansas program cost just over \$1 million the first year, says Rothenbach, including state funds and grants from private sources. The program will cost only about a third of that next year.

There also have been complaints that BMI reports are intrusive, embarrassing to students, and a waste of time. And there is no evidence that BMI reports are effective.

"There is no consensus in the health community on the value of BMI testing," says Brenda Greene, director of school health programs at NSBA. "Data is good to have, but BMI testing is only one part of the solution."

"If schools have that but don't change their food services, nutrition education, and physical education opportunities, and the environment in families and the whole community doesn't change," she says, "then what's the point of this data?"

But others say school is the most logical place to begin to address the obesity crisis because schools already test vision and hearing and a document from school has credibility. Perhaps most compelling is the argument that it is in schools' best interest to have healthy children.

"Students with poor nutrition, inactivity, and weight problems have a higher prevalence of physical conditions and psychological/ social problems that are frequent causes of absenteeism," says *The Learning Connection*, a report by Action for Healthy Kids, a partnership of more than 40 national organizations and government agencies, including NSBA.

Sixteen percent of school aged children, or nine million, are overweight, and that figure has risen threefold since 1980, the report states. Between 70 and 80 percent of overweight children and adolescents remain overweight or become obese adults.

Being overweight can contribute to elevated cholesterol and blood pressure, which are risk factors for heart disease, gallbladder disease, asthma, sleep apnea, and diabetes.

The Centers for Disease Control and Prevention estimates that if current obesity trends continue, one-third of all children -- and one half of African American and Hispanic children -- born in 2000 will develop diabetes.

Rothenbach says, when Arkansas began BMI testing, "We were not quite aware of all the ramifications. It created a dialogue around the state -- both good and bad."

"For the first time, we have data that says we are heading toward some very bad health problems for the children of our state," she says. "Already we have schools that are beginning to implement policy and program changes, and we will have something that we can bring back to them over time to tell them if their changes are working." And she's heard from parents, who say they are eating healthier and exercising together.

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Sub comm 2/9/10

Massachusetts Department of Education

Mass In Motion

To: Superintendents of Schools, Charter School Leaders and Other Interested Parties
From: Mitchell D. Chester, Ed.D, Commissioner of Elementary and Secondary Education
John Auerbach, Commissioner of the Department of Public Health
Date: January 22, 2009

Almost every new year begins with resolutions by millions of people to eat healthier and exercise more. Yet it would seem that most such commitments end up falling short since we have seen an unprecedented increase in the percentage of overweight children and adults in our state and around the country. At present more than half of the adult population is overweight as are at least 15% of high school students - and the trend toward higher weight is increasing! The consequences of this "epidemic" are serious. Type 2 diabetes is almost twice as prevalent in Massachusetts as it was just a decade ago. And overweight and obesity are contributing to numerous other chronic conditions including heart disease, some cancers and arthritis. The causes are clear. Not enough exercise. Too much time in front of the television and computer screens. Not enough fruits and vegetables. Too much unhealthy junk food. School nurses around the state report they are seeing children with Type 2 diabetes and other obesity-related conditions in record numbers. Clearly something needs to be done.

For these reasons, we are pleased to announce a new and exciting multi-faceted statewide campaign led by the Massachusetts Department of Public Health (DPH) to promote wellness and combat obesity called **Mass In Motion**. We encourage you to support this important effort which will have a number of components that focus specifically on schools and school-aged children. Among the activities that will be launched in January 2009 are:

- A statewide wellness public information campaign involving Governor Deval Patrick and other "champions";
- An interactive website directed to parents and caregivers, worksites, and communities (including schools) that complements the information campaign (see www.mass.gov/massinmotion);
- Proposed regulations that require Body Mass Index (BMI) screening in schools and reporting to parents to identify the weight status of children;
- Proposed menu labeling regulations that require fast food restaurants to post information on the nutritional content of the foods they offer;
- An executive order that will require state agencies purchasing large quantities of food to follow specific nutritional standards;
- The expansion of a successful DPH worksite wellness program to new worksites; and

- The release of a RFR for municipalities that will support active living and healthy eating.

There are numerous ways to support this effort within your school district, including:

Support the efforts to collect Body Mass Indexes (BMI) for school children and share the information with parents* (along with low-literacy and multi-lingual explanatory information and useful links to resources). The state's Public Health Council will likely pass a regulation in the coming months that requires that schools measure BMIs for first, fourth, seventh and tenth graders. **The BMI can be easily calculated using existing data - namely, height and weight - that the schools already have. This regulation was developed with input from school nurses. It decreases some of the current mandated screening activities so as not to overload the nurses (and Essential School Nurses contracts will be adapted to include this as a core contractual activity). The experience from other states that have similar regulations is that school superintendents are key in how successful this process is.

**Work with your mayor or other local elected officials to draw attention to the importance of school meals and physical activity programs* - A growing number of mayors and local elected officials are making fitness a priority by mobilizing local departments and managers to adapt their current practices to encourage healthier eating habits and exercise. We believe that school leaders should be in the forefront of such initiatives. To further promote this movement DPH is joining with 5 foundations and Blue Cross/Blue Shield to create a "Mass in Motion City and Town Planning and Implementation" grant program to help local elected officials with activities of this kind.

**Increase the attention paid to the implementation of school wellness plans:* The federally-mandated wellness plans that schools have developed provide insight into what can be done to help combat obesity. Many school districts have already taken impressive steps to make school meals more nutritious and improve the foods sold in vending machines on school grounds. Continued attention to the successful implementation of wellness policies that encourage healthy eating and daily physical activity, including quality physical education programs, will enhance school environments and encourage optimal health and learning among Massachusetts youth.

Your support for efforts to promote wellness among the school children in your district is not only important to improve their health. There is a growing body of evidence that kids with healthy diets and sufficient physical activity do better academically. Therefore, please join us in endorsing **Mass In Motion** and becoming active in supporting the expansion of efforts to create conditions that optimize our children's health.

Last Updated: January 23, 2009



BMI Initiative

Introduction

In 2003, the Arkansas General Assembly passed and Governor Mike Huckabee signed into law Act 1220. This is a multi-pronged initiative with one goal in mind: to improve the health of Arkansas children.

One component of this act focuses on measuring and reporting the Body Mass Index of each child to their parents or guardians.

Description, History, and Current Activities

Act 1220 mandates that parents shall be provided with an annual Body Mass Index (BMI) by age of their child, as well as an explanation of what BMI means and health effects associated with obesity.

The Arkansas Child Health Advisory Committee, a committee mandated by the Act and charged with making recommendations on the implementation of Act 1220, decided that parents will receive information regarding their child's BMI on a confidential health report. Reports such as these are recommended by the American Academy of Pediatrics for all children every year.

ACHI was asked to take the responsibility of developing and implementing standardized statewide BMI assessments and reporting. This information will provide parents with important knowledge regarding any health risks their child may incur as a result of being overweight or underweight. To accomplish this, ACHI put together a BMI Task Force in partnership with local school districts, the Arkansas Departments of Education, the Department of Health and Human Services, staff from the Arkansas Children's Hospital, and the UAMS College of Public Health. The BMI Task Force developed a timeline and a strategy for implementation.

Year one (2003-04) was carried out in three phases. Eleven schools volunteered to work with ACHI staff to organize an assessment day, share necessary information to accurately calculate BMI on each child, record height and weight data, and send home a confidential child health report to parents. Comparison testing on assessment equipment was done at nearly every school with multiple measures being taken. The BMI Task Force wanted to be able to recommend quality equipment at the best possible price should schools wish to purchase any equipment to complete assessments. The tested strategy was then rolled out statewide.

Year two (2004-05) continued with BMI collection using paper assessment forms that were processed through a data entry center. Schools received child health reports to print and disseminate to parents by using their unique password on a secured web system. Two school districts also piloted a web-based entry system for collecting heights and weights. One school district used Pocket PCs' while another collected heights and weights and entered directly into the web program.

Year three (2005-06) expanded the technology component to 16 school districts where over 130,000 students were entered into the new web-based entry system. Some schools chose to enter heights and

weights from paper records but many set up computers at their assessment stations to collect BMI data and enter directly into the web-based system. Reports were then ready to be generated.

Year four (2006-07) included a statewide rollout of the web-based entry system. All schools were trained to use this technology. It eliminated the need to print forms, package and send to a data entry center, or wait for report generation.

Important community resources for the Task Force and school personnel have been Community Health Nurses, one of whom is placed in each educational co-op. These nurses were certified by experts in height and weight research measurements at Arkansas Children's Hospital. They, in turn, trained school health nurses and any other school personnel responsible for assessment in the appropriate methods to collect assessment data. These same Community Health Nurses were trained to be trainers of the web-based data entry system.

Guiding Principles for BMI Reporting in Children & Adolescents When Performed in a School Setting

- BMI assessment is a health screening tool like vision, hearing or scoliosis screenings routinely performed in public schools
- All students should be assessed – no one singled out
- Confidentiality should be maintained in measuring and reporting:
 - Scale should be located in a private setting
 - The child should be asked to step on the scale backward and not told his or her weight; results should be recorded non-verbally
 - If a child's weight is more than the scale will measure, "exceeds scale" should be recorded with no comment made to the child
 - Confidential Child Health Report should be sent directly to, or picked up by, a parent or legal guardian; the report should not be given to the child.
- Confidential Child Health Reports are a health advisory tool for parents – not a grade or report card. They should be sent to parents of all students to advise parents if their child is underweight, healthy weight, at risk for overweight or overweight and should include:
 - An explanation of BMI and the child's assessment
 - Recommendations for a healthy lifestyle
 - Recommendation to discuss questions or concerns about the child's health report with the child's physician

Resources

University of Arkansas for Medical Sciences, Fay W. Boozman College of Public Health, Year Three Evaluation: Arkansas Act 1220 of 2003 To Combat Childhood Obesity, 2006

Sample Confidential Child Health Reports

Arkansas Department of Education's Rules Governing Body Mass Index for Age Assessment Protocols in Arkansas Public Schools

Obesity in Arkansas: From Contemplation to Action, the 2002 Arkansas Preventive Nutrition and Physical Activity Summit, *Journal of the Arkansas Medical Society*, February 2004

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Year Two Evaluation
Arkansas



Act 1220 of 2003
to Combat Childhood Obesity

University of Arkansas for Medical Sciences

Fay W. Boozman
College of Public Health

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BMI Measurement

Opinions of parents Interviews of parents in 2005 indicated that 71 percent remembered receiving a BMI report from the school. Of those, 95 percent indicated that they had read at least some of the report, and approximately 67 percent said that the report had been helpful in some way.

The majority of parents (71% in 2005; 69% in 2004) continued to be confident of the confidentiality of the reports and comfortable with the idea of receiving a BMI report from the school (65% in 2005; 70% in 2004).

Opinions of adolescents In interviews in 2005, a similar percentage of adolescents (61%) indicated comfort with the idea of their parents getting a BMI report from school as in the previous year (63%). This indicates that the majority of students had a comfortable experience with the measurement and reporting process.

Adolescents continued to be comfortable with the confidentiality of the process (91% in 2005; 90% in 2004). Only 12% of students indicated that they were embarrassed at all by having the measurements taken.

Opinions of school personnel As noted, school nurses reported that the height and weight measurements of students generally proceeded more smoothly in the 2004-2005 school year.

They did report, however, some continued frustration with logistics and a perceived lack of communication and planning among the Division of Health, Arkansas Center for Health Improvement, and the Department of Education.

In responding to the 2005 surveys, 74 percent of principals and 71 percent of superintendents reported no real problems with BMI measurements. Of those who did report problems, the most common were logistics, time away from academic instruction, and negative feedback from parents.

School personnel continue to question the value and necessity of BMI measurements and reports to parents. Some question the validity and accuracy of the body mass index itself. Others interviewed believed that weight issues are best dealt with by physicians and that the school was an inappropriate setting for such measurements.

A common theme in interviews was a description of a number of parents who complained about the BMI measurements. School personnel reported that parental responses to the BMI measurements were mixed, but generally more positive in the second year of implementation.

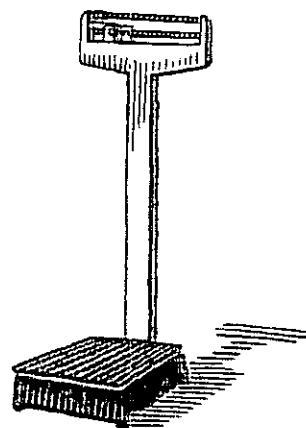
Interestingly, approximately one third (34%) of the superintendents who responded to the 2005 survey indicated that they had had no parent who contacted them about the BMI measurements, and 75 percent had been contacted by fewer than 10 parents. Similarly, the majority of principals (52%) had not heard from any parents about the BMI measurements, and 76 percent had less than five contacts from parents.

All of the school nurses and many superintendents and principals relayed some parental and child concerns about privacy and confidentiality, and some concern about body image issues related to the BMI. There were fewer of these concerns in the 2005 interviews than had been noted in baseline interviews, but some expressions of anxiety remained about these issues.

Despite the general acceptance of BMI measurement by parents and students, BMI measurement and reporting continue to be the primary issues of concern about the Act among school personnel. This seems to reflect a notable difference in attitudes among school personnel as compared with parents and children.

School personnel reported that the nutrition and physical activity aspects of the legislation were received with more enthusiasm from parents, students, and school personnel. Several of those interviewed were of the opinion that addressing nutrition and physical education of children would be a better tactic than BMI letters to reduce childhood obesity.

*In 2005,
parents generally
remained comfortable
with the confidentiality
of the BMI report.*



Year Two Evaluation of Arkansas Act 1220

EXECUTIVE SUMMARY

In April of 2003, Arkansas Legislative Act 1220 was signed into law by the Governor of Arkansas, Mike Huckabee. This is the second annual report evaluating efforts to implement the Act. More details about the Act itself and the history of its development can be found in *Establishing a Baseline to Evaluate Act 1220 of 2003, an Act of the Arkansas General Assembly to Combat Childhood Obesity* (2004). The 2004 report is available online at www.uams.edu/coph/reports.

This report summarizes results of the second year of evaluation activities. It presents a brief history of the Act and the progress of its implementation is presented, as well as the current findings gleaned from interviews and surveys. Overall, we note that **change is beginning to occur among schools and families.**

Key findings include:

- *Opinions about Act 1220 overall and its individual components continue to be generally positive.*
- **Parents and adolescents continued to be generally accepting of and comfortable with BMI measurements and reporting in the schools.**
- **No negative outcomes were found which seemed to be related to BMI measurement.**

Other findings include:

- Changes to the BMI measurement process reduced the length of time between measurement and distribution of letters to parents.
- After much discussion and consideration, the recommendations of the Child Health Advisory Committee were adopted as rules and regulations for implementation in the 2005-06 and subsequent school years.
- *Local school environments are beginning to change, frequently as a result of the input received from Local Nutrition and Physical Activity Advisory Committees.* Examples of reported changes include: prohibiting the use of foods as a reward for student behavior or achievement; making changes to cafeteria offerings, such as adding more fruits and vegetables to menus, removing deep fryers, adding fruit, and removing cookies; and increasing the availability of low-fat and low-sugar beverages and snacks in vending machines, snack bars, and school stores. It is important to note that the changes observed in this second year of implementation are voluntary on the part of schools.

- Parents' awareness of health problems associated with overweight in childhood increased. Other aspects of parental knowledge, attitudes, and beliefs remained unchanged.

- While physicians report that parents have brought BMI reports to them for discussion, health care systems in communities have not been inundated by requests from parents for weight consultation and intervention.

- Parents did not report an increased utilization of non-medically supervised weight-loss programs.

- After the first year of BMI reporting, parents of children who are overweight or at risk for overweight significantly improved their ability to accurately identify their child's weight-risk status.

- Parents reported no significant changes in family physical activity.

- There was a substantial increase in the proportion of families reporting that they eat meals together each evening, as well as an increase in the percentage of families reporting daily modification of recipes to make foods healthier.

- Parents and adolescents continue to believe that the contents of vending machines in schools should be changed to include at least some healthier options.

- Adolescents did not report any changes in either eating or physical activity patterns. However, they did report changes in their patterns of purchasing from vending machines. Specifically, the proportion of adolescents who said they never purchased from beverage machines at school rose significantly, and the proportion who said they purchased daily declined significantly.

- Teasing because of weight did not increase after implementation of BMI measurements.

- BMI measurement did not result in an increased frequency of unhealthy skipping of meals and/or snacks.

- There was no increase in adolescents' use of diet pills and/or herbal supplements after BMI screening.

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The Risks of a Quick Fix: A Case Against Mandatory Body Mass Index Reporting Laws

Authors: Jeanine C. Cogan ^a; Joslyn P. Smith ^b; Margo D. Maine ^c

Affiliations: ^a Eating Disorders Coalition for Research, Policy & Action,

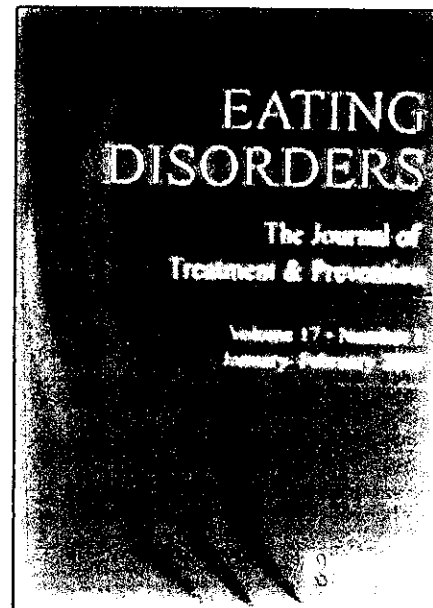
^b American Psychological Association,

^c National Eating Disorders Association,

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Abstract

As the United States addresses obesity, a number of state legislatures are considering laws that require schools to track and report students' body mass index (BMI), a measurement of body weight ($\text{weight}/\text{height}^2$). This article describes the state level activity on mandatory BMI reporting, offers numerous arguments against this practice, and suggests an alternative approach to promoting health in youth. Mandatory BMI reporting laws place a new and inappropriate responsibility on the schools. Proponents of such laws imply that BMI reporting will have positive outcomes, yet there is virtually no independent research to support this assumption. The authors argue that these laws could do significant harm, including an increased risk for children to develop eating disorder symptoms.

Introduction

Reports consistently indicate that obesity has increased in all segments of American society. According to the Centers for Disease Control (2004), the number of obese children doubled and the number of obese adolescents tripled in the last 30 years. Public attention to the obesity epidemic has ballooned and rarely a day goes by without a news story of the latest diet product or trend. School systems and state legislatures are also grappling with how to address obesity in youth. In response, a number of state legislatures are considering laws that require schools to track and report students' body mass index (BMI), a measurement of body weight ($\text{weight}/\text{height}^2$) to parents. In this article the authors describe the state level activity on mandatory BMI reporting, offer numerous arguments against this practice, and suggest an alternative approach to promoting health in youth.

OVERVIEW OF STATE ACTION

Since 2003, five states have enacted legislation requiring schools to calculate students' BMI. Currently, Arkansas, Pennsylvania, and Tennessee mandate that schools notify parents of their child's BMI results. Missouri and West Virginia track students' BMI scores and use the confidential data to measure the effectiveness of wellness programs but do not report the scores to parents. Additionally, both Florida and Illinois passed legislation that require schools to track students' height and weight but do not specify that BMI is the measurement tool used. Certain school districts do use the BMI to meet

this requirement and some districts choose to report the scores to parents.

Fourteen other states introduced bills between 2005 and January of 2007 that, if passed, would mandate BMI reporting by schools. Oregon is one state that has introduced such legislation. The Oregon House Bill 2329 declares childhood obesity a state emergency and requires certain schools to participate in a pilot program testing students' BMIs. Health status report cards would be sent to parents, which include "recommendations for simple weight loss programs or other means by which a student whose body mass index indicates the student is overweight may attempt to lose weight." The same students would have their BMI recalculated during the following academic year for the purpose of determining weight loss progress. This bill language is the most troublesome as it explicitly uses the school structure to promote weight loss in children.

As states implement BMI-specific legislation, some lawmakers are encountering concerns. Most recently, Arkansas state Senator Keven Anderson introduced legislation in January 2007 that would repeal the state's BMI reporting mandate. Arkansas Governor Mike Beebe publicly supported a revocation of the BMI reporting mandate stating that parents, rather than schools, should take responsibility for keeping children in good health and commented that the BMI reporting was hurting children's self esteem (Nasaw, 2007). This recent legislation is the second attempt to rescind the BMI mandate. In 2005, state Senator Kim Hendren, an original supporter of the Arkansas legislation introduced a bill to retract the mandate, noting his reasons for doing so were twofold: 1) since the policy's enactment some athletes are being incorrectly labeled as overweight and 2) that school personnel should be focused on educating the states' children versus measuring their size (Health Policy Tracking Service, 2005).

Although legislation was introduced in Georgia in 2005 to mandate BMI testing and parental notification, one sponsor of the bill, Representative Stephanie Stuckey Benfield, chose to not support the legislation after hearing concern from constituents that it could harm students' self-esteem (Health Policy Tracking Service, 2005). In 2005, Maine enacted legislation to address childhood obesity yet eliminated an original provision requiring BMI testing. In 2006, a measure to implement mandatory BMI testing of all students in Maryland failed after receiving a negative report from the Education, Health and Environmental Affairs Committee. A position statement issued by the Maryland Association of Boards of Education (MABE) urging the Committee to issue an unfavorable report stated that, "MABE opposes [SB 329] because it would inappropriately impose a mandate on all public schools to conduct a medical screening of each public school student, repeatedly throughout the student's elementary and middle school years. In addition, this bill would impose on public school systems the responsibility for developing and disseminating the results of these screenings in the form of a newly mandated student health report card."

WHY IS MANDATORY BMI REPORTING A BAD IDEA?

The authors agree with the expressed concerns of these lawmakers that BMI reporting laws place a new and inappropriate responsibility on the schools. The mission of schools and educational settings is to promote learning and academic achievement for children. The ultimate irony is that well-intended school-based initiatives that encourage dieting and weight loss may actually compromise this goal. Children's brains are still forming and maturing from early childhood throughout adolescence. Nutritional intake directly affects brain maturation and functioning; skipping meals, restrictive dieting, or the consequences of purging lead to deficits in concentration, attention and memory (American Psychiatric Association, 2006). Learning, self-confidence and achievement all suffer when children are not fed well. Schools are in the business of teaching and creating the optimal context for learning, not promoting weight loss programs. Thus, the doctor's office, not the school, is the appropriate environment for measuring weight. This seems apparent to a number of policy makers as they reconsider their support of mandatory BMI reporting.

What follows are additional arguments that suggest mandatory BMI reporting laws are not the right answer to solving the problem of childhood obesity.

No Solid Research Basis

Proponents of mandatory BMI reporting imply that doing so will have positive outcomes, yet there is virtually no independent research to support this assumption. They also argue that because the prevalence of obesity among children in the United States has reached such high levels, there is no time to wait for research to be conducted on the

consequences of certain obesity interventions among youth. Though we understand the urgency, implementing widespread interventions based on non-existent or hasty research findings has the potential to exacerbate severe problems related to disordered eating and eating disorders. We should not cause harm when creating new policy. Currently the only information that is available on the efficacy and/or repercussions of this policy comes from the state of Arkansas after three years of mandatory BMI testing in the schools. According to a report of the **University of Arkansas for Medical Sciences College of Public Health (2006)**, there were no negative outcomes associated with the BMI assessment and reporting process. While this report found no increase in skipped meals or use of dietary pills and supplements, and this may in fact be the case, this conclusion is premature given that eating disorder symptoms are not easily evident after such a short evaluation period. Those with eating disorders often do not disclose and sometimes overtly hide symptoms (**Becker, Grinspoon, Klibanski, & Herzog, 1999**). Additionally, up to fifty percent of eating disorder cases go unrecognized in clinical settings (**Becker, et al. 1999**). Given the difficulty in detecting eating disorders in such settings, it is unlikely that school professionals, with virtually no training in eating disorders, will recognize eating disorders. While there currently is no research proving that mandatory BMI reporting laws increase eating disorder symptoms in students, we offer a cautionary note that the potential is there.

The Body Mass Index is an Imperfect Measurement

The Body Mass Index (BMI) is based on the ratio of weight in kilograms to the height in meters. It has become the standard for defining obesity because it includes the calculation of height rather than just using weight and it can be easily computed. Though popular, the use of BMI¹ as an accurate measurement of obesity and a predictive tool of health has been called into question by leading experts and professional organizations.

According to a policy statement on the Prevention of Pediatric Overweight and Obesity (2004) by the American Academy of Pediatrics, BMI has its limits as an accurate measurement of obesity. For example, children often grow unevenly, gaining weight before growing in height. Some children are more muscular due to physical activity and genetic factors so, despite a lean body mass, their weight and, therefore, their BMI, will be higher and in the "obese" range. Hence, many athletes are miscategorized as obese. Frame size may also affect the BMI. A child can naturally have a larger body type, without having excessive fat or any health risks. The BMI formula can also fail to recognize children who have excessive adiposity, despite the fact that it is fat tissue and not weight per se that is considered the risk factor (**Dietz & Bellizzi, 1999**). None of these factors are accounted for in the BMI calculation.

The standard interpretations of the BMI do not include an analysis and understanding of race or ethnicity. These factors need to be considered as they will provide a more thorough picture of obesity among different populations. For example, American Indians at BMIs significantly higher than the accepted norm do not have an increased mortality or health risk (**National Institutes of Health, 1998**). Additionally, African-Americans with a BMI above the norm actually have a lower death rate than those who are in the normal or lower ranges (**National Institutes of Health, 1998**).

Lastly, when schools are asked to calculate BMIs, they may sometimes ask students for either their height or weight, or both, rather than doing their own measurements. These BMIs may be inaccurate as children often do not know their current measurements.

Guidelines from the **Centers for Disease Control (CDC, n.d.)** indicate that BMI alone does not signify if a child is overly fat and at increased health risk as a result. The CDC recommends an in-depth assessment of children whose BMI are above the 95th percentile, including:

- medical history of any underlying medical conditions or any weight-related health problems;
- family history of obesity, eating disorders, type 2 diabetes, heart disease, high blood pressure, and abnormal lipid profiles;
- dietary assessment of food intake patterns to indicate if caloric intake is excessive or imbalanced;
- physical activity assessment to evaluate the time spent in sedentary versus active behaviors;
- physical examination which includes examination of body frame and muscularity.

Although BMI charts are convenient, they are not necessarily predictive of health or health risks for children. After an extensive review of the research on childhood obesity in 2005, the Childhood Obesity Task Force of the U.S. Preventive

Services Task Force concluded that there were no accurate obesity or weight status criteria to identify children who are at risk for future adverse health outcomes (Moyer et al., 2005; Whitlock, Williams, Gold, Smith, & Shipman, 2005). One recent comprehensive study examining the relationship of childhood weight to adult cardiovascular disease concluded that childhood BMI does not appear to be associated with increased risk for cardiovascular disease later in life (Lawlor & Leon, 2005).

Could Do Harm

While there are virtually no data on the effectiveness of mandatory BMI reporting, research does suggest that the potential is there to do harm. A focus on weight often has a boomerang effect. The area of athletics is a prime example. When body weight is emphasized as a criteria for determining success in sports (such as wrestling, gymnastics or ballet), those sports are more likely to have a high prevalence of people with eating disordered behaviors and performance is adversely impacted (Thompson & Heinberg, 1999).

Underlying the notion that BMI reporting may help to decrease the rates of obesity is the assumption that the at-risk individual will begin to diet and will then lose weight. Dieting, however, is often associated with weight gain and not with weight loss, due to the incidence of binge-eating (Field et al., 2003; Stice, Cameron, Killen, Hayward, & Taylor, 1999). In fact, adolescent girls who diet are at 324% greater risk for obesity than those who do not diet (Stice et al., 1999).

An additional consideration is that there is no scientifically proven effective weight loss strategy. Decades of research on various forms of restrictive dieting have consistently found that most people do not maintain *long term permanent* weight loss (Cogan & Rothblum, 1992; Gaesser, 2002; Miller, 1999; Stunkard & McLaren-Hume, 1959). Those who are not successful internalize this as a personal failure (Jefferey, French & Schmid, 1990). Individuals told to lose weight can be at risk for using dangerous weight loss strategies such as the abuse of diet pills and diuretics, and use of thyroid hormones, intestinal bypass, vomiting, fasting, and very low calorie diets (Berg, 1999; Miller, 1999).

Project EAT, a population-based study of nearly 5,000 teens, reports that more than half of teen girls and one-third of boys use unhealthy weight control behaviors such as fasting, vomiting, laxatives, skipping meals, or smoking to control their eating/appetites. Notably, higher weight and overweight teens engage in both binge-eating and unhealthy weight control more often than normal weight teens. In fact, 20% of overweight girls and 6% of overweight boys engage in using laxatives, vomiting, diuretics, and diet pills (Neumark-Sztainer, Story, Hannan, Perry, & Irving, 2002). As overweight youth may already be engaging in risky weight control behaviors, the added pressure of a BMI report card may only intensify these behaviors and contribute to full blown eating disorders such as anorexia or bulimia, both dangerous and life threatening illnesses. Anorexia has the highest mortality rate of all psychiatric disorders. People with anorexia have an 18-fold increase in the risk of death when compared to those of similar age not suffering from the disorder (Birmingham & Beaumont, 2004; Norring & Sohlberg, 1993).

Information without Meaningful Strategies

The public is bombarded with contradictory information about healthy eating, healthy weight and effective strategies for weight loss daily. How do parents navigate all these data? Some parents may focus on the child's weight as another important arena for achievement and encourage diets and other weight loss strategies that could inadvertently be harmful. Mandatory BMI reporting laws force parents to walk the fine line between encouraging healthy eating and endorsing risky weight loss strategies that can put the child at risk for developing negative body image and eating disorder symptoms.

Puts Children at Risk for Bullying and Teasing

The central problem with BMI reporting is that it focuses on weight rather than health as the measuring stick for children. This weight-centered approach toward health is a result of a thinness bias, where all that is thin is good and all that is fat is bad (Cogan & Ernsberger, 1999). Studies have found that overweight and obese school-aged children are more likely to be the victims and perpetrators of bullying behaviors than their normal-weight peers (Janssen, Craig, Boyce, & Pickett, 2004). Additionally, obesity-related stigma where fat people are stereotyped, judged as morally lacking, or are considered otherwise inferior is very much alive today. Research shows that people who are obese are less likely to be chosen as friends, spouses and employees, and are more likely to face bias from healthcare professionals (Gortmaker, Must, Perrin,

Sobol & Diets, 1993; Puhl & Brownell, 2001). Exposure to weight related comments or teasing increases the risk to develop an eating disorder (Fairburn et al., 1998). Mandatory BMI reporting feeds into and further perpetuates this obesity related stigma.

Redundant and Inappropriate

The **American Academy of Pediatrics (2004)** recommends periodic calculations of BMI throughout a child's life at routine annual health exams. Pediatricians are trained on how to measure and calculate weight, height and BMIs as well as how to professionally advise parents and children if BMIs rise or fall significantly. School personnel receive no such training. Pediatricians provide children and families with professional guidance regarding how to shape a child's physical activity, eating, and health status. These interventions can be individualized and comprehensive, thus more likely to respond to the child's situation than a screening at school with little feedback to parents other than that their child is overweight or obese.

SOLUTION: PROMOTE HEALTHY ENVIRONMENTS THAT SUPPORT HEALTHY BEHAVIORS

We recommend some relatively simple changes to be implemented within the school system that are consistent with schools' aim of creating an optimal learning environment and would also have an immediate positive impact on children's health. The recommendation is that schools provide opportunities for exercise and nutritionally balanced meals to students. Given the consistent evidence of both the physical and mental health benefits of exercise (e.g., **Miller, 1999**), schools should reinstitute mandatory physical education. Schools also should offer nutritionally healthy food options not only in the lunch rooms but in school vending machines. Soft drinks that are high in simple sugars have no nutritional content, impact concentration and swell caloric intake. A recent study tracked notable changes in nutritional choices among a group of fourth-graders who had access only to USDA-backed school lunches in fourth grade which changed when they moved to fifth grade and gained access to school vending machines, snack bars and other food sources. With this access to food in vending machines and snack bars as fifth-graders, their consumption of fruit dropped 33 percent, their consumption of vegetables dropped 42 percent and their consumption of milk dropped 35 percent. Additionally, they ate 68 percent more fried foods and drank 62 percent more soft drinks and other sweetened beverages (**Cullen & Zakeri, 2004**). Soft drinks can be easily replaced with juice and water as has been successfully done in certain school districts such as North Community High School in Minneapolis.

Children are more likely to choose healthy food options if they are available. In 2002 Senator Tom Harkin passed a bill that provided free fresh fruits and vegetables to students in 100 schools, 25 of them in his home state of Iowa. This is a proactive approach to attending to the nutritional needs of children. Rather than promoting mandatory BMI reporting laws, federal and state governments and local school districts can work together to replace non-nutritious foods with healthy alternatives.

Addressing Eating Disorders and Obesity in Tandem

Although the attention paid to obesity in our youth is enormous, eating disorders are important co-existing and widespread problems. Thirty percent of high school girls and 16% of boys suffer from disordered eating (binging, fasting, vomiting, laxatives, diet pills or excessive exercise (**Austin, Ziyadeh, Lelliher, Zachary & Forman, 2001**). The American Psychiatric Association estimates that as many as 7.9% of young women have anorexia nervosa or bulimia nervosa (2006); this does not include the number of cases of Eating Disorders Not Otherwise Specified, which are equally serious. The broad range of eating and weight issues suggests the need for a comprehensive and well-planned proactive approach. Many of the risk factors leading to obesity and to eating disorders are similar (**Neumark-Sztainer, 2005**). These include dieting, self-esteem, media exposure, family meal patterns, eating and health practices of parental role models, exposure to weight related teasing and criticism, food availability in schools, social norms and expectations regarding food intake, exercise, appearance and body image (**Neumark-Sztainer, 2005**). The authors would add genetics as another important risk factor for both obesity and eating disorders that need to be better understood and incorporated into well-grounded proactive approaches (**Striegel-Moore & Bulik, 2007**).

Furthermore, goals to prevent and address both eating disorders and obesity also include some common features

(Neumark-Sztainer, 2005), including:

- normalizing eating, both amounts and frequency;
- learning to recognize internal cues of hunger and satiety;
- enjoying moderate physical activity.

SHIFTING THE PARADIGM

A longer-term but equally important goal is to shift our paradigm of how we approach obesity and health in this nation (Cogan & Ernsberger, 1999). We must rethink the dangerous trend in public health policy that minimizes the structural and organizational forces on health and places sole responsibility on the individual (Cogan, 1999). The US has developed systemic approaches in response to many issues affecting child welfare. For example, in response to large numbers of accidental deaths and injuries in children, the public and families have shaped effective educational campaigns and joined manufacturers for creating safer guidelines, standards and products. Such campaigns have been very successful, but they have taken time, coordination and forethought. When it comes to obesity, we seem to lack the bigger picture of how many factors came together to create the problem. Instead, we take a blaming and stigmatizing approach, targeting the individual rather than also acknowledging the systemic factors of the problem. We need to come up with balanced policies to obesity prevention in which both the individual and the culture are viewed as playing a significant role.

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¹ The authors are aware that zBMI may be a more sensitive measure for children than BMI. Since this is a z-score or percentage of BMI all the arguments still apply.

Testimony

NB 1479 FN

Rep. Jean H. Schuler

(1)

This bill was submitted as a result of the work of the Commission to Prevent Childhood Obesity. Fourteen recommendations were made. This bill proposes that hts. wts. be done for all children in grades 1, 4, 7 + 10. The measurements are used to calculate their Body Mass Index (BMI) which is a measure of whether the person's weight is healthy in proportion to height. These are transition times for children in school and also when growth spurts are seen. It is known that this process is being done in some schools but not in all.

: that children with medical homes may have this procedure done + addressed
: that many children do not have medical homes

: that physicians do not always address obesity with parents or children.

cf. child + mass

In some regions hts. wts. are being done. It was found that 1/3 of NH's children are overweight 14% are obese. This follows U.S. trends.

It would be prudent to see progress by tracking unidentified statistics. It can easily be done with computer technology. A public awareness program around the use of BMI as a health screening tool should be done.

This procedure can be done in a sensitive manner. In areas of U.S. where it is now done there are no complaints. The procedure can be offered in the same way as hearing and vision screenings. There is always a opt out.

Reports can be shared with parents in a confidential manner.

I saw this procedure as part of a school nurse's duties. Today a school nurse has an expanded role. They are responsible for many more complex medical issues. The school health educator or physical education person takes this responsibility. 250 personnel have been trained to carry out a program called Fitness gram. An education piece is part of the program. The school nurse could provide education. If we recommend this method. The fiscal note will go away.

Fitness gram is an integrated fitness and activity assessment program that can greatly enhance the effectiveness of school based physical education program

Schools are critical in setting a pattern of healthy eating and drinking habits in our children. They can bring the family along. Some schools have excellent programs. Rep Nancy Stiles will address this further.

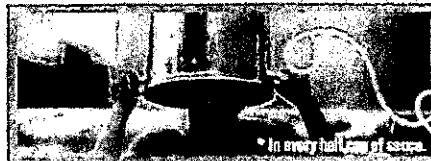
appropriate
current
school
personnel

The health of our children is the responsibility of all. It is sad to learn that it is predicted that our children will not live as long as their parents.

The ramifications of obesity in childhood is frightening. An overweight child often becomes an expensive obese adult. The effects of obesity can cause bodily harm starting in childhood i.e. diabetes II, hypertension, early symptoms of hardening of the arteries, fatty liver which can lead to cirrhosis and some cancers. There are psychosocial considerations such as low self-esteem, negative body image, less of productivity. The cost of treatment is high, much higher than coping with the problem now.

Please make the necessary changes to this bill and pass it.

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BMI Calculator

Are your kids over or underweight?

Parents often wonder if their children are overweight, underweight or just right. Using our body mass index calculator, you can figure out if your child is at an appropriate weight for his or her height. The BMI calculator also works for adults!

What is your child's gender? male female

How old is your child (or choose 'Adult')?

10 years and 0 months old

Child's

Weight: _____ pounds

Child's

4 feet and _____ inches

Height:

[Calculate BMI using metric units](#)

BMI Resources:

- [BMI](#)
Learn more about BMI or body mass index, including a BMI Calculator, BMI Tables, and BMI Growth Charts for boys and girls.
- [Understanding BMI](#)
Review how to calculate and interpret your child's body mass index or BMI to help determine if he is overweight, underweight, or at a healthy weight.

- [BMI Tables](#)
New recommendations from the American Academy of Pediatrics call for health professionals to calculate and record children's body mass index at yearly well child checks. My new Children's BMI Tables make finding child's BMI easy.
- [Childhood Obesity](#)
Obesity in kids has reached epidemic levels. Experts estimate that 15% of kids are overweight and another 15% are at risk of becoming overweight. And two thirds of these overweight kids will become overweight adults. Learn to prevent obesity and help your kids stay at a more healthy weight.
- [How Many Calories Are in a Pound of Fat?](#)
Understanding how many calories it takes to gain a pound of fat can help you understand how your kids become overweight so quickly.
- [Calorie Calculator](#)
This Calorie Calculator will help you determine how many calories that you and your kids need each day.
- [Who's to Blame for Childhood Obesity?](#)
Obesity in kids is a new epidemic. Who's to blame? Fast food? TV? Soft Drinks? Snacks? Video Games? You?
- [Ideal Body Weight Calculator](#)
Parents often wonder if their children are overweight, underweight or just right. Using our ideal body weight calculator, you can figure out if your child is at an appropriate weight for his or her height. The ideal body weight calculator also works for adults!

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January 27, 2010

2

Good Morning Madame Chair and Committee Members

For the record I am Nancy Stiles, Rockingham 15, Hampton and vice-chair of the obesity commission that has studied this issue over the past two years.

I appear before you today in support of HB 1479 requiring that body mass index be assessed in all pupils in grades one, 4, 7, and 10. Generally recognized as the ages in which there is the greatest growth spurts.

School personnel (in some instances it was the school nurse in others it was the physical education teacher) used to assess the height and weight of students in the beginning of the year and in my school years, which was well before 28a, it was also done at the end of the school year so parents could see the physical growth of the student over that period.

Our schools continued to collect that information until; I believe it was the 1980's, perhaps if a school nurse is testifying behind me they could give you the accurate time frame. The reason I'm told that it was stopped was that nothing was done with that data in any aggregate form.

You are probably aware that childhood obesity has doubled for some age groups of students and tripled for children ages 6 to 11 years according to Center for Disease Control. You need only look around when you walk in the mall or any area where students congregate. NH has no baseline data. Do we have a problem, if so how big (no pun intended)? What are some of the steps local communities can initiate to make changes so that we can anticipate that this generation can expect a lifespan as long as their parents? Overweight and obesity are front runners to Type II diabetes, heart disease, cancer and stroke. Changing behaviors early in life can at least stay the onset if not eliminate it.

I can tell you in my professional life in the mid 70's the folder on children with allergies contained about two pages and when I retired in 2004 it was about two inches thick many of which were type II diabetes for 2nd graders. Obesity is an epidemic that not only has enormous physical implications to the individuals it also has enormous health care costs to the nation, state, and individual insurance policy holders. Studies done for CDC indicate the medical costs related directly to obesity at \$147 billion annually. The medical costs of diabetes alone were \$116 billion. According to the study people with diagnosed diabetes have medical costs that are 2.3 times higher than those without the disease.

So why ask the schools to do this? It is the most formal system we have to capture measurement data on children with NO NAME attached to the data that is then forwarded to DOE in order to give a baseline, note improvements or not over time and of its abundance in our state. BMI is widely accepted as a reliable and valid tool for assessing overweight in children. BMI is measured differently in children than it is in adults. One of the visions discussed in the Commission was to have this information included in a **screening** report sent home with parents. That report would include screenings done for vision, hearing, scoliosis, etc. to provide a parent/guardian with an awareness of any of the issues. It would then be up to the parent/guardian to follow up the discussion with their personal appropriate medical authority.

The Center for Disease Control has a BMI Tool for Schools to download that would do the calculations for the school personnel. (as provided for you on the gold sheet) You will note there is no name attached to this. It would be up to the school personnel to add this information to the individual student screening record. Then ONLY the parent/guardian would receive that personal screening information report.

There are guiding principles for BMI reporting when performed in a school setting; such as the scale should be located in a private setting, children should be asked to step on the scale backward and not told his/her weight, if the child's weight is more than the scale will measure "exceeds scale" should be recorded with no comment to the child, the report should be sent directly to or picked up by a parent /guardian and should not be given to the child. Perhaps at parent teacher conference time.

PA, AK, MA, FL, and SD are some of the states that successfully conduct BMI screening programs in schools. (According to the Institute of Medicine)

Children's BMI Tool for Schools

Download the BMI Tool for Schools

- Children's BMI Group Calculator - English Version (XLS-3.8Mb)
- Children's BMI Group Calculator - Metric Version (XLS-3.6Mb)

The Children's BMI Tool for Schools is an Excel spreadsheet intended for use by school, child care, and other professionals who want to compute Body Mass Index (BMI)-for-age for a group of up to 2000 children, for example a school class room or grade.

This calculator computes BMI and BMI percentiles for individual children in a group using height and weight measurements, sex, date of birth, and date of measurement information that you enter, or import from a spreadsheet or data file. It provides a group summary of children's BMI-for-age categories and graphs for Prevalence of Overweight and Obesity, and Prevalence of Overweight and Obesity by Sex.

This calculator is an Excel spreadsheet that can be downloaded onto your computer. To allow all of the features of this calculator to work, please click "Enable Macros" if prompted when you open the application. The spreadsheet has 3 worksheets entitled "INSTRUCTIONS", "MEASUREMENTS", and "GROUP SUMMARY". You can view each of these using the tabs at the bottom of the window.

Note: The English version was updated on April 2, 2009, to fix a decimal entry problem.

Body Mass Index Measurements in Schools

This guidance document describes the purpose of school-based BMI surveillance and screening, examines current practices, summarizes the recommendations of experts, identifies concerns surrounding programs, and outlines needs for future research. Guidance is provided on specific safeguards that need to be addressed before schools decide to collect BMI information.

BMI Calculator for Child and Teen

English | Metric

Birth Date:

month day year

Date of Measurement:

month day year

Sex:

boy girl

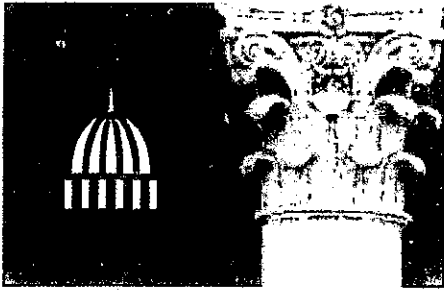
Height, to nearest 1/8 inch:

feet, inches, fractions of an inch
(12 inches = 1 foot; Example: 4 feet, 5 1/2 inches)

Weight, to nearest 1/4 (.25) pound:

pounds, fractions of a pound
(8 ounces = 1/2 pounds; Example: 75 3/4 pounds)

Calculate



National Conference of State Legislatures

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NOVEMBER/DECEMBER 2008

VOL. 16, No. 46

Body Mass Index Screening for Students

By Amy Winterfeld

About 12 million U.S. children and adolescents are obese.

Approximately 12 million U.S. children and adolescents are obese; their body mass index (BMI) is at or above the 95th percentile. Obesity is a major risk factor for many serious health conditions, including type 2 diabetes, heart disease, stroke, high blood pressure and certain cancers. These health risks, the costs to treat obesity-related health conditions, and how that affects state budgets have led many policymakers to consider ways to prevent and reverse obesity.

Among the proposed approaches to address obesity is student body mass index measurement. Body mass index is a measure of whether a person's weight is healthy in proportion to height. For children, the calculations also take into consideration age and gender to account for "baby fat." Body mass index is widely accepted as a reliable indicator of body fat content and a screening tool for weight categories that may lead to health problems.

Schools are an excellent screening site.

The ease of measuring height and weight, without using expensive equipment, makes body mass index screening convenient. Schools are an excellent screening site because virtually all children can participate.

Screenings at schools can help motivate families to adopt healthier habits that can reduce childhood obesity, especially when results are clearly explained to parents and suggestions for making healthy changes are communicated. When obesity-related health risks are identified, screening reports also should provide parents with information about how to seek further evaluation and appropriate follow-up.

Some state programs report aggregate body mass index data.

State Action Some states have initiated body mass index screening in all schools. In addition to measuring individual students, some programs also include screening for specific health risks or reporting aggregate data. When schools measure individual body mass index, they generally send the information to parents in a confidential letter that explains the results and indicates whether the child's body mass index poses a health risk. Some letters also encourage parents to discuss screening results with their child's health care provider. States that collect aggregate body mass index data typically report the information anonymously. Aggregate body mass index screening data from a specific school district, city, county, region or state can help assess a community's risk for weight-related health problems, monitor statewide obesity trends, or evaluate the results of programs intended to reduce or prevent obesity.

Arkansas began measuring every public school student for body mass index in 2003 as part of a comprehensive law designed to address the state's epidemic 38 percent rate of childhood obesity and overweight. The legislation also requires schools to eliminate elementary students' access

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Executive Director
William T. Pound

Denver
7700 East First Place
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Phone (303) 364-7700
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to vending machines and to develop nutrition and physical activity standards. Annual evaluations found that, in just three years, Arkansas halted progression of the state's childhood obesity epidemic. Despite initial controversy that children might feel stigmatized by body mass index measurement, research shows positive results and general public acceptance of the program, including the body mass index measurement component.

Federal Action Institute of Medicine experts recommend annual school-based body mass index screening. The American Academy of Pediatrics also calls for pediatricians to measure and plot body mass index as part of a child's annual pediatric check-up.

State Programs to Measure Student Body Mass Index				
State	Individual or Aggregate BMI	Statewide, Pilot or Regional Program	Other Health Risks Screened	Legislatively Created (L) or Health (H) or Education (E) Department
Arkansas	Individual	Statewide	No	L
California	Individual and Aggregate	Statewide	Diabetes* Fitness and Body Composition	L, E
Delaware	Individual	Pilot	Fitness	L
Florida	Individual	Statewide	No	L, H, E
Illinois	Individual	Statewide	Diabetes	L
Missouri	Aggregate	Statewide	No	L
New York	Individual	Statewide	No	L
North Carolina	Aggregate	Statewide statistical sample	No	L
Oklahoma	Individual	Pilot to be developed	Fitness	L, H, E
Pennsylvania	Individual	Statewide	No	H
Tennessee	Individual	Statewide	Health	L
Texas	Individual	Regional	Diabetes	L
Vermont	Individual	Statewide to be developed	No	L, H
West Virginia	Aggregate	Statewide statistical sample	No	L

*Diabetes risk assessment pilot program in specific locations expired in 2008; it was replaced by statewide distribution of diabetes risk information.
Source: NCSL, 2008.

In three years, Arkansas halted progression of the state's childhood obesity epidemic.

Experts recommend annual body mass index screening in schools.

The U.S. Centers for Disease Control and Prevention concludes that student body mass index screening meets many American Academy of Pediatrics' criteria for successful school screening programs, including feasibility, accuracy and identification of health risks that may go unrecognized without screening. Effective use of body mass index information is bolstered by policies that support family choices for healthy eating and a physically active lifestyle.

Resources

American Academy of Pediatrics. "Prevention of Pediatric Overweight and Obesity." *Pediatrics* 112, no. 2 (August 2003).

Centers for Disease Control and Prevention. *Body Mass Index Measurement in Schools*, "Executive Summary." Atlanta: CDC, 2007; www.cdc.gov/HealthyYouth/Overweight/BMI.

Institute of Medicine. *Preventing Childhood Obesity: Health in the Balance*. Washington, D.C.: The National Academies Press; 2004; www.nap.edu/catalog/11015.html.

Phillips, M.M., J.M. Raczynski, and J.F. Walker. *Year Four Evaluation: Arkansas Act 1220 of 2003 to Combat Childhood Obesity*. Little Rock, Ark.: Act 1220 Evaluation Team, April 2008; www.rwjf.org/files/research/3300.31871.uamsyearfourval.pdf.

Contacts for More Information

Amy Winterfeld
NCSL—Denver
(303) 364-7700, ext. 1544
amy.winterfeld@ncsl.org

CDC Body Mass Index Calculator
for Children and Adults
www.cdc.gov/nccdphp/dnpa/healthyweight/assessing/bmi/index.htm



Body Mass Index Table

	Normal					Overweight					Obese					Extreme Obesity																				
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.



HOUSE EDUCATION COMMITTEE

January 27, 2010

HB 1479

**Screening of body mass index (BMI) in selected school grades
to help prevent childhood obesity**

Testimony

Good afternoon, Madam Chair and members of the Committee. My name is Leslie Melby, and I am the Vice President for State Government Relations at the New Hampshire Hospital Association, representing the state's 32 acute care community and specialty hospitals.

I am here to testify in support of HB 1479. New Hampshire does not have a statewide system to track the prevalence of unhealthy weight in children and youth. Body Mass Index (BMI) is a number calculated from a child's weight and height. BMI is a reliable indicator. It is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems. For children and teens, BMI is age- and sex-specific and is often referred to as BMI-for-age.

Hospitals and the health professionals who work in hospitals see and treat many of the chronic disease problems associated with unhealthy weight among children and adults. Treating chronic diseases is very costly and often leads to time missed from school or work. Reversing the epidemic of obesity requires all sectors of our society to work together to employ different prevention strategies that address the problem. HB 1479 proposes a key component in dealing with this challenge by creating a method for us to collectively monitor and measure statewide progress.

On behalf of New Hampshire's hospitals, I urge you to pass HB 1479.

Thank you.



American Heart Association | American Stroke Association
Learn and Live.

Heart Disease and Stroke. You're the Cure.

American Heart Association / American Stroke Association
2 Wall Street, Manchester NH 03101

Testimony in Support of House Bill 1479
House Education Committee
Nancy Pederzini
Director of Advocacy – NH

Chairman Rous and members of the Education Committee, the American Heart Association is pleased to support HB 1479, requiring that body mass index be assessed in all pupils in grades 1, 4, 7 and 10, by highly qualified school staff. The collection of BMI data is a first step toward addressing the childhood obesity epidemic and one of the recommendations of the Commission on the Prevention of Childhood Obesity.

Obesity is an independent risk factor for the development of cardiovascular disease. Obesity was associated with 13% of CVD deaths in 2004. Children who are overweight are being diagnosed with a host of obesity-related health conditions previously seen exclusively in adults, such as type 2 diabetes and high blood pressure. Obesity negatively impacts both the health of the child and that of the healthcare system due to the severe financial costs associated with the condition over the life of the diagnosed. Most importantly, while children may not represent a large portion of current healthcare costs, overweight children who become obese adults represent a staggering burden in terms of future healthcare expenditures. Overweight children face a 70 -80% chance of growing into overweight and obese adults.

Obesity and its associated diseases have a steep price tag. According to one study, overall estimates show that the annual medical burden of obesity has increased to almost 10% of all medical spending and reached almost \$147 billion in 2008. By 2030, it is estimated that total healthcare costs attributed to obesity will account for 18% of total healthcare spending in our country.

The American Heart Association places a high priority on addressing the childhood obesity epidemic and supports a BMI assessment in schools for the purpose of surveillance to support the goals of eliminating the burden of heart disease and stroke. BMI surveillance in schools may serve to expand the understanding of childhood obesity trends and help to determine the efficacy of obesity prevention programs and support program planning. Public reporting of aggregate BMI levels within a school or district with school boards and the Department of Education will be very useful data for those tracking trends and changes.

It is important that those conducting the assessment be familiar with proper measurement techniques, privacy protection and effective parental notification. School nurses and physical

education teachers who are highly qualified in these techniques and issues will help ensure procedures are properly followed.

The American Heart Association applauds the efforts of the Commission on the Prevention of Childhood Obesity and its recommendations. The passage of HB 1479 would be a good first step in addressing solutions to childhood obesity. Thank you for your consideration of this very important health issue. Please support HB 1479 with a committee recommendation of Ought to Pass.

Nancy Pederzini
Director of Advocacy – NH
Nancy.pederzini@heart.org
603-518-1555

13



FOUNDATION FOR
HEALTHY COMMUNITIES

House Committee on Education - January 27, 2010

HB 1479 – relative to assessing Body Mass Index (BMI) in selected grades

Shawn LaFrance, Executive Director, Foundation for Healthy Communities

I am here to speak in support of HB 1479. Obesity is robbing children of a healthy future. It is the first time ever when the gains in the life expectancy in the US may be reversed because of growing numbers of overweight and obese children who are at increasing risks of chronic diseases such as diabetes, high blood pressure, heart disease, stroke, etc at earlier ages.

Assessing Body Mass Index (BMI) of school children in selected grades will help children to reduce their risks of chronic diseases. HB 1479 will build upon best practices in many NH schools to strengthen our public health system in measuring efforts to combat the obesity epidemic. The cost of ignoring the childhood obesity problem or doing nothing is enormous.

Overweight and obesity with their associated health problems have a significant economic impact on the U.S. health care system. A 2006 report by Thomson Medstat investigated the prevalence and cost of childhood obesity and found:

- Children treated for obesity are roughly 3 times more expensive for the health system than the average insured child;
- Annual healthcare costs are about \$6,700 for children treated for obesity covered by Medicaid and about \$3,700 for obese children with private insurance; and
- Children diagnosed with obesity are two to three times more likely to be hospitalized.

A 2004 study focused on state-level estimates of adult medical expenditures attributable to obesity (BMI greater than 30) estimated 5% of the adult population in NH were obese and direct medical costs were \$302 million. It estimated that 8.6% of New Hampshire adult Medicaid enrollees were obese at a cost of \$79 million¹.

BMI is a public health tool that is very effective when measured over time among different age groups. The legislatively established Commission on the Prevention of Childhood Obesity determined that identifying the BMI of children in grades 1, 4, 7 and 10 would adequately measure growth over time, while accounting for growth spurts apparent in all children.

There are 20 states that currently require BMI collection in schoolsⁱⁱ, and a number of others are considering enacting such legislation. Collection of BMI in schools, as a part of the routine health assessments, can help to raise awareness of a growing child health problem, inform parents and provide state policy makers with useful information about the child health trends. A comprehensive public awareness program around the use of BMI as a health screening tool should be delivered alongside any effort.

The Commission endorsed a set of best practices defined by the US Centers for Disease Control and Prevention (CDC), which can help to ensure that the BMI measurement ensures privacy and respect for all students. The CDC advises that BMI measurement programs should adhere to the following safeguards:

- introduce the program to school staff and community members and obtain parental consent,
- train staff in administering the program (ideally, implementation will be led by a highly qualified staff member, such as the school nurse),
- establish safeguards to protect student privacy,
- obtain and use accurate equipment,
- accurately calculate and interpret the data,
- develop efficient data collection procedures,
- avoid using BMI results to evaluate student or teacher performance, and
- regularly evaluate the program and its intended outcomes and unintended consequences.

BMI data collection will help health professionals and parents to recognize children who are at risk of childhood obesity and related chronic diseases. Identifying children early, makes it possible to help children, their families and the community to modify the environment where children learn and play and support healthy eating and active living.

ⁱ Finkelstein, EA, Fiebelkorn, IC, Wang, G. State-level estimates of annual medical expenditures attributable to obesity. *Obesity Research* 2004;12 (1):18–24.

ⁱⁱ Arkansas, California, Delaware, Florida, Illinois, Iowa, Louisiana, Maine, Massachusetts, Mississippi, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, West Virginia

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Recommendations from the
New Hampshire Childhood Obesity Expert Panel

Preventing Childhood Obesity: Promoting physical activity & healthy eating

April 2007



Foundation for Healthy Communities



Recommendations for Schools (continued)

Recommended Resources

School Health Assessment

- ♥ CDC School Health Index
- ♥ *Changing the Scene*
UNH Cooperative Extension:
(extension.unh.edu)
- ♥ School Nutrition Association.
(www.schoolnutrition.org)

BMI measurement and reporting

- ♥ Sonneville BMI Wheel*
- ♥ "BMI Measurement" sample protocol*
- ♥ Sample "health report letter"*

Education

- ♥ 5-2-1-0 education materials*
 - Physical activity and nutrition handouts
 - 5-2-1-0 Posters
 - Power Point slides on childhood obesity*

Classroom curriculum

- ♥ Granite State FitKids
(www.granitestatefitkids.org)
- ♥ CATCH (www.sph.uth.tmc.edu/catch/about_science.htm)
- ♥ Planet Health
(www.hsph.harvard.edu/planproj_planet.html)
- ♥ Eat Well & Keep Moving
(www.hsph.harvard.edu/nutritionsource/FWK/)
- ♥ Stanford Adolescent Heart Health Program (med.stanford.edu)

Media Awareness

- ♥ Media Smart Youth
(www.nichd.nih.gov/ansyl)
- ♥ MediaSmart
(www.childhealthservices.org)
- ♥ Stanford S.M.A.R.T.
(noty.stanford.edu)

For a full list of evidence-based programs and promising practices, visit www.healthyNH.com

available by contacting info@healthynh.com or visiting www.healthyNH.com

General

You can:

- ♥ Conduct an assessment of your school's current nutrition and physical activity environment.
 - Use the results to engage the staff, students, parents, and the community in creating an action plan for your school's wellness policy.
 - Take steps to monitor and evaluate your progress implementing your action plan.
- ♥ Promote healthy lifestyles among school staff so they serve as role models.
- ♥ Consider health-focused field trips to farms, supermarkets, or hiking trails.
- ♥ Ask local businesses to help sponsor health and fitness activities in the school (healthy cookbooks, pedometers, snowshoes, health fairs, etc.).

Work with school officials to:

- ♥ Provide training to school nurses on:
 - BMI measurement and classification.
 - Motivational interviewing to help counsel students and families.
- ♥ Measure BMI once a year in all students:
 - Ensure the privacy of every student.
 - Do not communicate results directly to students. Communicate results to the parents of *every* student along with other health tests (eyesight, hearing, scoliosis, etc.). We do not recommend singling out any one student or student group (i.e., overweight or obese students only).
 - Use appropriate language that is sensitive and non-judgmental:
 - ✓ Focus on the "health" of the student, not their weight. BMI may be in a "healthy" or "unhealthy range."
 - ✓ Educate parents of children $\geq 85^{\text{th}}$ percentile that their child's BMI "may put them at risk for several chronic conditions such as diabetes, heart disease, skeletal disorders, sleep apnea, etc."
 - ✓ Inform and educate parents prior to sending letters with BMI information.
 - If necessary, ask local health care organizations to assist with effort.
- ♥ Provide community education:
 - Use the aggregate BMI data to educate school administration, staff, parents and the community about the health status of students.
 - Educate school administration, staff, and the community about the value of physical activity and healthy eating.
 - Educate parents about physical activity and healthy eating at open houses, health fairs, family nights and school newsletters.
 - Increase awareness regarding school meals, food services, nutrition and physical activity curriculums, and the efforts of the school district wellness committee.
- ♥ Provide media literacy training to students.
- ♥ Provide health education that emphasize behavioral skills focused on increasing physical activity, improving dietary habits, and decreasing sedentary time.



New Hampshire Childhood Obesity Expert Panel

Chuck Cappetta, MD	NH Pediatric Society
Madeline Dalton, PhD	Hood Center for Children and Families, Dartmouth Medical School
Joe Drake	Plus Time NH
Amy Dumont, MSN, RN, CCRN	NH Heart Association and St Joseph Hospital
Merrill Friedman, MA, LCMHC	Slatoff and Ward Psychological
David B. Gill	NH Recreation and Park Association
Yvonne Goldsberry, PhD	Community Health, Cheshire Medical Center
Travis Harker, MD	Capital Region Family Health Care
Martha Judson, RN, MS	Nutrition Connections, UNH Cooperative Extension
Audrey Knight, RN	State of New Hampshire Department of Health and Human Services
Robert Lister	Portsmouth School System
Susan Lynch, MD	Cholesterol Treatment Center, Concord Hospital
Sharon Malenfant, MS, APR	The Memorial Hospital
Evelyn Mariani, RD	St Joseph Hospital
Melissa McAllister, RD, MEd	Anthem Blue Cross & Blue Shield
Louise McCormack, EdD	Department of Health and Human Performance, Plymouth State University
Mary McGowan, MD	Cholesterol Treatment Center, Concord Hospital
Lila Monahan, MD, FAAP	Partners in Pediatrics Southern NH Medical Center, Nashua
Katherine Rannie, MSc, RN	Education Consultant, Office of School Health State of New Hampshire
Heidi St. Hillaire, RN	Elliot Hospital
Evie Stacy, MS, ARNP	Center for Life Management
Lisa Sutherland	Hood Center for Children and Families, Dartmouth Medical School
William Tombari, MD	Derry Pediatrics, PA
Ellen Turcotte	Whitefield School
Jennifer Warren, MD	Physicians Healthy Weight Center
Rick Wilson, MD	Lakes Region Health Care

Foundation for Healthy Communities Staff

Bernie Cameron, RN	Community Coordinator
Beth Gustafson Wheeler	Community Coordinator
Shawn LaFrance	Executive Director
Eric Pollak, MD	Senior Advisor for Clinical Affairs
Rachel Rowe, RN	Associate Executive Director



FOUNDATION FOR HEALTHY COMMUNITIES

125 Airport Road
Concord NH 03301
603.225.0900
www.healthyNH.com

January 27, 2010

Subject: HB 1479- An act requiring that body mass index be assessed in all pupils in grades one, 4, 7, and 10

Dear Chairman Rous and Members of the House Education Committee:

The New Hampshire Public Health Association (NHPHA) asks that you **support** HB 1479 which requires body mass index to be assessed in all pupils in grades one, 4, 7, and 10 who have not opted out for religious reasons. This bill is a request of the commission on the prevention of childhood obesity. NHPHA was pleased to serve as a member of the Childhood Obesity Prevention Commission and to be an active participant in the commission meetings as well as helping to formulate the recommendations.

We have an obesity epidemic in this country. Rampant obesity has now emerged as the gravest threat to American public health, although we have barely begun to experience its full medical consequences and fiscal burdens.¹ Unlike previous generations of Americans who looked forward to longer lives and better health than their parents, today's children face shorter life spans.²

Today, two thirds of American adults are overweight or obese. Since the mid-1980's, the prevalence of overweight and obesity has increased steadily in both children and adults of all ages. New Hampshire is no exception. 24% of New Hampshire adults are obese³; 33% of New Hampshire third graders are overweight or obese⁴; and 25.7% of New Hampshire high school students are overweight or obese.⁵

This dramatic increase in obesity not only has severe consequences for the health of our population, but dramatically increases our health care costs. Obesity is known to increase the risk of heart disease, diabetes, some cancers, and death. Overweight and obesity are estimated to be second only to smoking as avoidable causes of death.

P.O. Box 2304, Concord, NH 03302-2304
Telephone: (603) 228-2983 Website: www.nhpha.org

¹ "Why Our Health Matters: A Vision of Medicine That Can Transform Our Future," Andrew Weil, MD, 2009.

² APHA Issue Brief: Shifting the Course of Our Nation's Health: Prevention and Wellness as National Policy, April 2009.

³ Centers for Disease Control and Prevention: "2008 State Obesity Rates".

⁴ New Hampshire Department of Health and Human Services: "New Hampshire 2008-09 Third Grade *Healthy Smiles - Healthy Growth Survey*".

⁵ New Hampshire Department of Education: "2009 Youth Risk Behavior Survey".

The annual medical costs for obesity in New Hampshire are estimated at \$302 million or \$232 per person. While New Hampshire needs to take a comprehensive approach to obesity prevention, this legislation before us today will help identify those children who are at risk of being overweight or obese and provide parents with information to help them take appropriate action. BMI data collection is one way the state can identify children early so that we can improve public health by reducing obesity and related costs.

The New Hampshire Public Health Association bases its opinions and recommendations on scientific evidence and fact-based strategies that promote health and reduce disease and injury. The Association has more than 200 members of individuals and organizations committed to the public health and safety of all New Hampshire residents.

I am happy to address any questions you might have regarding my letter. Please feel free to contact me at anytime at (603) 545-1389. Thank you for your attention.

Sincerely,

A handwritten signature in black ink that reads "Kristina L. Diamond". The signature is written in a cursive style with a large, prominent "D" at the end.

Kristina L. Diamond
Policy Director

January 26, 2010

Did not testify

RE: HB 1479

To: the Members of the House Education Committee:

I would like to offer the following points in support of NH House Bill 1479, requiring assessment of body mass index (BMI) in all pupils in grades 1, 4, 7 and 10.

State and National data indicate that New Hampshire's pediatric obesity and overweight prevalence ranges from 29.4 to 33 %* Many medical complications caused by obesity are now being seen in our children, including, Type 2 Diabetes Mellitus, Cholesterol disorders, Hypertension, Metabolic syndrome, Fatty liver (which can lead to cirrhosis), Polycystic ovary disease, Gall bladder disease, Gastro-esophageal reflux disease, obstructive sleep apnea, increased risk of asthma, psychological problems including anxiety, depression and low self-esteem. Over time, these children will be at risk for various cancers and cardiovascular disease and may expect a shorter life span than their parents.

Presently, we have no good statewide mechanism to track overweight and obesity prevalence in our children to learn if this problem is improving or worsening and to assess if various interventions may be helping,

Collecting statewide BMI data through the schools will give us such data to track.

While BMI is measured and documented in the medical record by primary care physicians, not all children are being followed by a primary care physician. Further there is no easy way to access all of this data in individuals' medical records.

The BMI can easily be obtained by trained school nurses or other personnel such as PE teachers, health teachers, etc., to monitor body fat of NH's students, much in the same way health screening for vision, hearing or scoliosis has been performed in schools. This data can be anonymously collected by the State and local school departments for tracking or monitoring purposes.

This screening would not single out or stigmatize any child as every child would be screened. BMI data would not be given directly to the student. This is an accepted best practice in many other states (e.g. Arkansas). While there are costs associated with BMI monitoring by the public schools, the costs of overweight and obesity in our children will be much greater if we do nothing.

Thank you for your time and interest in this matter.

Sincerely,
Susan Lynch, MD

*December 2009 – NH DHHS Third Grade Oral Health/BMI Report, July 2009 – Trust for America's Health Report (F as in Fat), September 2006 – Foundation for Healthy Communities (NH), April 2006 – NHANES Data published in JAMA

Report of the New Hampshire Commission on Prevention of Childhood Obesity



November 2009

Commission Members

Representative Joan Schulze (D-Nashua), Chair, Member of the House Health and Human Services Committee

Representative Nancy Stiles (R-Hampton), Vice Chair, Member of the House Education Committee

Senator Margaret Hassan (D-Exeter), Majority Leader, NH State Senate

Megan DeVorse, Governor's appointee, Member of the Concord School Board

Regina Flynn, representing the Commissioner of the NH Department of Health & Human Services

Judith Fillion, EdD, representing the Commissioner of the NH Department of Education

Sandi Van Scoyoc, representing the Citizens Health Initiative

Charles Cappetta, MD, representing the NH Pediatric Society

Mary McGowan, MD, representing the NH Expert Panel on Childhood Obesity

Jon Wahrenberger, MD, representing the American Heart Association--New Hampshire

Jackie Moulton and Dianne Rappa, representing NH Association for Health, Physical Education, Recreation & Dance

Andy Bohannon, representing the NH Recreation and Park Association

Yvonne Goldsberry, PhD, representing the NH Public Health Association

Colette Janson Sand, RD, PhD, representing the UNH Cooperative Extension Service

Staff

Shawn V. LaFrance, Executive Director, Foundation for Healthy Communities

Christina D'Allesandro, Program Consultant

Acknowledgements

Funding to support the staff and printing of this report were generously provided by the Harvard Pilgrim Health Care Foundation (www.harvardpilgrim.org/foundation). The Foundation for Healthy Communities provided in-kind staff support to assist the commission and to prepare this report (www.healthynh.com). The commission expresses its appreciation to all of the state agencies, voluntary organizations and individuals who provided testimony and information to help in the development of these recommendations.

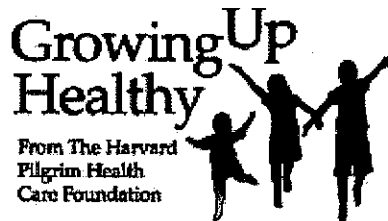


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Introduction

Obesity is robbing children of a healthy future. It is the first time ever when the gains in the life expectancy in the US may be reversed because of growing numbers of overweight and obese children who are at increasing risks of chronic diseases such as diabetes, high blood pressure, heart disease, stroke, etc. at earlier ages.



Many factors contribute to the unhealthy weight gains in children. Individual behavior is often a key focus for change but this assumes that healthy choices are easily available. The commission's focus was not on recommending changes in individual behaviors but on policies that will help create an environment where healthy choices are available and desirable to children.

Policies are important because they provide guidance and a framework for creating a healthy environment where children live, learn and play. Policy can be established at different levels too. State level policy can provide broad guidance that supports places where physical activity and food choices contribute to children maintaining a healthy weight as they grow. Policies in local communities can determine whether there are sidewalks, bike lanes or recreation spaces for children to safely have opportunities for physical activity. Organizational policies in schools or child care settings can determine whether children can have healthy drinks and snacks or more fat, sugar-sweetened or salty choices.

Developing policy is not a simple process and it can happen in different ways. A board of directors or trustees may set policy for an organization. Elected officials legislate public policy. Individual advocates may encourage leaders to enact policies or organize coalitions to promote change. PolicyLink, a national research and action institute (www.policylink.org), suggests "the voices of local advocates allow policymakers to understand protective and risk factors from a community perspective. Successful approaches can become the basis for regional and statewide agendas for change."ⁱ

But policies are only meaningful if they are implemented with specific standards and accountability. There is a great need for parents, teachers, health providers and other concerned citizens to advocate for the implementation and monitoring of policies. Advocacy is needed to ensure that the policy is achieving its desired intent and/or make policy changes to improve it.

This report is focused on the prevention of childhood obesity but the Commission recognizes that some children and adolescents have eating disorders that make them underweight. The US National Center for Health Statistics estimates that 3.3% of children ages 2-19 years were underweight in 2006, down from 5.1% in 1974.

The **5-2-1-0** message reminds us to eat **5 vegetables and fruits a day**, to **limit screen time in front of a TV or computer to 2 hours** or less, to participate in **1 hour of moderate to vigorous exercise** and to **restrict soda or sugar-sweetened drinks**.

This is a simple message readily available to use in most settings where children learn and play. The strength of this message is in its simplicity and clarity.



Background

The NH Expert Panel on Prevention of Childhood Obesity, a diverse group of professionals representing many different disciplines in health and education, issued a set of recommendations for individuals and organizations related to nutrition and physical activity in 2007 (http://www.healthynh.com/fhc/initiatives/ch_obesity/index.php). These recommendations were practical strategies for New Hampshire, based on national research studies. Following the release of these recommendations, a group of private funders pooled resources to help implement the Expert Panel recommendations between 2007 and 2009 in two areas of the state – the Mount Washington Valley region in the north and the Derry/Londonderry area in the southern part of the state.

Implementation was focused on several fronts – primary/pediatric care providers, schools, municipal recreation agencies, after school programs and a variety of youth serving organizations. It became apparent during the implementation work that the practical strategies focus of the Expert Panel did not address state level policy issues that influence the ability of individuals and local organizations to implement desired prevention strategies. For example, pediatric clinicians were engaged in identifying the Body Mass Index of children and assessing and advising them on eating and activity levels, but when a child in the Medicaid program was identified as obese, the Medicaid program would not pay for follow-up counseling with a registered dietician. Additionally, New Hampshire has no state level guidelines related to the food served in schools that is not part of the federal USDA lunch and breakfast programs. These two examples illustrate, in part, why legislation was introduced (HB1422) to establish a legislative commission on the prevention of childhood obesity that would examine relevant state policies and make recommendations on policy changes to the governor and legislature. The Foundation for Healthy Communities, a non-profit organization with a mission to promote health and health care, provided staff support for the commission's work with funding from the Harvard Pilgrim Health Care Foundation.

Body Mass Index (BMI) is a number calculated from a child's weight and height. BMI is used as a screening tool to identify possible weight problems in children.

It is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems. For children and teens, BMI is age- and gender-specific and is often referred to as "BMI-for-age." After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking.



In May 2008, the Foundation for Healthy Communities was selected by a consortium of funders to be the lead organization in New Hampshire for coordinating implementation of the NH Healthy Eating Active Living (HEAL) Action Plan (www.healnh.org). The HEAL Action Plan calls for interventions related to policy, practice and communications. It was decided to make the commission's work the focus for policy activities rather than establish a new HEAL policy work group.

House Bill 1422 was introduced with bi-partisan sponsorship in the fall of 2007. Its sponsors were: Rep. Schulze, Hills 26; Rep. Stiles, Rock 15; Rep. Gile, Merr 10; Rep. Gargas, Hills 5; Rep. Daler, Hills 4; Sen. Foster, Dist 13; and Sen. Roberge, Dist 9. Public hearings were held and the bill received strong support from many individuals, organizations, and the NH Children's Advocacy Network. Elementary school children from Nashua and Concord advocated at the public hearing for the legislation. The commission was established by House Bill 1422 in the 2008 Session (Chapter 219). The legislature amended HB 1422 in its review process to explicitly request that the commission develop "recommendations to assist schools in adopting and implementing school nutrition standards." The bill was signed by Governor John Lynch on June 16, 2008.

Commission Duties

House Bill 1422 established a commission on the prevention of childhood obesity with 14 members. The duties (219:3) of the commission are:

The commission shall identify and consider legislative and policy strategies that may be effective in the prevention of childhood obesity in New Hampshire. The commission shall seek input from individuals or entities that the commission deems relevant to its study. The commission's study shall include, but not be limited to:

- a. The efficacy of current laws, regulations, education and certification standards, and clinical protocols in promoting physical activity and healthy eating;
- b. An examination of evidenced-based or promising practices from other states and jurisdictions relative to statewide policy, local ordinance, and educational programming strategies;
- c. The health consequences and economic impact of childhood obesity in the state and the economic impact of any prevention policies or strategies;
- d. Strategies to address the needs of particular regions of the state or certain populations within the state most impacted by childhood obesity; and
- e. Developing recommendations to assist schools in adopting and implementing school nutrition standards.

The commission shall report its findings and any recommendations for proposed legislation to the speaker of the House of Representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library on or before November 15, 2009.

219:6 Effective Date. This act shall take effect upon its passage. Approved: June 16, 2008, Effective Date: June 16, 2008.

The first meeting of the commission was held July 31, 2008. The process of engaging key stakeholders in the commission's work has been instrumental in educating and building awareness among groups such as school administrators, children's advocates, teacher unions, local food advocates, etc. A record of the commission's meetings is available at www.healnh.org in the "About HEAL" policy web page.

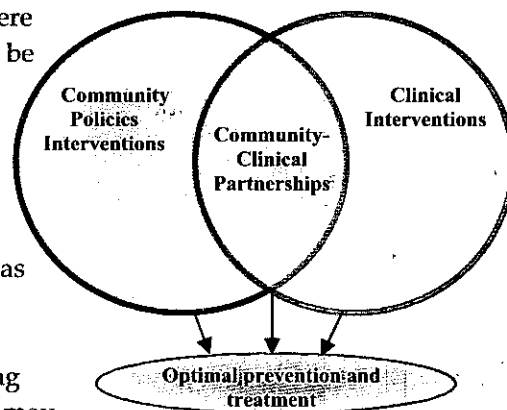
The commission held 15 meetings and public hearings. Members identified four major criteria in helping to determine their recommendations:

- Is this recommendation based on the best evidence or knowledge available?
- Will the recommendation help to raise awareness of the childhood obesity issue and advance the well-being of children?
- How does this recommendation relate to legislative or policy strategies of the state?
- What is the likelihood of some practical action to result from this recommendation?

The Problem of Childhood Obesity

There are many factors that contribute to childhood health outcomes. There are genetic factors, which can increase or decrease potential for a child to be overweight or obese. While this is important to note, there is no indication that genetic factors have significantly changed over the past few decades or are drastically influencing the current rise in childhood obesity. Environmental factors, including access to parks and recreation, TV time, food access and availability, can also drastically impact child health. Another significant set of factors include behavioral choices such as energy intake and levels of physical activity.

A social-ecological approach to addressing unhealthy weight gains among children takes into account an understanding of the multiple factors that may



influence behavior. Spheres of influence include the individual, interpersonal/lifestyle, institutional/organizational, community, and public policy. Childhood obesity is a health issue that may be addressed through a social-ecological approach because there are many community policies and clinical factors related to its prevention and treatment. Community coalitions are critical to advocating for changes that will help to prevent childhood obesity.



At its core, the obesity epidemic is fueled by an imbalance of energy. The Robert Wood Johnson Foundation's Center to Prevent Childhood Obesity (www.reversechildhoodobesity.org) explains, "A child's energy balance is affected by the energy (calories) consumed and the energy expended to support normal growth, physical activity, and daily living. What children eat and drink, and how much physical activity they get, are influenced by key features of their social, built, natural and food environments." Too many children are not engaging in adequate physical activity, nor are they eating appropriate foods. These behavioral factors contribute to increased weight gain and health risks.

Significant changes must occur in the short term if we are to stem this epidemic. These changes will impact all areas that involve children--home, schools, child care, after-school programs, and communities. One approach being implemented by the U.S. Centers for Disease Control and Prevention to address a community perspective is called 'MAPPS.' It aligns interventions on nutrition and physical activity into five strategies: Media, Access, Point of Purchase/Promotion, Price and Social Support & Services. The obesity epidemic is the result of many factors. Policy changes that support systemic strategies will help to alter the factors creating this problem.

Current Data

New Hampshire does not have a statewide system to track the prevalence of unhealthy weight in children and youth but there are some national reports and special studies that have been done within the state that help to document the problem. The N.H. DHHS conducted a BMI and oral health survey of third graders in 81 public schools in the state during the 2008-09 school year. The results of the survey will be released soon.

Among pre-school age children, the Pediatric Nutrition Surveillance System (PNSS) is a source of prevalence data. This surveillance system monitors the nutritional status of low-income children in selected federally-funded maternal and child health programs. The 2007 PNSS found that 15.8% of children between ages 2 to 5 years of age in the N.H. WIC Program were obese (95th percentile BMI-for-age) compared with a national rate of 14.9%. The best rate in this state-by-state comparison was 9.2% in Hawaii (www.cdc.gov/pednss).

Among older children, the National Survey of Children's Health (NSCH), is a phone survey of parents with children ages 10-17 years, conducted by the US Department of Health and Human Services to monitor this health problem. The 2007 NSCH identified the New Hampshire prevalence rate at 29.4% of children overweight or obese. Minnesota and Utah tied for the best rate, with 23.1% of children overweight or obese.

The Youth Risk Behavior Surveillance (YRBS) is a national data system that focuses on youth in grades 9-12. Among 30 states participating in the 2003 YRBS, New Hampshire youth self-reported that 13.4% were at risk of becoming overweight (range: 11-16.7) and 9.9% reported being overweight (range: 7-15.7). The 2007 YRBS in New Hampshire found self-reports of being at risk of becoming overweight increased to 14.4% and being overweight increased to 11.7% (www.cdc.gov/mmwr and www.ed.state.nh.us/). The national YRBS data in 2003 was analyzed by the Centers for Disease Control and Prevention for the association between physical inactivity and academic achievement. The CDC analyses found that students with higher grades were more likely to engage in sufficient vigorous physical activity, play on at least one school or community sports team, and watch less than 3 hours of TV on a school day (<http://www.cdc.gov/HealthyLiving/>).

The Foundation for Healthy Communities conducted a statewide study in New Hampshire in 2006 to help document the problem (www.healthynh.com). Primary care practices serving communities throughout New Hampshire were invited to participate in a voluntary statewide medical chart review project to document

Regional and Population Variations

An examination of a geographic subset of the Foundation for Healthy Communities data, which included three communities in Coos County (185 children ages 6-12 years old) that participated in the study, found a prevalence rate of 40% of children overweight or obese compared to the statewide average of 32.8%.

The Foundation for Healthy Communities study found that among children with private insurance 30.6% were overweight or obese compared to 37.7% of children in the Healthy Kids Program (Gold and Silver). Focusing only on obesity, it was highest among the children enrolled in Healthy Kids at 22.6% compared to 13.5% of children with private insurance.

The Manchester Department of Health report found 1 out of 3 (33.8%) of first graders who were overweight did not have health insurance or were enrolled in the Healthy Kids Gold (Medicaid) or Silver Program. More than half (51.3%) of the Manchester first graders who were overweight had private health insurance.

The Hood Center for Children and Families at Dartmouth Medical School studied adolescents in rural areas of New Hampshire and Vermont over a five year period. It found 28.9% of students surveyed among these rural towns were overweight (BMI at 85th percentile or greater). This was higher than either the statewide prevalence rates for NH or VT in 2007.

childhood obesity prevalence and better understand how it is addressed in the primary setting. The data were abstracted by a nurse from well-child visit records in a convenience sample of 25 primary care practices from 17 different communities. These descriptive statistics are from 1,453 children randomly identified in 2005 and stratified by gender and age (6-9 and 10-12 year olds). Key findings:

- Overall, 32.8% of children ages 6-12 years were overweight or obese. For females, 16.5% were overweight and 13.3% were obese. In males, 15.9% were overweight and 19.9% were obese.
- The survey found that among females, ages 6-9 years old, that 25.4% were overweight or obese (overweight: 13.9%; obese: 11.5%) compared to 34.6% for males in the same age range (overweight: 15.2%; obese: 19.4%).
- In the older age range, 10-12 years old, the overall percentage of overweight or obese children for both females and males was 37%. Among females 20.9% were overweight and 16.4% were obese. Among males, 17.1% were overweight and 20.3% were obese.

The Manchester Department of Health has published the most comprehensive local report on child obesity in New Hampshire. In 2001-02, it found that 39% of first graders were overweight and 19% were obese as determined by BMI at or above the 85th percentile and 95th percentile respectively.ⁱⁱ

Economic Consequences

The cost of ignoring the childhood obesity problem or doing nothing is enormous. Children are increasingly in need of treatment for obesity related conditions. Overweight and obese children face increasing health risks as they age. Furthermore, overweight and obese children are at far greater risk of developing long-term chronic health conditions such as Type II diabetes, high blood pressure, elevated cholesterol and many forms of cancer. Overweight and obesity with their associated health problems have a significant economic impact on the U.S. health care system.

A 2006 report by Thomson Medstat investigated the prevalence and cost of childhood obesity.ⁱⁱⁱ It found substantial disparities associated with different insurance coverage and health status.

- Children treated for obesity are roughly three times more expensive for the health system than the average insured child.
- Annual health care costs are about \$6,700 for children treated for obesity covered by Medicaid and about \$3,700 for obese children with private insurance.
- The national cost of childhood obesity is estimated at approximately \$11 billion for children with private insurance and \$3 billion for those with Medicaid.
- Children diagnosed with obesity are two to three times more likely to be hospitalized.



A 2004 study focused on state-level estimates of adult medical expenditures attributable to obesity (BMI greater than 30) estimated 5% of the adult population in New Hampshire were obese and direct medical costs were \$302

million. It estimated that 8.6% of New Hampshire adult Medicaid enrollees were obese at a cost of \$79 million.^{iv}

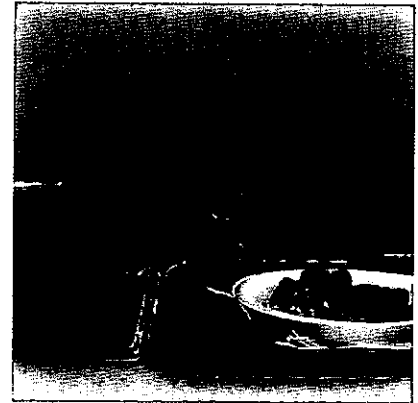
State-level estimates can assist policy makers in determining how best to allocate public health resources and provide information concerning the economic impact of obesity in a state.

In addition to the economic costs of childhood obesity, there are social and emotional costs. Obesity can impact a child's self-esteem and exacerbate existing health conditions. Lowered self-esteem may affect academic performance, with potentially even more serious adverse social outcomes in the long term.

Current Policy, Evidence-based Interventions and Recommendations

Food and Healthy Choices

The food and drinks that children consume are strongly influenced by what is made available for them. Parents are a key influence in what is available at home and at restaurants or other out-of-home locations where food is available. A majority of parents are concerned about their child's health and want them to eat and drink healthy food and beverages. Adolescents have more independence and more opportunities to make choices about what they consume, but parents still want to encourage healthy choices. Information about the nutritional aspects of what is provided to children can help parents make informed choices about the food they provide and help them to teach their children about making healthy choices. Foods made available to children by their school can either help to prevent unhealthy eating or contribute to this problem.



The N.H. Department of Education (DOE) has primary responsibility for food in schools. The Bureau of Nutrition in the DOE oversees the U.S. Department of Agriculture (USDA) meal programs. State law RSA 189:11a requires that a minimum of one meal be served at school each day and that meals shall be served without cost or at a reduced cost to any needy child who is unable to pay the full cost of a meal.

The USDA does not have authority to regulate foods sold outside the cafeteria or outside of meal times. USDA's policy does not allow "foods of minimal nutritional value" (FMNV) to be sold in the food service area during meal times. But those foods can be sold at any other time or place. USDA defines FMNV as foods that provide less than 5% of the Reference Daily Intake (RDI) for each of eight specified nutrients per serving. Thus, only foods like jelly beans, popsicles, and soft drinks are prohibited. Ironically, though, seltzer water is forbidden, while candy bars are allowed.

Foods provided outside the USDA meal programs include competitive foods or a la carte items, foods and drinks in vending machines, classroom snacks or events, school stores and school fund raisers. The sale of competitive foods may, at the discretion of the state agency, be allowed in the food service area during lunch period only if all income from the sale of such food accrues to the benefit of the nonprofit food service or the school or student organization approved by the school. DOE data show that for the school year August 2007-June 2008, food service revenues outside the meals (a la carte items) program were \$41.6 million. Federal public school reimbursable revenues were \$2.7 million (\$3.1 million breakfasts) and \$16 million (\$18.2 million lunch/after-school snacks). Also, there is \$823,000 of state funds for reimbursable meals. The DOE does not have established competitive food rules. Foods of minimal nutritional value are categories of foods which may not be sold in the food service area anytime during a meal period.

In 2008, the DOE completed a statewide content review of all school wellness policies. While most schools meet the minimum standard of the law for a school wellness policy, more needs to be done to put policy into practice. Nutrition standards were one of six components examined in their review. There were five schools districts which were rated 100% for their nutrition standards in the DOE school wellness policy and seven that were rated 0. The statewide average for this component was 57.2%.

Food is provided in schools in many ways, and the factors that influence food in schools are varied. The USDA Child Nutrition Programs are a key influence on food in schools through their lunch and breakfast programs. Local schools may also prepare and sell other foods and drinks during the lunch periods and at snack times. Local school districts and/or schools may contract for their food services to a vendor rather than employ staff to prepare and serve food in schools. Also, school children may bring food and drinks to school for their own consumption. The commission decided to focus its attention on the all foods and beverages that are not a part of the USDA programs because policies and requirements for USDA are set at the federal level.

There have been some efforts at improvements in other states. A number of states have passed legislation to directly combat childhood obesity.^v The new "F as in Fat" report identified 17 states that now have nutritional standards for school lunches, breakfasts and snacks that are stricter than current USDA requirements. In addition, 22 states have nutritional standards for competitive foods sold a la carte in schools. These laws regulate the range of foods not associated with the USDA school lunch programs.

The Dietary Guidelines for Americans (Dietary Guidelines) provides science-based advice to promote health and to reduce risk for major chronic diseases through diet and physical activity. An important component of each 5-year revision of the Dietary Guidelines is the analysis of new scientific information by the Dietary Guidelines Advisory Committee. The intent of the Dietary Guidelines is to summarize and synthesize knowledge regarding individual nutrients and food components into recommendations for a pattern of eating that can be adopted by the public. The recommendations are based on the preponderance of scientific evidence for lowering risk of chronic disease and promoting health. The recommendations in the Dietary Guidelines are for people over 2 years of age.

RECOMMENDATION #1

The commission recommends that the N.H. Board of Education use its school approval rulemaking authority by October 2010 to support the sale and distribution of single-serving size, nutrient dense foods in all schools during the school day ('bell-to-bell'). We recommend that nutrition standards address the different school grade levels (elementary, middle and high school) for all food and beverages available for sale to students. Nutrient dense foods are those foods which provide students with calories rich in the nutrient content needed to be healthy. In an effort to support the availability of nutrient dense foods in schools, we recommend that schools follow a nutrition guideline such as the Institute of Medicine or American Heart Association-Alliance for a Healthier Generation or Action for Healthy Kids-NH for foods sold in schools other than those regulated by the U.S. Department of Agriculture school meals program. These guidelines provide a framework to create healthier choices for foods and promote health. Establishment of national standards would override any state efforts.

The commission examined three sets of nutrition guidelines in studying this issue. The Institute of Medicine (www.iom.edu/en/Global/Topics/Food-Nutrition.aspx) has developed a guideline that is being promoted nationally. The American Heart Association and the William J Clinton Foundation have partnered with industry to create the Alliance for a Healthier Generation (www.healthiergeneration.org) and a set of guidelines. The N.H. Action for Healthy Kids (http://a4hk.org/state_profile.php?state=NH) also has developed guidelines.

Certain key elements are common to each of these guidelines. For example, both sets of recommendations emphasize low-fat and fat-free milk, 100% juice and water for beverages in schools and both sets of recommendations limit the amount of added sugar in flavored milks. The AHA/Alliance recommendation makes it possible for children to get their recommended serving of 100% juice in one sitting, while the IOM recommendation spreads that requirement throughout the day. IOM does not acknowledge that some 100% fruit juices are more nutritionally dense than others, whereas AHA/Alliance guidelines require that these juices contain at least 10% of the recommended daily value for three or more vitamins and minerals.

The **Gilford, NH, School District** offers a practical example of how these different guidelines have been adopted and implemented. The district's guidelines for food and beverages in a la carte school lunch sales are:

Food Items

- **Packaged snacks** - Will be a single serving and contain no more than 35% of calories from fat and no more than 35% added sugar by weight.
- **Fruits and vegetables** - Shall be fresh frozen, dried or canned and contain no more than 35% added sugar by weight.
- **Dairy products** - Shall consist of low fat cheese, yogurt and milk and contain less than 32 grams of total sugar per 8-ounce serving.
- **Ice cream novelties** - Will be limited to a 3-ounce serving, plain cups will be limited to 4 oz.
- **Meat and beans** - Shall contain no more than 35% of calories from fat.
- **Trail mixes/nuts/seeds/nut butters** - Portions shall not exceed 1.25 oz.

Beverages

- **Juices** - 100 % fruit & vegetable juice only, maximum container size of 12 oz.
- **Water**
- **Milk** - Maximum 2% fat, maximum 4 grams per ounce of total sugars (i.e. lactose and added sweetener), maximum container size of 16 oz.
- **Flavored water and lite beverages** - Not carbonated unless exempted by USDA, no caffeine, no fortified water, no more than 10 calories per 8 oz. from sugar or other caloric sweeteners, only non-caloric sweeteners approved by USDA.
- **Sports beverages** - No sport beverages will be sold on the school campus.

In addition, only foods that meet the nutrition and portion size standards for a la carte school lunch sales will be sold in vending machines and school stores on school campuses. Schools may hold an unlimited number of parties or celebrations if the food they are serving meet the nutrition and portion size standards for a la carte school lunch sales. Schools should limit parties and celebrations that involve food that do not meet the nutrition and portion size standards for a la carte school lunch sales during the school day to no more than one party per class per month. Schools will not use foods or beverages, as rewards or prizes or punishment.

The AHA/Alliance agreement does allow for the consumption of other beverages in high school, including sports drinks, diet soda and low calorie juices. The IOM permits diet soda only after school in high school and does not allow for sports drinks except when provided by coaches to children participating in vigorous sports lasting more than an hour.

Fat limits are the same for both the IOM and AHA/Alliance. For sugar, IOM measures carbohydrates by calories to allow for a greater variety of "dry" products like cereals and granola bars that have high nutrient content. The more commonly used 35% by weight measure adopted by the AHA/Alliance favors foods with higher moisture content. Additionally, IOM focuses on whole grains, while the AHA/Alliance uses fiber as the measure for healthful consumption.

Calorie limits in both standards are essentially the same although the AHA/Alliance guidelines are slightly stricter, taking into account the difference in calorie needs between older and younger children. The AHA/Alliance criteria incorporate positive nutrient contribution (e.g. fiber, calcium, potassium, Vitamin E) for snack foods over 100 calories. The IOM does not allow for reduced fat cheese or an egg as competitive snack foods.



A strong majority of parents believe that schools play a major role in maintaining and promoting healthy lifestyles among children, according to a September 2009 national survey by KRC (www.krcresearch.com) for Alliance for a Healthier Generation. This survey found that younger parents (under 45 years old) are more likely than older parents (age 45+) to believe schools play a major role in promoting healthy lifestyles (66% vs. 57%). Limiting access

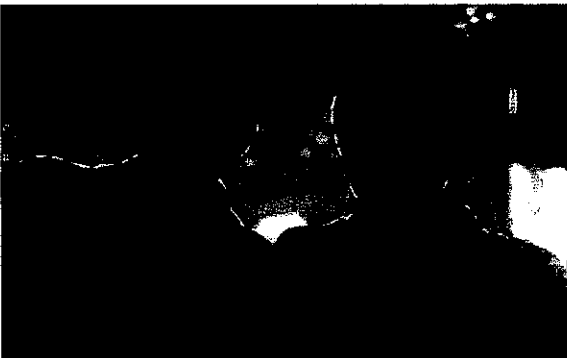
to unhealthy foods such as chips, candy and sugary drinks was rated as important (extremely or very important) by 81% of parents surveyed.

Food rating systems are marketed by the food industry in partnership with organizations such as the American Diabetes Association (*Smart Choices*), and the American Heart Association (red check mark on product). Other rating systems are employed by supermarket chains such as Price Chopper with *NuVal* and Hannaford with *Guiding Stars*. In N.H., *Guiding Stars* is offered by Hannaford Brothers supermarket to help consumers evaluate food based on its nutritional content. Foods are given points for the presence of vitamins, minerals, dietary fiber and whole grains, and lose points for the presence of trans fats, saturated fats, cholesterol, added sugars, and added sodium. Once a food's points are added up, its score results in a *Guiding Stars* rating from 0 (does not meet the nutritional criteria to receive a Guiding Star), to a maximum of 3 stars (best nutritional value). In 2009, *Guiding Stars* was introduced into the school food service at the University of New Hampshire (UNH) in Durham. Each prepared meal, salad bar and grab-and-go item served by UNH will receive a star rating.

Foods available in schools are not the only area where improvements are needed. With so many people eating meals away from home, it is essential that everyone have access to accurate information about the nutritional content of the food being served. Menu labeling with information on calories, fat, sodium and other selected nutrients can allow for a more informed choice by the consumer purchasing food in a restaurant. A June 2009 report by Healthy Eating Research, a national program of the Robert Wood Johnson Foundation, (www.rwjf.org/programareas/) found:

- While some restaurants provide nutritional information, most do not make this information available at point of purchase.
- Most consumers underestimate calories and fat in away from home foods.
- Most consumers would like to see nutrition information at places where they go out to eat.

Sixteen states have had legislation introduced to require some form of menu labeling with California being the only



one to pass a statewide requirement. Local legislation has been approved in New York City, Philadelphia, Seattle and Portland, OR. The National Restaurant Association agrees that providing consumers consistent information to a nationally agreed standard serves both consumers and restaurants. They launched an "Ask Us" program in 2005 to assist restaurant owners in providing nutrition information to customers (www.restaurant.org/nutrition/index.cfm).

The New York City menu-labeling law was implemented in July 2008, and a study of 12,000 customers in 2009 found that 56% reported viewing the calories data in fast-food restaurants, and those who viewed the information and used it consumed 106 fewer calories than those who did not. Significant calorie reductions among customers surveyed were noted at McDonalds, Au Bon Pain, KFC and Starbucks (www.rwjf.org/files/research2009).

RECOMMENDATION #2

New Hampshire should implement menu labeling in chain restaurants to ensure that nutritional information is made available at point of purchase. This consumer information is particularly important for children's menus.

SUBWAY is a national restaurant chain with branches in New Hampshire that provides the customer with information at the counter on the calories and fat content of sandwich items. Customers can decide on what they want to order with the nutrition information about the items-bread, meat, cheese, etc. before their sandwich is made.

Physical Activity

Physical activity for young people needs to be an essential element of any strategy looking to curb childhood obesity. Current state guidelines recommend that children engage in developmentally appropriate physical activity each day in school. Too often this recommendation is overlooked or ignored. The reasons for this are many. With increasing pressures to meet academic standards, some schools are eliminating physical education or recess to gain valuable minutes for the academic curriculum. Other schools choose to deny recess to children as punishment. The commission strongly disagrees with these practices. Denying recess or other physical activity ignores the holistic health needs and learning of children. While the added classroom time available when physical education is eliminated may seem to offer short-term gain, compelling evidence exists that physical activity can help to improve academic performance.

There is new research showing an association between better academic achievement and being physically active. A 2009 report by the National Association of State Boards of Education which looked at several research studies states, “students who are healthy and physically active are more likely to be motivated, attentive and successful academically.”^{vi} A study of elementary school children in Illinois demonstrated a positive association with aerobic capacity and achievements in mathematics and reading achievement. Castelli et al. found that among 259 third and fifth graders from four Illinois middle schools, field tests of physical fitness were positively related to academic achievement.^{vii} Specifically, aerobic capacity was positively associated with achievement, whereas BMI was inversely related. Associations were demonstrated in total academic achievement, mathematics achievement, and reading achievement, thus suggesting the aspects of physical fitness may be globally related to academic performance in preadolescents.

Another study of high school students who were underperforming in literacy found that students who took part in physical activity class and a literacy intervention gained improvement on a standardized reading test compared to those students who only participated in the literacy intervention.^{viii} In 2004, Naperville Central High School in Illinois began a “learning readiness” physical education program. Students identified as underperforming in literacy were offered an early morning physical education session immediately followed by a literacy support class. By the end of the semester, the students who took part in both the early morning physical education class and the literacy intervention gained 1.34 years of improvement on a standardized reading test. Their peers who did not participate in the physical education class prior to literacy instruction made only about 0.7 years of improvement. The school then followed this approach for mathematics instruction. The results were even more impressive. Students who exercised prior to the math intervention class increased their standardized algebra test score by 20.4 percent compared with their peers in the control group who only made 3.87 percent improvement.



RECOMMENDATION #3

All schools must adhere to the requirement to adopt and implement written policies that recommend developmentally appropriate daily physical activity and exercise (NH Ed 306.04 Policy Development (a) (15)).

The Department of Education already recommends daily physical activity for all children. It is essential that individual school districts ensure that all children engage in physical activity. This is particularly true for students in middle and high school, who are often overlooked when it comes to enforcing the requirement for daily physical activity. To this end, the commission recommends that all schools adhere to this requirement.



The NH Department of Transportation's **Safe Routes to School (SRTS)** Program helps communities by reimbursing them for the costs of developing walking and bike paths that allow children to get themselves to school. SRTS is designed for children from kindergarten through grade 8, including those with disabilities, who live within approximately two miles of school. More than 60 communities have been awarded over \$2 million for planning, infrastructure and education that support safe routes to school. Visit www.nh.gov/dot/ to learn more.

Opportunities for daily physical activity for children may take many forms. Interscholastic sports provide a significant opportunity for youth to compete and develop skills while in school. They also provide a vehicle for school spirit and community-building. Intra-mural sports and physical activity clubs are available in approximately 49% of middle schools and 45% of high schools according to national data. A study of rural areas in New Hampshire and Vermont by the Dartmouth Hood Center for Children and Families found that larger schools (enrollment > 950) offered more sports than smaller schools and that on average about 20% of students participate in at least one intramural sport.^x The most common intramural sports offered were skiing, snowboarding, Frisbee, dancing and basketball. The Hood Center research found that all schools in their study offered inter-scholastic athletics with an average of 10 sports offered for males and females. High schools offered nearly twice the number of sports than middle schools did. Sixteen percent of schools required a fee to participate compared to 32% nationally, although most will waive the fee if a student cannot afford to pay. Examining information on the amount of public funds allocated for inter-scholastics, intramural teams and recreational physical activity (e.g., dance, hiking club, etc.), and the number of individual children who participate in the programs offered can help policy advocates to understand the range of opportunities available and children served.



In addition to physical education classes, recess, interscholastic sports and club or intramural sports in school, there are other approaches to classroom-based physical activity. 'Take 10' (www.take10.net) and Activity Bursts in Classroom ("ABC") (www.davidkatzmd.com) are two strategies that classroom teachers can use to integrate physical activity within the daily academic curriculum.

One related initiative gaining increasing momentum is a movement to schedule recess before lunch as opposed to the traditional scheduling of recess after lunch. A report from Montana schools indicated having recess before lunch helps improve student behavior on the playground, in the cafeteria and classroom. Also, it increased nutrient intake as students wasted less food and drank more milk. There are toolkits on-line which can help to provide guidance for schools willing to consider this change (www.peacefulplaygrounds.com).

Physical education and health education are a critical part of a child's school day. They allow children to learn about their bodies and understand the implications of decisions they are making. Fitness assessments, such as the President's Challenge and the *FITNESSGRAM*, allow for a comprehensive measure of fitness as opposed to athletic ability. There is evidence that fitness assessments compliment BMI assessments, and offer the potential for students to learn about their overall health. The Commission strongly encourages the completion of a comprehensive fitness assessment annually by qualified personnel. These assessments should be shared with students and parents and can be compared over time to gauge progress over the long-term.

RECOMMENDATION #4

Qualified school personnel should complete a comprehensive fitness assessment for children and provide a health fitness report to children and parents every year.

FITNESSGRAM is an evidence-based comprehensive fitness assessment. It includes measures of aerobic capacity, body composition, muscular strength and endurance and flexibility. It has a set of standards, Health Fitness Zones, based on a child's gender and age. No one fails the fitness test although 'Needs Improvement' is a category. **FITNESSGRAM** is used at the Symonds School in Keene. Staff there looked at their grade 4 data to understand the fitness levels of students as a group and found that 60% of boys and 63% of girls met the fitness standard in 2006. Keene schools are planning to expand their collection and analyses of health information as part of their community Vision 2020 Envisioning a Healthier Future.

The Amherst school district uses **FITNESSGRAM** at each grade level. The child fitness level is provided to each student, and fitness plans and goals are generated from them. Additionally, programmatic decisions are driven from the collective data. The data is analyzed and disaggregated for use in comparisons with national data.

A study in California of students in grades 5, 7 and 9 has documented that as overall **FITNESSGRAM** scores increased, the mean reading and math standardized achievement scores also improved.^x **FITNESSGRAM** physical fitness test scores were compared to reading and mathematic scores on the standardized achievement tests. Subjects included all 5th, 7th, and 9th grade students in California public schools in 2002 for whom there was a complete set of data. The research found that as overall fitness scores improved, mean achievement scores also improved. The relationship between fitness and academic achievement appeared to be stronger for females than males and stronger for higher socio-economic status (SES) than lower SES students.

Best practices that derive from individual school approaches, as well as evidence-based curricula, should be shared with physical education and health teachers across the state. While professional associations help, there is currently no direct support to health and physical education teachers from the Department of Education. In the face of this burgeoning epidemic, and with the increased attention on schools and their potential to impact the obesity epidemic, there is a need for increased support for individual teachers.

RECOMMENDATION #5

Reinstitute the Physical Education and Health Coordinator position within the NH Department of Education to help support schools to implement their health and wellness programs and to share best practices.

Physical activities should be constructed to encourage participation from all children. The Commission heard testimony about evidence-based curricula, a number of which consist of non-competitive games. The Commission also heard about some out-of-school programs which promote lifelong habits of physical activity. These included fishing, hunting, snowshoeing and hiking clubs.

Children's Programs and Facilities

Offering healthy food choices and increasing physical activity must occur in all aspects of a child's life for sustained change. Schools cannot do it alone. For this reason, any comprehensive childhood obesity strategy must look at other locations which have sustained contact with children, including before and after school programs and child care centers.

There is a wide variety of different after-school programs, some of which are licensed, others are not. Some programs provide snacks and others do not. However, all programs have considerable contact with children and all can influence a child's life. The behavior that children observe in these environments can have a powerful

influence on the choices they make. The YMCA in Manchester testified before the Commission regarding recent changes to their job descriptions, which requires that all staff members participate actively with children, modeling the activity that the YMCA desires to see in all children.

RECOMMENDATION #6

All licensed and licensed-exempt after-school programs should serve and/or promote healthy snacks and provide for some physical activity each day.

Coordinated Approach to Child Health (CATCH) Kids Club is an evidence-based, coordinated school health program designed to promote physical activity and healthy food choices, and prevent tobacco use in children from preschool through grade 8. CATCH aims to equip children with knowledge, skills, self-efficacy and intentions to make healthy dietary and physical activity decisions. In 2004, the Keene Parks and Recreation Department implemented CATCH Kids Club (CKC), an after school program that combines physical activity and nutrition education. CKC has expanded to 57 program sites that include recreation departments, YMCAs, Boys & Girls clubs, etc. The Harvard Pilgrim Health Care Foundation is supporting this statewide expansion effort.

The Derry Boys and Girls Club has a CKC program and serves approximately 2,000 children in grades K to 5 in their after school program. In October 2007 the club decided to change to healthier snack options. The vending machines no longer sell sugary soda and candy bars in favor of water, juice, diet soda, granola bars, baked chips and Fig Newton cookies in single serving packages. Sales initially dropped 50%, but climbed back to 90% of sales within six months. In the spring of 2009, CKC members and staff planted a garden on-site to increase availability of fresh fruits and vegetables. It was a seed-to-table approach that taught the kids about growing food, harvesting it, food preparation and healthy eating.

Equally important is the influence of child care centers. These centers are a significant influence on children as they are developing lifelong habits. It is essential that they utilize best practices when caring for children. Therefore, recommendations on TV time limits and physical activity can provide useful guidance to help them provide the best care for children in line with emerging evidence.

The New Hampshire Child Care Program Licensing Rules regulate all licensed child care centers in the state of NH. The NH DHHS Bureau of Child Care Licensing reported 1,141 licensed child care providers facilities with 47,171 slots available in 2008. Current licensing rules focus on health and safety concerns, but do not address risk factors that can lead to unhealthy weight.

RECOMMENDATION #7

The commission recommends that child care licensing rules be modified through the rulemaking process no later than the next revision or no later than 3 years, to include specific language promoting physical activity, stimulation and limiting sedentary time for children in the care of licensed child care providers.

The **Lakes Region Child Care Center** in Laconia and Belmont serves 155 children ages 6 weeks to 6 years in child care and another 150 children in an after-school program. The center participates in the federal food program for child care and have successfully shifted the food program to healthier foods and local foods when available. In addition, the center changed how the food is served by using a family-style approach where children are able to select what they would like to eat and are part of the meal process. Marti Ilg, Executive Director, and her staff are leading this effort.

There is another group of children who require specific oversight to ensure that their needs are being met. These are the children in direct care of the State of New Hampshire. Children removed from their families are in the care of the DHHS Division of Children Youth and Families or the Division of Juvenile Justice Services. These are some of the most vulnerable children in our society and may face several health risks.^{xi} The 2007 NH KIDS COUNT reported that there were 1,646 children in out-of-home placements with about half of those children in foster homes in 2004. The remaining half live in group homes, a secure residential facility or therapeutic foster care.^{xii}

RECOMMENDATION #8

The commission recommends that the NH Department of Health and Human Services develop guidelines and an accountability procedure that ensures that all children in direct care of the State receive a BMI percentile-for-age assessment, at least one hour of daily physical activity and that congregate meals served to them meet the Dietary Guidelines for Americans.

Spaulding Youth Center is one of the oldest child facilities in the nation. It is located on a 470 acre hilltop site in Northfield and provides a safe, caring and supportive environment for youth to heal, learn, grow, and play. A professional staff of more than 180 offers 24/7 intensive residential treatment, educational and community services, including foster and respite care, for children and youth ages 6-20 with autism or other neurological impairments and boys in grades 1-8 with emotional and behavioral problems. Spaulding's Healthy Kids Initiative is designed "To inspire and nurture students and their families to achieve a healthy future through healthy life style choices." This initiative started 2 years ago with a primary focus on obesity prevention among the students by improving the amount of time that the children are physically active and the nutritional content of food consumed throughout the day.

Community Connections

Any effective response to childhood obesity should consider all areas of a child's environment. This includes all adults who through their decision-making or actions directly influence the built and natural environments of children and their families. The Commission heard testimony from many community advocates concerned about transportation, town and city planning, local agriculture and the pervasive influence of media that surrounds children today. The Commission was engaged in all the community issues and concerns that were raised and made specific recommendation related to two items.

The natural environment in New Hampshire is a significant asset to residents and visitors to the state. The commission heard about the educational and economic opportunities to increase the understanding of agriculture among children and their access to locally grown food.

The **New Hampshire Children In Nature Coalition** is dedicated to fostering experiences in nature that:

1. Improve physical and emotional health and well-being
2. Increase understanding of and care for the natural world
3. Promote stronger connections to community and landscape

The Coalition started in 2007 with the goal of bringing together various groups interested in reconnecting children with nature. An active on-line community and conferences create opportunities to learn more about effective strategies for engaging children and communities with nature (www.wildlife.state.nh.us/ChildrenInNature/).

In addition to an increasing number of garden projects linked to schools, child care centers and after-school programs, N.H. Farm to School (NHFTS) helps to bring local agriculture into the classroom. NHFTS works to strengthen relationships between local farms and schools by integrating agricultural production, school food procurement and school curriculum. NHFTS seeks to develop a healthy, community-based, community-supported school food system.

Through innovative programs, NHFTS works with both farms and schools to foster mutually beneficial relationships. The program started with the Apples and Cider project in 2003, which facilitated the purchase of locally grown apples and cider for 11 schools in NH. Currently over half of NH schools are purchasing through this program, the students benefiting not only from the quality fruit, but also from learning about lessons on nutrition, sustainability and food production. Other projects include the Get Smart/Eat/Local program, which takes the experience learned from the Apples and Cider project and applies them to a wider variety of products. The Fresh Fruit and Vegetable Project (FFVP), a USDA initiative, delivers funding to procure fresh fruits and vegetables to schools with lower-income students. NHFTS works alongside the Department of Education, UNH Cooperative Extension and others to support local procurement where appropriate.

RECOMMENDATION #9

Increase the number of schools in the N.H. Farm to School program, which purchase food from N.H. farms and help children learn more about healthy eating.

Laconia's Woodland Heights Elementary School students are enjoying locally grown foods. The USDA Fresh Fruit and Vegetable Project provides funds to schools with 50% or more students receiving free or reduced lunch, specifically for purchasing fresh fruits and vegetables, offered free to students at non-meal times during the school day. Woodland Heights has been a recipient of the FFVP for the last 2 years. The school is using this support to serve 600-700 pieces of fruit or vegetables a day, free of charge to students. The fruit and vegetables are set up in the cafeteria between breakfast and lunch. Students are welcome to help themselves, or bring items to distribute to their classrooms. This fall, students are enjoying local McIntosh apples from Surowiec Farm in Sanbornton. Surowiec Farm started out as a dairy farm in 1917, and has been a family farm ever since. Laconia's elementary and middle school cafeterias all offer salad bars with fresh vegetables and fruit.

Another Farm to School effort in Coos County has schools in Stewartstown and Colebrook purchasing local carrots and tomatoes from North Country Farm Fresh Cooperative.



A focus on "pedestrian-friendly environments, safety and actively promoting bicycling and walking by connecting and adding sidewalks wide enough for people to meet and talk" were recommendations of the New Hampshire Long-Range Transportation Plan issued by the Community Advisory Committee to the Commissioner of the NH Department of Transportation in June 2006

(<http://www.pps.org/transportation/info/>

[transportation_projects/nh_lrtp](http://www.pps.org/transportation/info/transportation_projects/nh_lrtp)). This plan emphasized that policy-makers need to link municipal land use decisions and transportation planning.

Town and city master plans are very important in creating an environment where children may safely engage in active living/physical activity. These plans should consider recreation and alternate forms of transportation for their communities. The commission believes a policy for local master plans should include a section that addresses the importance of walking and bicycling in their communities.



RECOMMENDATION #10

The commission recommends a section (o) be added to RSA 674:2 to address the importance of making communities places where people of all ages and physical abilities can easily and safely enjoy walking and bicycling as forms of transportation and recreation.

Excerpt from the **New Boston Master Plan** adopted by the New Boston Planning Board on September 12, 2006:

Livable, Walkable Community Goal:

To make New Boston a place where people of all ages and physical abilities can easily and safely enjoy walking and bicycling as forms of transportation and recreation.

Livable, Walkable Community Objectives:

1. To maintain and enhance the placement of and signage for crosswalks.
2. To employ traffic calming measures including education, enforcement and engineering.
3. To increase the availability of well connected, constructed and maintained sidewalks to include winter plowing.
4. To adopt and enforce motor vehicle noise performance standards.
5. To incorporate bicycling and walking facilities into all transportation projects as required by the American Association of State and Highway Transportation Officials (AASHTO) Standards and the Americans with Disabilities Act (ADA) standards.
6. To provide easy, safe and accessible walking and bicycling to all key destinations throughout the town.
7. To investigate and create innovative alternative parking options.
8. To improve nighttime lighting for easy and safe walking and bicycling while limiting or prohibiting light pollution as prescribed by the International Dark-Sky Association.
9. To explore alternative routes across town without accessing the town center.
10. To develop a contiguous walking, bicycling and recreational trail system throughout the town.

The commission heard testimony about the issue of new school construction and the accessibility of schools for children who want to walk or bicycle. According to the US Environmental Protection Agency (EPA), in 2001, 15% of students ages 5-15 years walked to or from school and 1% biked compared to 48% who walked or biked in 1969.^{xiii} The EPA study found that school proximity to students matter for walking and bicycling and the built environment influences student travel choices. They estimate that neighborhood schools would produce a 13% increase in walking or biking. The NH Department of Education oversees State building aid funds for schools. The Department has school siting standards related to motor vehicle parking and outdoor space requirements but no policy on school siting to encourage pedestrian accessibility of new schools. It does have a waiver process for schools that want to use State funds for renovation or new construction that do not meet the standards for motor vehicle parking and other outdoor space. The NH Preservation Alliance (www.nhpreservation.org) is leading an effort in the state to examine issues related to schools and sustainable energy and economic practices.



Another issue raised in testimony before the commission was media literacy. Media literacy can be a powerful tool for helping children to understand media messages in order to make healthy choices. Media Awareness Network (MNet) did a comprehensive study of the connections between media literacy and childhood overweight and obesity. They found young people today are media savvy, spending a great deal of their time engaged in various forms of media. Screen time for our children continues to grow, with weekday averages of 5-6 hours, rising to 6-7.5 hours per day on the weekends with many kids using various forms of media at the same time. MNet reports that on an average weekday, our kids spend: 54 minutes instant messaging; 50 minutes downloading and listening to music; 44 minutes playing online games; and 30 minutes doing school work.

According to New Hampshire's own Media Power Youth (www.mediapoweryouth.org) children see 10,000 food ads annually - predominantly for sugary, fatty, salty foods which are dense in saturated fat and calories. In 2005, the Institute of Medicine found that advertising affects children's food choices, food purchase requests, and diets, and plays a key role in the current epidemic of childhood obesity, diabetes and other health problems. Billions are spent annually to market food and beverages to children and about 80% of foods advertised on television shows intended for children are for convenience/fast foods and sweets.^{xiv} Media Power Youth in New Hampshire provides training and education to help immunize children against media's influence on health issues including obesity. Using a community-wide collaborative approach, lesson planning and training sessions demonstrate how to incorporate media literacy into multiple curricula and classroom settings.

Health Care

One key intervention to help a child achieve a healthy weight is nutritional counseling. A registered dietician (RD) has the expertise to help a child, and their parent and/or caregiver, understand the nutritional elements in the food and beverages they consume.

RECOMMENDATION #11

The commission recommends that all insurance carriers in New Hampshire (both Medicaid and private insurers) allow a minimum of four registered dietician visits, if clinically recommended, for all children with a BMI-for-age percentile equal to or greater than 85%.

Private health care insurance is the largest source of coverage in N.H. More than 70% of children in NH are insured through the private sector. There are about 60,000 children who receive insurance through the Medicaid program. The three major private health insurance companies are Anthem Blue Cross Blue Shield, Harvard Pilgrim Health Care and CIGNA. The three major insurers offer individual nutrition assessment and counseling for children by a registered dietician to prevent or treat a medical illness and ordered by a primary care provider or other contracted provider. The NH Medicaid Program currently does not offer individual nutrition counseling by an RD for children who are obese or overweight unless they have a diabetes diagnosis. They will pay a physician to do nutrition counseling although most pediatricians do not have the expertise in nutrition to counsel and often believe this may not be the best use of their time.

An example of a patient that can be helped by **working with a Registered Dietician** is TAZ, a 16 year old, obese male with dyslipidemia and a strong family history of coronary artery disease. Weight: 249 pounds, 6 feet tall, BMI 33.2, Cholesterol- 169 mg/dL, Trigs-180 mg/dL, HDL- 35 mg/dL, LDL 130 mg/dL. He was seen for a 45-minute nutrition consultation to discuss dietary strategies to promote weight loss and improve lipids. He was asked to avoid cheese, cream in coffee, and avoid sugar rich beverages. At a follow-up consult, 3 months later - weight: 244 pounds, BMI 32.5, Cholesterol-151 mg/dL, Trigs-146 mg/dL, LDL 87 mg/dL and HDL 35 mg/dL. TAZ is now back in school and would benefit from bringing lunch from home since he is buying school lunch daily. Another follow-up consult is scheduled in 3 months.

Very few medical professionals receive adequate training on childhood obesity issues. As a result, many in the medical community do not have sufficient knowledge or experience on how to assess and advise overweight or obese children and their parents on the risk factors and strategies related to preventing and addressing childhood obesity. Despite numerous clinical guidelines, only 39 percent of pediatricians believe they could effectively manage obesity in their patients and, worse, only 12 percent of them report high self-efficacy in this skill set. To help boost their confidence in managing childhood obesity and, in turn, to assist in the interpretation and adoption of the AMA recommendations, physicians need access to educational programs, clinical tools, and weight-management and community-based physical activity programs.^{xv}

Systemic improvements in integrating the promotion of good nutrition and clinical skills are warranted in the education of the primary care physician. Currently, there are opportunities for the already practicing physician to be taught strategies to prevent and manage childhood obesity, and to learn about reimbursement for these office visits. Although nutrition education has been added to the curricula of some residency programs, more comprehensive efforts are needed to consistently teach residents the clinical skills necessary to promote optimal nutrition and physical activity in their patients.

RECOMMENDATION #12

A continuing medical education unit for physicians, registered nurses, registered dietitians and other health providers who work with children should be made available that specifically relates to childhood obesity and healthy choices.

The American Academy of Pediatricians identifies professional education opportunities on line at www.aap.org/profed/html, and the American Academy of Family Physicians lists programs at www.aafp.org.

BMI: Screening for Health

New attention has focused on measures that can help to identify children at risk of obesity. Body Mass Index (BMI) is widely accepted as a relatively easy and effective way to identify children who might be at risk of overweight or obesity. BMI relates to the amount of body fat and can provide a useful glimpse into overall health. The American Academy of Pediatrics (AAP) recommends that BMI should be calculated and plotted annually on all children as part of normal health supervision within the child's medical home. The Commission endorses this approach.

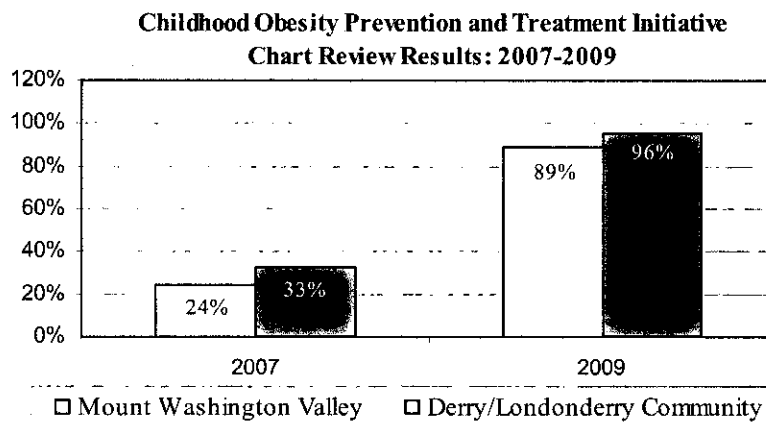
This can normalize the assessment of BMI and help parents to become more aware of the health risks of an unhealthy weight.

RECOMMENDATION #13

The commission recommends that all pediatric primary care providers assess the BMI percentile-for-age for everyone between 2-20 years of age as part of their annual well-child/well adolescent visit.

BMI can help a pediatric clinician, child and parent to identify children at risk of being overweight or obese. BMI is measured against a developmentally appropriate level, based on age and gender. While this measure is useful in isolation, recording and comparing BMI at different ages can help to identify children at risk, open the dialog about unhealthy weight gain and its associated health risks. This could potentially allow for behavior changes before the child is clinically obese.

Strategies for Improved Clinical Care in NH: In January 2007, a team of Nashua nurses, physicians, dietitians and administrators from Southern New Hampshire Medical Center, Saint Joseph Hospital, Dartmouth-Hitchcock, and Lamprey Health Care formed Stay'NHealthy. This collaboration was an adaptation and expansion of the successful and nationally recognized Maine Youth Overweight Collaborative (MYOC). The purpose of Stay'NHealthy is to increase the ability and effectiveness of primary care providers to prevent, manage and treat overweight/obese youth and their families by providing clinicians with needed training, tools and support. The program also strengthens links with community partners. This program had a wide reach, involving approximately 78% of the pediatric clinicians and reaching two-thirds of the children from 2-18 years in the greater Nashua area.



Rich Laracy, DO, a pediatrician at **Saco River Medical Center** in Conway knew that fewer children were at a healthy weight but knew it would take a community effort to make change. Dr. Laracy and his clinical colleagues made a commitment to assess BMI on all their patients and to assess and advise children about physical activity, healthy eating and screen time. They used the 5-2-1-0 message to help guide their effort. The doctors at **Londonderry Pediatrics**, a practice with about 1,000 patients, made a similar commitment to help prevent childhood obesity. Their busy practice uses a paper medical record and adapted the 5-2-1-0 assessment tool in their office. In addition, Dr. Kerry Houston and Dr. Shanon Gruchot became engaged in their school wellness committee to help create a healthier learning environment in school. The practice also has added dietitians to help with nutrition consults.

Testimony to the commission revealed that in Manchester, an estimated 2,500 children in the city had no primary care physician. The 2007 New Hampshire KIDS COUNT Databook estimates 6% of children ages 0 to 17 in NH (15,700 to 21,700 children) have no health insurance coverage. Uninsured children are less likely to receive routine well-child care. The commission decided for this reason, as well as for overall state public health surveillance, to recommend school-based BMI screenings for all children.

The Institute of Medicine recommends annual school-based BMI screenings. The CDC expresses some concern about BMI measurement in school because the link or lack thereof, between BMI measurement and referral for treatment. It is therefore important that schools help to link parents with community health providers.

RECOMMENDATION #14

The commission recommends that BMI be assessed every year in school by a qualified/trained individual and that this be enforced through school accreditation process.



BMI is a public health tool that is most effective when measured over time among different age groups. The Commission determined that identifying the BMI of children in grades 1, 4, 7 and 10 would adequately measure growth over time, while accounting for growth spurts apparent in all children. The collection of this BMI data at these four time periods will balance the need for information to understand the problem and monitor changes over time.

There are 20 states that currently require BMI collection in schools, and a number of others are considering enacting such legislation. Collection of BMI in schools, as a part the routine health assessments, can help to raise awareness of a common child health indicator, inform parents, engage

school nurses in positive dialog with children and provide the state with useful information about the trends in childhood obesity. A comprehensive public awareness program around the use of BMI as a health screening tool should be delivered alongside any effort.

Pine Tree Elementary School in Center Conway is a K-6 grade school with 216 students that does an annual BMI screening on all students. School nurse Cheryl Clapp, RN confidentially sends the BMI screening results home to parents so they can be aware if further follow-up with the child's pediatric primary care provider is advisable.

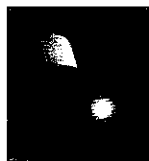
The Commission endorses a set of best practices defined by the CDC, which can help to ensure that the BMI measurement ensures privacy and respect for all students. The CDC advises that BMI measurement programs should adhere to the following safeguards:

- introduce the program to school staff and community members and obtain parental consent,
- train staff in administering the program (ideally, implementation will be led by a highly qualified staff member, such as the school nurse),
- establish safeguards to protect student privacy,
- obtain and use accurate equipment,
- accurately calculate and interpret the data,
- develop efficient data collection procedures,
- avoid using BMI results to evaluate student or teacher performance, and
- regularly evaluate the program and its intended outcomes and unintended consequences.

BMI data collection will help health professionals to recognize children who are at risk of childhood obesity and related diseases. Identifying children early, makes it possible to help children, their families and the community to modify the child's environment and unhealthy behaviors and support healthy eating and active living.

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FOUNDATION FOR
HEALTHY COMMUNITIES

125 Airport Rd.
Concord, NH 03301
603-225-0900
www.healthynh.com

Recommendations from the New Hampshire Commission on Prevention of Childhood Obesity

1. The commission recommends that the N.H. Board of Education use its school approval rulemaking authority by October 2010 to support the sale and distribution of single-serving size, nutrient dense foods in all schools during the school day ('bell-to-bell'). We recommend that nutrition standards address the different school grade levels (elementary, middle and high school) for all food and beverages available for sale to students. Nutrient dense foods are those foods which provide students with calories rich in the nutrient content needed to be healthy. In an effort to support the availability of nutrient dense foods in schools, we recommend that schools follow a nutrition guideline such as the Institute of Medicine or American Heart Association-Alliance for a Healthier Generation or Action for Healthy Kids-NH for foods sold in schools other than those regulated by the U.S. Department of Agriculture school meals program. These guidelines provide a framework to create healthier choices for foods and promote health. Establishment of national standards would override any state efforts.
2. New Hampshire should implement menu labeling in chain restaurants to ensure that nutritional information is made available at point of purchase. This consumer information is particularly important for children's menus.
3. All schools must adhere to the requirement to adopt and implement written policies that recommend developmentally appropriate daily physical activity and exercise (NH Ed 306.04 Policy Development (a) (15)).
4. Qualified school personnel should complete a comprehensive fitness assessment and provide a health fitness report to children and parents every year.
5. Reinstitute the PE and Health Coordinator position within the N.H. Department of Education to help support schools to implement their health and wellness programs and to share best practices.
6. All licensed and licensed-exempt after-school programs should serve and/or promote healthy snacks and provide for some physical activity each day.
7. Child care licensing rules should be modified through the rulemaking process no later than the next revision or no later than 3 years, to include specific language promoting physical activity, stimulation and limiting sedentary time for children in the care of licensed child care providers.
8. The N.H. Department of Health and Human Services should develop guidelines and an accountability procedure that ensures that all children in direct care of the State receive a BMI percentile-for-age assessment, at least one hour of daily physical activity and that congregate meals served to them meet the Dietary Guidelines for Americans.
9. Increase the number of schools in the N.H. Farm to School program, which purchase food from N.H. farms and help children learn more about healthy eating.
10. Add a section (o) to RSA 674:2 to address the importance of making communities places where people of all ages and physical abilities can easily and safely enjoy walking and bicycling as forms of transportation and recreation.
11. All insurance carriers in New Hampshire (both Medicaid and private insurers) should allow a minimum of four registered dietician visits, if clinically recommended, for all children with a BMI-for-age percentile equal to or greater than 85%.
12. A continuing medical education unit for physicians, registered nurses, registered dietitians and other health providers who work with children should be made available that specifically relates to childhood and healthy choices.
13. All pediatric primary care providers should assess the BMI percentile-for-age for everyone between 2-20 years of age as part of their annual well-child/well adolescent visit.
14. BMI should be assessed every year in school by a qualified/trained individual and enforced through school accreditation process.



- 5:** Fruits and vegetables...more matters! Eat at least 5 servings a day. Limit 100% fruit juice.
- 2:** Cut screen time to 2 hours or less a day.
- 1:** Participate in at least one hour of moderate to vigorous physical activity every day.
- 0:** Restrict soda and sugar-sweetened sports and fruit drinks.
Instead, drink water and 3-4 servings/day of fat-free/skim or 1% milk.

Contact the Foundation for Healthy Communities for more information on how you can promote 5-2-1-0 in your community!
Email us at info@healthynh.com or visit our website at www.healthynh.com to download 5-2-1-0 materials.

Voting Sheets

HOUSE COMMITTEE ON EDUCATION

EXECUTIVE SESSION on HB 1479-FN

BILL TITLE: requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.

DATE: February 16, 2010

LOB ROOM: 207

Amendments:

Sponsor: Rep. N. Stiles OLS Document #: 2010 0671h

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.) **AMENDMENT 0671h**

Moved by Rep. N. Stiles

Seconded by Rep. J. Day

Vote: 6-14 (Please attach record of roll call vote.) **HAND VOTE - MOTION FAILED**

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. R. Ladd

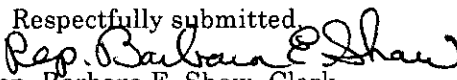
Seconded by Rep. K. Shaw

Vote: 16-4 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Barbara E. Shaw, Clerk

HOUSE COMMITTEE ON EDUCATION

EXECUTIVE SESSION on HB 1479-FN

BILL TITLE: requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.

DATE:

LOB ROOM: 207

Amendments:

Sponsor: Rep. *Stiles* OLS Document #: 2010-0671h
Sponsor: Rep. *[Signature]* OLS Document #:
Sponsor: Rep. OLS Document #:

① Motions: *amendment 0671h*
OTP OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. *Stiles*
Seconded by Rep. *Day*
Vote: *6-14* (Please attach record of roll call vote.) *hand vote*

② Motions: OTP, OTP/A, ITL Interim Study (Please circle one.)

Moved by Rep. *Ladd*
Seconded by Rep. *R. Shaw*
Vote: *16-4* (Please attach record of roll call vote.)

minority - Stiles

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,
Rep. Barbara E. Shaw
Rep. Barbara E. Shaw, Clerk

EDUCATION

Bill #: NB 1479-FN Title: requiring that BHI be assessed in all pupils in grades one, 4, 7 and 10.

PH Date: 11/27/2010

Exec Session Date: 2/16/2010

Motion: ITL

Amendment #: _____

MEMBER	YEAS	NAYS
Rous, Emma L, Chairman	Y	✓
Reever, Judith T, V Chairman	✓	
Yeaton, Charles B		✓
Clarke, Claire D	✓	
Shaw, Barbara E, Clerk	✓	
Shaw, Kimberly C	✓	
Day, Judith E	✓	
O'Neil, James M	✓	
Burke, Rachel B	✓	
Harvey, Philip R		✓
Casey, Kimberley S	✓	
Price, Pamela G	✓	
Ingbretson, Paul	✓	
Stiles, Nancy F		✓
Hutchinson, Karen K	✓	
Boehm, Ralph G	✓	
Laurent, John J	✓	
Ward, Brien L	✓	
Fleck, Joseph W	✓	
Ladd, Rick M	✓	
	16	4

Committee Report

REGULAR CALENDAR

March 3, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

**The Majority of the Committee on EDUCATION to
which was referred HB1479-FN,**

**AN ACT requiring that body mass index be assessed in
all pupils in grades one, 4, 7 and 10. Having considered
the same, report the same with the following**

**Resolution: RESOLVED, That it is INEXPEDIENT TO
LEGISLATE.**

Rep. Rick M Ladd

FOR THE MAJORITY OF THE COMMITTEE

MAJORITY COMMITTEE REPORT

Committee: **EDUCATION**
Bill Number: **HB1479-FN**
Title: **requiring that body mass index be assessed in
all pupils in grades one, 4, 7 and 10.**
Date: **February 16, 2010**
Consent Calendar: **NO**
Recommendation: **INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

In an effort to address obesity, this bill requires the body mass index (BMI) to be administered to all children in grades 1, 4, 7 and 10 whose parents have not requested an exception. The irony of well intended initiatives such as the BMI is that unintended consequences can compromise the desired outcome. First, there is an assumption that BMI is an accurate indication of a person's health. This is not the case as BMI ignores the critically important factors of body composition and frame size. The majority is further concerned that by implementing BMI, many healthy children will end up with their lives in turmoil because they don't fit an outdated, inaccurate tool administered and interpreted by an individual who may not be versed in proper nutritional and medical understandings. Harmful impacts that do result from BMI include: parent promotion of child dieting without medical guidance, increased stigmatization of obesity, lower self esteem, increased body dissatisfaction, eating disorders, and increased anxiety regarding body weight during growth years. Due to a child's physical, psychological and general well-being, the bi-partisan majority believes that this is an issue best addressed through the child's parent working directly with the family doctor, and should not be conducted in schools.

Vote 16-4

Rep. Rick M Ladd
FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

EDUCATION

HB1479-FN, requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.
INEXPEDIENT TO LEGISLATE.

Rep. Rick M Ladd for the **Majority** of EDUCATION. In an effort to address obesity, this bill requires the body mass index (BMI) to be administered to all children in grades 1, 4, 7 and 10 whose parents have not requested an exception. The irony of well intended initiatives such as the BMI is that unintended consequences can compromise the desired outcome. First, there is an assumption that BMI is an accurate indication of a person's health. This is not the case as BMI ignores the critically important factors of body composition and frame size. The majority is further concerned that by implementing BMI, many healthy children will end up with their lives in turmoil because they don't fit an outdated, inaccurate tool administered and interpreted by an individual who may not be versed in proper nutritional and medical understandings. Harmful impacts that do result from BMI include: parent promotion of child dieting without medical guidance, increased stigmatization of obesity, lower self esteem, increased body dissatisfaction, eating disorders, and increased anxiety regarding body weight during growth years. Due to a child's physical, psychological and general well-being, the bi-partisan majority believes that this is an issue best addressed through the child's parent working directly with the family doctor, and should not be conducted in schools. **Vote 16-4.**

Original: House Clerk
Cc: Committee Bill File

In an effort to address obesity, this bill requires the body mass index (BMI) to be administered to all children in grades 1, 4, 7 and 10 whose parents have not requested an exception. The irony of well intended initiatives such as the BMI is that unintended consequences can compromise the desired outcome. First, there is an assumption that BMI is an accurate indication of a person's health. This is not the case as BMI ignores the critically important factors of body composition and frame size. The majority is further concerned that by implementing BMI, many healthy children will end up with their lives in turmoil because they don't fit an outdated, inaccurate tool administered and interpreted by an individual who may not be versed in proper nutritional and medical understandings. Harmful impacts that do result from BMI include: parent promotion of child dieting without medical guidance, increased stigmatization of obesity, lower self esteem, increased body dissatisfaction, eating disorders, and increased anxiety regarding body weight during growth years. Due to a child's physical, psychological and general well-being, the bipartisan majority believes that this is an issue best addressed through the child's parent working directly with the family doctor, and should not be conducted in schools.

ER

In an effort to address obesity, this bill requires the body mass index (BMI) to be administered to all children in grades 1, 4, 7 and 10 whose parents have not requested an exception. The irony of well intended initiatives such as the BMI is that unintended consequences ~~do~~ ^{can} compromise the desired outcome. First, there is an assumption that BMI is an accurate indication of a person's health. This is not the case as BMI ignores the critically important factors of body composition and frame size. The majority is further concerned that by implementing BMI, many healthy children will end up with their lives in turmoil because they don't fit an outdated, inaccurate tool administered and interpreted by an individual who may not be versed in proper nutritional and medical understandings. Harmful impacts that do result from BMI include: parent promotion of child dieting without medical guidance, increased stigmatization of obesity, lower self esteem, increased body dissatisfaction, eating disorders, and increased anxiety regarding body weight during growth years. Due to a child's physical, psychological and general well-being, the bi-partisan majority believes that this is an issue best addressed ~~with~~ through the child's parent working directly with the family doctor and should not be conducted in schools.

Ladd

COMMITTEE REPORT

COMMITTEE: Education

BILL NUMBER: HB 1479-FN

TITLE: requiring that body mass index, etc.

DATE: 2-16-10 CONSENT CALENDAR: YES NO

- OUGHT TO PASS
- OUGHT TO PASS W/ AMENDMENT
- INEXPEDIENT TO LEGISLATE
- INTERIM STUDY (Available only 2nd year of biennium)

Amendment No.

STATEMENT OF INTENT:

COMMITTEE VOTE: 16-4

- Copy to Committee Bill File
- Use Another Report for Minority Report

RESPECTFULLY SUBMITTED,
Rep. *ERous for Rick Ladd*
For the Committee

REGULAR CALENDAR

March 3, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

**The Minority of the Committee on EDUCATION to
which was referred HB1479-FN,**

**AN ACT requiring that body mass index be assessed in
all pupils in grades one, 4, 7 and 10. Having considered
the same, and being unable to agree with the Majority,
report with the following amendment, and the
recommendation that the bill OUGHT TO PASS WITH
AMENDMENT.**

Rep. Nancy F Stiles

FOR THE MINORITY OF THE COMMITTEE

MINORITY COMMITTEE REPORT

Committee: **EDUCATION**
Bill Number: **HB1479-FN**
Title: **requiring that body mass index be assessed in
all pupils in grades one, 4, 7 and 10.**
Date: **February 16, 2010**
Consent Calendar: **NO**
Recommendation: **OUGHT TO PASS WITH AMENDMENT**

STATEMENT OF INTENT

This bill came as a result of the two year commission on overweight and obesity in children and is one of the fourteen recommendations to come forth from that commission. Overweight and obesity has reached epidemic proportions in this country and medical research tells us that this generation of children may be the first generation to have a shorter life expectancy than their parents. Overweight and obesity not only has severe consequences for the health of our population, but dramatically increases our health care costs. National medical costs are reported to be \$174 billion annually. The state of New Hampshire Medicaid program spent \$79 million in 2004 to treat medical problems associated with obesity and New Hampshire's public health currently reports our costs to be \$304 million annually. Schools have taken height and weight measurements for a number of years and are accepted as the most logical setting to collect this aggregate data on children. The proposed amendment clarified questions about procedures raised at the public hearing and respected local school district procedures for implementation. No personal identification would be attached to the collected aggregate data. More than 15,000 children in New Hampshire do not have regular access to a pediatric health provider nor is there a central site to collect that baseline data for the state. The bill included a provision for parents to have their student opt out. Overweight and obesity in children is a priority of New Hampshire's First Lady and most recently was announced as First Lady Michelle Obama's priority agenda.

Original: House Clerk
Cc: Committee Bill File

Rep. Nancy F Stiles
FOR THE MINORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

EDUCATION

HB1479-FN, requiring that body mass index be assessed in all pupils in grades one, 4, 7 and 10.
OUGHT TO PASS WITH AMENDMENT.

Rep. Nancy F Stiles for the **Minority** of EDUCATION. This bill came as a result of the two year commission on overweight and obesity in children and is one of the fourteen recommendations to come forth from that commission. Overweight and obesity has reached epidemic proportions in this country and medical research tells us that this generation of children may be the first generation to have a shorter life expectancy than their parents. Overweight and obesity not only has severe consequences for the health of our population, but dramatically increases our health care costs. National medical costs are reported to be \$174 billion annually. The state of New Hampshire Medicaid program spent \$79 million in 2004 to treat medical problems associated with obesity and New Hampshire's public health currently reports our costs to be \$304 million annually. Schools have taken height and weight measurements for a number of years and are accepted as the most logical setting to collect this aggregate data on children. The proposed amendment clarified questions about procedures raised at the public hearing and respected local school district procedures for implementation. No personal identification would be attached to the collected aggregate data. More than 15,000 children in New Hampshire do not have regular access to a pediatric health provider nor is there a central site to collect that baseline data for the state. The bill included a provision for parents to have their student opt out. Overweight and obesity in children is a priority of New Hampshire's First Lady and most recently was announced as First Lady Michelle Obama's priority agenda.

Original: House Clerk

Cc: Committee Bill File

Stiles

MINORITY REPORT

COMMITTEE: Education

BILL NUMBER: HB 1479-EN

TITLE: requiring that body mass, etc

DATE: 2-16-10 CONSENT CALENDAR: YES NO

- OUGHT TO PASS
- OUGHT TO PASS W/ AMENDMENT
- INEXPEDIENT TO LEGISLATE

Amendment No. <u>16714</u>

HB 1479 ~~EN~~ Representative Nancy F. Stiles Minority Report

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questions about

ER

RESPECTFULLY SUBMITTED,

• Copy to Committee Bill File

Rep. Nancy F. Stiles
For the Minority

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ER