Committee Meeting

of

ASSEMBLY REGULATORY OVERSIGHT

"Review and discussion of the increasing rate of childhood obesity and the rate of asthma in New Jersey"

LOCATION: Committee Room 14
State House Annex
Trenton, New Jersey

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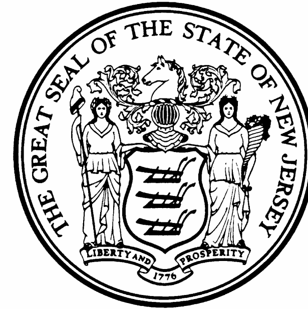

MEMBERS OF COMMITTEE PRESENT:

Assemblyman William D. Payne, Chair
Assemblyman Alfred E. Steele, Vice Chair
Assemblyman Peter J. Barnes III
Assemblyman Bill Baroni
Assemblyman Samuel D. Thompson

ALSO PRESENT:

Raysa J. Martinez
Tracey F. Pino Murphy
Office of Legislative Services
Committee Aides

Jennifer Taylor
Assembly Majority
Committee Aide

Natalie A. Collins
Assembly Republican
Committee Aide

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ASSEMBLYMAN WILLIAM D. PAYNE (Chair): Good morning.

My name is William Payne, and I'd like to welcome you to our Committee meeting here today -- the Assembly Regulatory Oversight Committee meeting today. And I'm very pleased to have you here.

We're going to be talking about what I think is an extremely important issue that impacts on all of Americans.

Before we start, I'd like to call the roll of our Committee.

MS. MARTINEZ (Committee Aide): Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: Here.

MS. MARTINEZ: Assemblyman Carroll. (no response)

Assemblyman Barnes.

ASSEMBLYMAN BARNES: Here.

MS. MARTINEZ: Vice Chairman Steele.

ASSEMBLYMAN STEELE: Here.

MS. MARTINEZ: Chairman Payne.

ASSEMBLYMAN PAYNE: Yes, here.

Let me indicate to you that Assemblyman Baroni is sitting in today for Mr. Carroll.

MS. MARTINEZ: Okay. Very well.

ASSEMBLYMAN PAYNE: Mr. William Baroni.

ASSEMBLYMAN BARONI: Here.

ASSEMBLYMAN STEELE: I noticed you didn't answer. I was wondering why.

ASSEMBLYMAN BARONI: I was concerned people were going to confuse me with Michael Patrick, so I figured I would just shut up. (laughter)

ASSEMBLYMAN STEELE: Oh, okay. No further comments.

ASSEMBLYMAN PAYNE: We hadn't received a written notification of that--

ASSEMBLYMAN BARONI: Oh, I'm sorry. It was filed, Mr. Chairman. I apologize.

ASSEMBLYMAN PAYNE: --to that effect.

MS. TAYLOR (Committee Aide): We have it.

ASSEMBLYMAN PAYNE: We have it here?

MS. TAYLOR: Yes.

MS. MARTINEZ: Well, we need that for the record.

MS. TAYLOR: Okay.

ASSEMBLYMAN PAYNE: Very good.

Thank you very much.

We're here today to talk about, as I say, two of the many health issues that impact on our community -- and it has gotten to the point where they are not just epidemics, but now seem to be a pandemic -- one of which happens to be obesity among children, and also adults. We're also going to be having -- hearing testimony today on asthma: the advent of asthma, the increase of asthma, and some of the causes there, as well.

You may or may not have heard this morning -- I did -- on the news, that New York City has reported today about the effect of asthma that's caused by the diesel fuel that school buses use, and that children who are riding on school buses are impacted by the pollutants that are emitted

from the school buses themselves. And they have shown -- and it's empirical data that shows an increase in the amount of asthma that youngsters are suffering from. And asthma happens to be the highest cause of absenteeism among children. And it's something that we really, really need to get out and do something about.

But first we're going to be talking about obesity. There's been a lot of talk about this phenomenon of obesity that's existing in our communities. And it's been noted that during the past 30 years, the rate of childhood obesity has more than doubled for children ages 2 to 5 and adolescents ages 12 to 19, and has more than tripled for those ages 6 to 11, according to the Institute of Medicine.

That's obviously a pandemic. And it's just something that we simply cannot continue to talk about. Frankly, I believe that if we had -- were able to overcome the plague of smallpox and polio in the past by concentrating our efforts on those issues, then we need to recognize that obesity is, in fact, at that same level of importance, that we need to have what we might call a *Manhattan Project*. You know, back during the Second World War and prior to that time, in order to create the atom bomb, they put together some scientists and they made them concentrate. They worked diligently and came up with the Manhattan Project -- the one that came up with the atom bomb.

Well, we need to have a Manhattan Project here to address this matter as well. It's that important. And I think that we need to, obviously, have the Department of Health involved much more. We need to have the Department of Education-- Because I believe that this matter can be addressed and begin to be resolved by having young people become aware

of the dangers here. And I think the Department of Education has to take a much more proactive stance in trying to address this matter. We simply cannot keep talking about it. And it goes on, and on, and on. My god, it's incredible.

The fact is that it has reached extremely high on the radar screen for many people. And my Congressman, Congressman Donald Payne, recently -- who happens to be related to me -- recently had a hearing in his district, his congressional district, to address this. And that is the problem of obesity. We're doing it, I'm doing it, not because of his involvement, but because of so many people who we see-- It's obvious to all of us that this is a situation that needs to be solved -- it needs to be resolved, and that it can be, if in fact we begin to concentrate our efforts on this.

If we can go to the moon-- John F. Kennedy said, "We will go to the moon one day." And we put everything together, and we did that. We also can do the same thing about resolving this problem of obesity and addressing the problem of asthma. We have to do it. It's not something that we should do; it's something that we must do. And your help will be very, very crucial. Because by your continuing to be advocates, and causing the Legislature and those of us in government to take positive action, I think that we'll be able to resolve this. We have to resolve it. There's no question about it.

Before I call upon those of you who will be testifying, I'm going to ask whether or not our members of our Committee have any comments they'd like to make before we move on.

Mr. Thompson?

ASSEMBLYMAN THOMPSON: No, thanks.

ASSEMBLYMAN PAYNE: Assemblyman Baroni.

ASSEMBLYMAN BARONI: Thank you, Mr. Chairman.

I will be very brief.

But I wanted to thank you, Chairman. This is a critical issue for our State. But it's a critical issue for me, personally. I was an obese child. I was-- By the time I graduated college, I was 312 pounds. I battled weight my whole life. And the issues of childhood obesity are something that I've lived through, and continue to live through as an adult. And the prospect--

Dr. Brownell, from the Yale Medical School, who oversees their obesity program, has estimated that we could have a situation where one-third of adults develop type 2 diabetes because of obesity. And the prospect of one out of every three people you run into being insulin-dependent is-- That is the pandemic. And we need to do everything we can.

Chairman, you deserve a lot of credit for holding this hearing today. This is not something that often gets the headlines, and it's not something that often gets the press coverage. But I don't want to be in a situation, 20 years from now, where you've got well over the majority of the population being obese, and all of the diseases that come from obesity. And obesity is already, I guess, the third highest cause of death. And it could conceivably get worse.

So, Chairman, thank you for holding this hearing -- both as a Legislator who cares a lot about public health issues, but also someone who

battles this issue every day, and someone who very much battled it as a child.

So, thank you, Chairman.

ASSEMBLYMAN PAYNE: Thank you very much, Mr. Baroni.

I had said earlier that it is propitious for us to have you here today. Not that you are obese, (laughter) but because you have some personal experience that you can share with us. And you can empathize with this matter.

Any of our other members have any comments they'd like to make?

ASSEMBLYMAN STEELE: I'm good, Mr. Chairman.

ASSEMBLYMAN PAYNE: Mr. Barnes.

ASSEMBLYMAN BARNES: No.

ASSEMBLYMAN PAYNE: Thank you very much.

We have someone who has requested that they speak first.

Thank you very much.

We're going to call upon Dr. Bresnitz, the Deputy Commissioner of the Department of Health and Senior Services; and Linda Holmes, Office of Minority and Multicultural Health.

If you will, come up please, Dr. Eddy -- Bresnitz.

Give your name, title, identification for us, please, for the record.

DPTY. COMM. EDDY A. BRESNITZ, M.D.: Good morning, Mr. Chairman, members of the Assembly Regulatory Oversight Committee.

My name is Dr. Eddy Bresnitz, and I'm the Deputy Commissioner of Health and Senior Services, and State Epidemiologist.

And I like the way you called me *Dr. Eddy*. That's what they call me at the Department, since they find it hard to pronounce my last name. (laughter)

I do appreciate the opportunity to address the Committee and provide some information on this, as you point out, very important public health problem -- namely, excess weight, which includes both obesity and overweight in this country.

You have my written testimony. I'm going to do a much shorter version of the written testimony. You have some additional facts there.

And as you point out, excess weight is a public health crisis. It is a pandemic. It's not just a problem here in the United States or New Jersey, but it's a worldwide problem, although it seems to be that we're facing it more so than other parts of the world.

And you mentioned some of the data. I think, when you look at the data that's available to us, I think you would all agree that it's really appalling, in terms of the level of overweight and obesity in this country. When you look at those two conditions in New Jersey, about 60 percent of people in this state are overweight or obese. And we're the 10th best in the nation -- which is kind of hard to believe, but it's true.

Excess weight is the nation's second-leading preventable cause of death. Smoking is still number one. Although, probably as our smoking rates go down, obesity will overtake that. And it causes about an estimated -- up to 300,000 excess deaths in the nation on an annual basis.

Now, you mentioned the rising level of obesity in our childhood and teenage population. There's a national survey that was done that estimated that about 15 percent of children right now are obese. And by 2010, it will be 20 percent nationally. The Department of Education and the Department of Health and Senior Services jointly conducted a survey -- retrospective survey -- back in 2003-2004. They surveyed about 2,400 kids -- 40 schools randomly selected around the state -- and found that 20 percent were obese and 18 percent were overweight, higher than the national average. And that included those-- That data applied to all racial and ethnic groups. But the state's African-American and Latino population -- or youth -- were more likely to be overweight than the whites. So the impact -- or the problem, is disproportionate, based on your race and ethnicity.

And, of course, obesity is costly. There have been estimates on what it costs the nation. In New Jersey, based on a national estimate in 2003, the cost to the State was about $2.3 billion. And, of course, half of that was picked up by public funding.

You heard from Assemblyman Baroni that, in fact, childhood obesity is a problem. And, clearly, childhood obesity can and usually does lead to adult obesity as well. And it is a lifelong problem, as many people who have been overweight or obese can attest.

So we need early intervention. I mean, people do become obese or overweight as they age. It's a natural tendency. Those of us who are a little bit older can attest to that. But clearly, if you start off life, and at an early age you are obese and overweight, that's going to be a problem for the

remainder of your life. And so we have to do everything we can to address that problem.

And the physical consequences are tremendous. Hypertension, high blood pressure -- all leading to early cardiovascular deaths. We have type 2 diabetes, insulin-dependent diabetes. But there are other problems as well in youth. We have asthma, we have sleep disturbances, menstrual abnormalities, orthopedic problems. And those are just the physical consequences. There are emotional consequences as well. Overweight or obese children are bullied, generally. They may be depressed. And some of them may have poorer academic performance.

Now, what's the cause of it? Well, the easy way to think about it is that excess weight results from an imbalance of too many calories in and not enough calories out. I mean, that's when people say, "How do you diet?" You can calorie-count and sort of balance that. But, really, it's a multifactorial problem. In some cases, there may be some genetic component, but that's not the major issue. The major issue is a decrease in regular physical activity and poor nutritional habits. I mean, that's basically what it comes down to.

Other factors that come into play can be broadly defined into three categories: demographic/cultural, behavioral and cognitive, and community factors. And I'm going to focus a little bit on those community factors. They include a decrease in school-based physical activity, as well as what we call an inadequate *built environment*. I don't know how many of you have heard of the term built environment. It's the way that land and buildings are designed and used, and a transportation system that provides or limits opportunities for physical activity and travel. New Jersey is a

commuter state. Everybody drives everywhere. There are many places where there are no opportunities to get around except to get in a car and to travel.

But the built environment, on the public health level, is increasingly emerging -- an increasingly emerging focus for health interventions. It involves how community designs impact physical activity, and how neighborhood factors influence eating patterns. Some key patterns are availability of sidewalks, bike paths, recreational spaces, safety of communities, types and numbers of restaurants and grocery stores in neighborhoods, and sprawl. These are all components of what we think of when we think of the built environment.

Earlier this year -- actually last Fall -- Governor Corzine unveiled a $74 million comprehensive pedestrian-safety initiative that provides funds to local governments for the creation of safe walkways, bikeways, and street crossings, and other measures that will promote exercise in the community. This is under the auspices of the Department of Transportation. And I know they put out a nice brochure: *New Jersey Safe Routes to School*, which is basically highlighting this program that will help the built environment.

In addition to this initiative by the Governor, allow me just to mention a few things we're doing at the Department of Health and Senior Services. There are many. Many of you probably know we have health goals in New Jersey, called Healthy New Jersey 2010. And the health goals -- the overarching goals are to improve the quality and length of healthy life, and to eliminate disparities in health outcomes based on race or ethnicity. Those are the broad, overarching goals. We have about 300 individual

goals in there, and some relate to the issue of childhood obesity, and nutrition, and exercise.

To help to achieve-- And they're not all responsibilities only of the Department of Health and Senior Services. These are broad-based goals for the State and all the stakeholders involved in achieving these ends. To this end, the Department has and continues to undertake activities to prevent obesity and promote physical activity and nutrition. We've had summits, we've had roundtables on the issue of obesity, bringing together key stakeholders to address the issues, share information, and make some recommendations.

Some of you may recall that the Legislature, a few years back in late 2003, early 2004, actually passed a law establishing the Obesity Prevention Task Force, which convened sometime in 2004 and actually, last June, released its report entitled: *The New Jersey Obesity Prevention Action Plan*. I brought some copies for the Committee today. There are seven overarching goals in this, and 39 varying strategies that -- recommendations on what we, as a State, can move forward.

Today, we're announcing the creation of the Office of Nutrition and Fitness within the Department of Health and Senior Services, to implement the Task Force's recommendations outlined in the report. This action plan basically has five, sort of, general components -- key areas, if you will -- for intervention. They include: increasing physical activity; improving nutrition in the state, particularly among children; decreasing what we call *screen time* -- watching television, video games, being on the computer; increasing consumption of fruits and vegetables; and exclusive breast feeding of infants. I see the Assembly Committee members nodding.

You probably have children who spend a lot of time on the screen and not enough time on exercise.

The report also mentions that special efforts are needed to reduce the disproportionate rates of overweight and obesity in our African-American, Latino, and low-income populations, as I mentioned earlier, with the data showing a disproportionate impact of the problem on those populations.

We've implemented many educational programs to encourage physical activities in the Department. We have other departmental programs that address nutrition and physical activity through the lifespan. Our WIC program -- our Women, Infants, and Children program -- together with the Department of Agriculture promotes healthy eating and good nutrition. We have a Child Regional Health Network training that does training of health professionals on the issues related to childhood obesity and overweight. Our family planning agencies distribute educational materials mostly to women who are taking care of young children. And we have lots of programs targeted to adults. I know today's hearing is focused on children, but adults also need counseling on nutrition and physical activity.

There are other State departments that are also addressing childhood obesity through various initiatives, including the Department of Education. But I'm not here to testify on their behalf, or on their programs.

So let me conclude by stating that, clearly, leading experts and policy folks like yourselves know and recognize that if we don't do something about this public health problem on excess weight, and we don't take a multifactoral, multipronged approach -- with the understanding that

this is going to be a long-term problem with long-term solutions -- that if we don't do those things, our current generation of children will lead shorter lives and sicker lives in the years to come. We need to do something now about this. We need to do it together, with all the stakeholders, lots of people, lots of approaches to take. And they're all complementary. They're not duplicative.

And with that, I thank the Committee for the opportunity to address them.

And after Ms. Holme's testimony, I'd be happy to answer any questions.

ASSEMBLYMAN PAYNE: Thank you very much for your testimony.

And yes, we'll hear from Ms. Linda Holmes.

One of the concerns we do have, of course, is that there is a disproportionate impact of obesity and some other health problems in the minority communities. And I want to make sure that we underscore that, and that we make sure that we also are putting a great deal of emphasis on this Office. I know the Office of Minority Health Disparities (*sic*) has been around for a while. But I do also know that there has been a time when this Department has been strongly supportive. Other times, it has been in the background. I want to make sure that we are giving the kind of support that this Department does need.

And before Ms. Holmes testifies, there is just one question I would like to ask, and that is: This $74 million comprehensive pedestrian safety initiative that was started by the Governor, started actually in Newark, on Ferry Street -- the very first announcement of this -- in Newark

a year or so ago. And I was just wondering whether or not we are following up, whether or not this initiative, in fact, is being implemented. You know, very often we do make announcements about things, and they kind of go by the wayside. And I want to make sure that that-- I want to find out where the status of that is, whether it's expanded anywhere, whether or not the budget crisis that we're talking about now will have an impact on this program also.

And then, finally, I'd like to just say, you mention a number of things that we're doing-- You mentioned that we are concentrating on youthful obesity. We know that it doesn't stop there and that not -- although that's what we're talking about today, we're also concerned about obesity throughout, and that we need a Manhattan Project-type program -- approach to this program. Because you mentioned a number of different programs that different departments have. And one of the things we find in State government, very often, is that there are disparate kinds of programs going on, and they're not brought together.

So before-- When this hearing is over, I certainly want to find -- come up with some kind of recommendation that would bring everything under one umbrella -- all the departments under one umbrella so that we can have really, really effective kinds of programs not working at cross-purposes. So that's one of the concerns I do have about this whole area.

Ms. Holmes, give your full name and--

LINDA HOLMES: Yes.

I'm Linda Holmes, and I'm the Director of the Office of Minority and Multicultural Health at the Department of Health and Senior Services.

Assemblyman Payne, it's good to be here again this morning, and for you to reiterate your support for the Office of Minority and Multicultural Health -- and for the work of the entire Department of Health and Senior Services -- as we continue to move forward in addressing the challenging issue of health disparities.

We thought it was important to update the Committee on the progress that has been made in terms of the development of the Health Disparities Plan. As Dr. Bresnitz has indicated, the issue of obesity is an underlying factor in several of the health issues that have a disproportionate effect on minority communities. And you will see, as you take a look at the plan, that not only is obesity discussed specifically, but many of the other areas -- such as diabetes, hypertension, asthma -- are also discussed in the plan.

As you've heard Dr. Jacobs -- the Commissioner of Health -- say, addressing health disparities is not only an important issue for the Office, but it's an important issue for the entire Department. And over the years, the Department has worked to reduce disparities in a number of areas that, again, go beyond asthma and go beyond obesity, including HIV/AIDS testing and addressing the problem of cancer.

A year ago I was before this Committee to talk about the fact that the Office was providing leadership in the Department in developing a Health Disparities Plan. I am pleased to say that that plan has been released. It was released in March, and it has become the guiding document for the Department as we move forward in this -- in addressing this issue.

The Department's plan makes a number of recommendations for strengthening programs and developing new initiatives to reduce health

disparities. And I just want to point out that, in addition to the medical areas of the plan, there are also several recommendations that address building the infrastructure of the Department. There have been several reports that look at issues that relate to addressing health disparities, such as increasing the number of minorities -- whether it's in the medical field or whether it's within health departments -- who are actually in a position to develop programs. So this plan recommends increasing the number of minorities in management positions, through a new mentoring program which will be launched, actually, this Spring, under the direction of Human Resources -- in our Department.

Other steps we are taking to address strengthening the Department's infrastructure include making sure that our health education materials are culturally and linguistically sensitive. For example, in our work that we're doing around obesity, around asthma, we want to make certain that our materials are not only published in English, but they're published in multiple languages, whether it be Spanish or Creole; and that those documents are actually available on our Web site, so that those who are active in communities can actually download those materials and distribute them in churches, wherever folks are that are in need of this information.

The plan also lists actionable strategies to eliminate health disparities, specifically in the area of asthma. I know that some of your discussion in this Committee meeting today has a specific focus on asthma. The Department has sponsored a Commissioner's Annual Asthma Summit, which has been successful in bringing together national and local experts, and designing strategies to reduce asthma disparities. That first summit was

actually held back in 2005. And it allowed health-care providers to exchange ideas on how to implement new asthma interventions in minority communities and within low-income populations; also, how to incorporate best practices as the basis of asthma management; and to develop partnerships with public and community health systems.

We've also formed a coalition called the Pediatric/Adult Asthma Coalition of New Jersey, PACNJ. And it has actually been successful in bringing together over 150 participating medical organizations and six active task forces focusing on this issue. And it includes -- Assemblyman Payne and the Committee -- I think most importantly, school nurses who are involved with asthma training. It also has been involved with creating what we call *asthma-friendly* day-care settings. We're also looking at distributing personalized asthma action plans for families and for moms to understand how to more effectively manage their children's asthma. And there have also been several train-the-trainer programs.

Other initiatives in the Department include educating physicians in partnership with the New Jersey Academy of Pediatrics, and a specific partnership here in Trenton. A national organization, called the Agency for Healthcare Research and Quality, has actually identified New Jersey as one of six states to participate in a leadership partnership to decrease disparities in pediatric asthma, based on the track record that New Jersey has already demonstrated in work in this area.

I'm not going to go into detail in terms of the other areas that are well-outlined in the disparities plan. And I think that that might be a more appropriate discussion when we want to discuss this plan in more detail. But I just want to conclude by saying, plans come and go. (laughter)

ASSEMBLYMAN PAYNE: Right.

MS. HOLMES: And we are committed to this plan not being a plan that sits on a shelf. We have, within our Department, as a part of developing the Health Disparities Plan, a Health Disparities workgroup, which Dr. Bresnitz and other members of the senior staff are a part of. And this group will continue to function as we move forward in implementation. Dr. Jacob's has made clear, as the Commissioner, that the release of the plan is the beginning. It's the implementation of the plan that counts.

So I will conclude my remarks there.

ASSEMBLYMAN PAYNE: Thank you very much for your testimony. And it is encouraging that we do have a plan now, as long-- We have to make sure that this plan is implemented. And as you say, plans come and go. But we want to make sure that this plan is implemented. And we will continue to try to draw attention to the fact that there are disparities -- that there are disparities that exist in the State of New Jersey when it comes to health -- access to health care, etc., and the rest of it.

And the idea that you're talking about a mentoring program to mentor young people to -- minorities to become more involved into the health-care profession, etc. -- that is an excellent one. Because very often we hear about conditions that exist that impact on a particular community, and some of the very people who are impacted by them are not present on the planning of it. I think it's very, very important.

It's important, however, to note that others are impacted by these conditions, as well. And I think Mr. Baroni happens to be an example of that, as well.

Thank you very much for your testimony.

Let's see if any of the members have any questions.

Mr. Baroni.

ASSEMBLYMAN BARONI: I do.

Thank you, Chairman.

To both of you: One of the issues that -- I also sit on the Education Committee -- that we're going to be facing in the next -- it could be six months, could be three months -- is the issue of the Schools Construction Corporation. One of the very good things that New Jersey has been a leader in is the idea of moving toward green buildings. And there's a focus in the education community of building new schools that are environmentally friendly, that are built to good green-building standards.

One of the things that there has sort of been a discussion in the obesity world -- if you want -- amongst academics, is whether or not you could build buildings and complexes, essentially, as healthy buildings, much as we have gun-free school zones, and drug-free school zones, and tobacco-free school zones. The idea being: Could we go to healthy school zones, which includes what goes on inside the building -- what we're teaching and eating -- but also the way the buildings are built, the way the grounds are constructed?

Has there been discussion between your Department, and the Schools Construction Corporation, and the Department of Education? There's obviously a lot of discussion about what's being eaten in the cafeteria, including the Department of Agriculture and your Department. But I also wonder, as we're about to-- We built some number of new schools; we're about to have to build a whole lot more. That whether, as we go through the threshold of this renewed school construction program,

whatever it's going -- however it's going to end up being paid for-- We don't know that yet. But as we go into it, shouldn't your Department be providing guidance as to how these buildings and grounds are constructed?

DEPUTY COMMISSIONER BRESNITZ: Thank you for that question.

I think the short answer, in terms of the built environment -- you know, thinking about the built environment, as far as schools are constructed, I'm not aware that we've had discussions; certainly not with the SCC, nor with the Department of Education. We've had discussions on having nutritious food in the schools.

If you're talking about healthy schools, we've certainly worked with the schools to promote healthy environments -- in terms of air quality, for example -- in the schools, through the Tools for Schools program. And that's including educating teachers about unsafe environments, using safe substances to clean the schools, and so on, minimizing the use of pesticides -- but not in terms of constructing the schools so, for example, students can walk further to classrooms and promote their exercise that way. There may be some issues, also, that relate to security in the schools that might impact on how you build the school as well.

So the short answer is, no. I've given you the long answer as well.

ASSEMBLYMAN BARONI: Just very briefly, one of the things that I sense is that because of the deterioration of our urban core school system -- and I don't think anyone who has visited an urban school district anywhere in New Jersey -- we all realize that we have a significant need. This may be an opportunity for the Department and the Schools

Construction Corporation -- not just for children in the minority community, but all children; but especially the children in our urban New Jersey, who have both a need for new schools, but also statistically -- as you pointed out -- statistically greater rates of obesity and greater rates of overweight. We shouldn't go into a process where we're going to spend some *X* billion dollars more on schools and not have your involvement in that discussion.

DEPUTY COMMISSIONER BRESNITZ: Yes.

ASSEMBLYMAN BARONI: So that's all I would-- It's not criticism in any way. I'd just like to see you have conversations with the Schools Construction Corporation about not just what goes into our stomachs in the schools, and not just what cleans the inside of the buildings, but how we're going to build these things, and how we can cooperate with municipal governments and -- to build a healthier physical plant.

MS. HOLMES: I was just going to agree, that I think it's an excellent idea. I'm thinking of-- I live in East Orange, and the school where I attended -- an elementary school -- just in terms of things like playgrounds-- Is there a bike stand? And some of these things aren't terribly costly. But safe places to play are extremely important in urban areas. And I think it's an avenue that we should think about exploring in terms of our discussions.

DEPUTY COMMISSIONER BRESNITZ: The only thing I would say to extend that -- and I don't know to what extent the Schools Construction Corporation has considered this in developing its plans for building new schools -- but, clearly, children have to get from their home to

the school. And so it's one issue to look at how a school is built; it's a whole other matter of making sure that there are safe ways to get to school. And what I mean by safe -- I don't mean safe from vehicular traffic, but also safe from a personal safety perspective, particularly in urban environments. And if that's not being considered by the Schools Construction Corporation, certainly that needs to be. And, of course, they can only have that discussion with the municipal governments.

ASSEMBLYMAN BARONI: Mr. Chairman, I have no further questions. But possibly you and I can chat later about, sort of, urging the Schools Construction Corporation to work with the Department on these issues.

And thank you for your answers.

ASSEMBLYMAN PAYNE: That's very good.

That's part of thinking outside of the box that we've been talking about, the kinds of areas that we never thought about. Who ever thought about the possibility of our having an -- or your having an involvement in the design of the schools, that impacts on the health, etc.? I think that's the kind of thing we need to do, and that's one reason why I'm glad we're having--

You mentioned the pesticides. Today, as a matter of fact, I have a bill that's being heard in one of the Committees -- in Environment -- that has to do with limiting the use of pesticides in our playgrounds, in our parks, etc., so that youngsters are not impacted in a negative way by that.

Thank you very much.

Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: Thank you, Mr. Chairman.

It's more in the way of comments than questions. In your written testimony, Dr. Bresnitz, you mention that a New Jersey Childhood Obesity Roundtable was convened in 2002, and a follow-up summit in 2003. It states: The attendees focused on what could be done in schools, communities, industry/worksites, insurance/HMOs, legislative/policy, advertising/advocacy, government, research, and other areas.

I don't believe that children get obese and overweight based upon just what they get at school. I think the problem is in the home. That is to say: the diets they have there, the guidance they get from their families, and so on. That is not listed as one of the areas that they were considering. I think we have to put more focus on how we can get the word into the home. Because that's where kids really get obese -- what they're fed, how much they're fed, how much they eat, etc.

Schools can be a contributing factor -- what does or doesn't, what is or isn't available at lunch, what's available in the snack machines, and so on. But, really, it is at the home that the problems really arise. And that's where I think we have to focus more attention -- getting that message out to the parents, and so on.

One other thing I would like to comment on, that I see as a significant contributor to the obesity and overweight that we're encountering, is the tendency of the private sector to keep going to bigger sizes. I mean, you know, we had the-- First you had a Burger King (*sic*), then you had a double burger, (laughter) then you had a triple burger. I think maybe they're up to a quadruple burger now.

I recently stopped in at one of these places and ordered a soda. I wanted a small soda. (laughter) Well, the size of the small soda was like

at least twice as much as I could drink. But you can't buy a small soda anymore.

I think we-- I don't know whether we need to get into it legislatively, or what, to require people to produce something smaller -- not necessarily they can't make a -- have a bigger one, too. But at least offer a smaller one so that when people want something small, they get something reasonable. Certainly, the amount that they get every time they go out-- I mean, the portions you get are just outlandish, nowadays, in many areas. And that has to be a major contributing factor.

Thank you.

ASSEMBLYMAN PAYNE: Thank you.

There has been-- I've noticed, on some programs, there has been some attention being drawn to this reducing the size of these things.

ASSEMBLYMAN THOMPSON: Super size.

ASSEMBLYMAN PAYNE: Super size. It's insane.

Anyone else have any--

ASSEMBLYMAN STEELE: Yes.

ASSEMBLYMAN PAYNE: Mr. Steele.

ASSEMBLYMAN STEELE: Mr. Chairman, if I may, I just want to reference the fact that you talked about the decrease in physical fitness, the whole exercising process. What would be the reason that young people are not exerting that kind of energy that usually comes naturally with youth -- at least when I was that age? (laughter)

DEPUTY COMMISSIONER BRESNITZ: There are probably a combination of reasons. I'm not an educator.

ASSEMBLYMAN STEELE: Sure.

DEPUTY COMMISSIONER BRESNITZ: My children are grown at this point. And I certainly had to push them, when they were young, to exercise.

I think part of it -- now I'm speaking somewhat from experience, again, with my children -- is that there has been, over the years -- in terms of exercise in a school setting -- an emphasis on sports and competition for the most part. And not every child is skilled or even-- They may be, what we used to say, *klutzes*, if you will. (laughter) They just don't have the ability to keep up with other kids who are just better at what they do. And so there is a disincentive for them to exercise.

I was just reading, before the testimony, an article that was actually in the *New York Times*, April 30, entitled "Phys Ed Classes Turn to Video Game That Works Legs." (laughter) And it talks about schools basically adopting this game called Dance Dance Revolution, where kids are basically -- in school they're dancing to music and to videos. And they're loving this. And this involves a lot of children who, perhaps, aren't very athletic. They can't hit a ball, they can't shoot a basket, they can't make a tackle, whatever the sport is. And to the extent that we can encourage schools to adopt these noncompetitive exercise approaches, I think we would do well to encourage children to do this.

The other thing is that--

Assemblyman, I agree with you. In all these public health issues -- whether it's eating, smoking, exercising -- there is personal responsibility that everybody has. At the end of the day, a person is putting food in their mouths, they're smoking, they're not exercising. So there is a certain amount of personal responsibility.

But those of us in government also feel that we have to provide that information to families, as well; at least give them the knowledge that -- and the opportunities to practice good behaviors. At the end of the day, they're the ones that are going to have to basically do this.

To the extent that we can encourage schools to provide these other exercise options in a school setting -- and they're not-- I can tell you, it cost the one school in Los Angeles about $500 to set up this Dance Dance Revolution kind of thing. Well, think of what it costs to put together and supply a -- well, basketball is relatively cheap -- but a football team, for example, is very expensive. And many schools basically support those kinds of operations. They cost a lot of money, and they cost a lot of money in injuries as well.

So I think these other options are the way to go, Assemblyman.

ASSEMBLYMAN STEELE: Okay. Sure.

ASSEMBLYMAN PAYNE: Very good point. And it's something that we need to--

You're on the Education Committee, Mr. Baroni?

ASSEMBLYMAN BARONI: Yes, Chairman.

ASSEMBLYMAN STEELE: Definitely, we need to revisit the whole process; that exercise should not center itself around sports, but actually physical fitness. That's most important.

ASSEMBLYMAN PAYNE: And the Department of Education also does -- can do things about educating youngsters on healthy eating, etc. I, again, saw a program where -- I think these are kids who are about 6 years old, who were being taken through the supermarket -- where they had been educated about the advertisement that's directed toward them, and they tell

their parents to buy things. Well, these youngsters were pointing out different kids of cereals and things like that, that had too much sugar in them and things like that. And the teacher would say, "What about those." And, of course, they would say, "Those are bad," and whatever. (laughter) But they can start very early. There's no question about it. And it really-- When it starts early, it leaves an impact on them for the rest of their lives, I believe.

MS. HOLMES: I just wanted to add, about safe places to play, I think New Jersey is making a lot of progress in terms of what we see happening, in terms of restoration of parks. On my block, I just happened to notice-- I was irritated when I turned down -- this is a one-block street -- and there were kids who had set up their own little basketball nets on the street and were actually playing. And it was kind of -- nobody was supervising it. But I think our kids are looking for safe places to play; and not only in the schools -- but the more open spaces there are where kids can kind of do their own thing-- I think that that's a way of encouraging exercise as well.

ASSEMBLYMAN PAYNE: Thank you very much.

We appreciate both of you being here.

Is anyone here -- anybody else to testify?

DEPUTY COMMISSIONER BRESNITZ: And I have--

ASSEMBLYMAN PAYNE: I'm sorry. Yes, sir.

DEPUTY COMMISSIONER BRESNITZ: I have copies for--

ASSEMBLYMAN STEELE: Yes, we welcome that.

ASSEMBLYMAN PAYNE: Thank you.

Anyone else here to testify on obesity, specifically? We do have asthma as well.

ASSEMBLYMAN STEELE: We have a young lady here.

ASSEMBLYMAN PAYNE: Yes, I see her also.

Why don't you come--

I have several people that are going to talk about--

Okay. Bill Whitlow--

ASSEMBLYMAN STEELE: Mr. Chairman.

F E L I C I A D. S T O L E R: I'm on the list.

ASSEMBLYMAN PAYNE: Yes, you are. Okay. Fine. We'll call you.

I'm calling some folks.

If we can have--

Who else is here to talk about obesity?

All right, fine.

MS. STOLER: Yes?

ASSEMBLYMAN PAYNE: Yes.

ASSEMBLYMAN STEELE: To be or not to be.

ASSEMBLYMAN BARONI: You brought cookies to a hearing on obesity? (laughter)

ASSEMBLYMAN PAYNE: I have the testimony here of Felicia Stoler.

MS. STOLER: That's me.

ASSEMBLYMAN PAYNE: Very good.

ASSEMBLYMAN STEELE: Is there any milk with this? (laughter)

ASSEMBLYMAN PAYNE: Why don't you introduce yourself and go ahead?

MS. STOLER: Do I need to turn this on, or is it on? (referring to PA microphone)

ASSEMBLYMAN PAYNE: Is the red light on?

MS. STOLER: Now it is.

ASSEMBLYMAN PAYNE: Your red light is on.

ASSEMBLYMAN BARONI: Only in Trenton red means go.

MS. STOLER: Okay. All right.

ASSEMBLYMAN PAYNE: Do you have any milk for the cookies?

MS. STOLER: Do we have anyone from the Dairy Council here? Come on.

All right. Thank you for the opportunity to speak.

First, my name is Felicia Stoler. I'm here with the New Jersey Dietetic Association. I'm here, actually, with a lot of hats. But I just wanted to tell you that the New Jersey Dietetic Association is the premiere resource for nutrition information in the State of New Jersey.

And I'm here with many hats on today. I'm the host of a reality show on the Learning Channel called *Honey We're Killing the Kids!* And it's a reality show about unhealthy kids and their families. So I know firsthand about working with families across the country. I'm a mother, I'm a registered dietician, and I'm an exercise physiologist. I'm a member of the New Jersey Council on Physical Fitness and Sports, in addition to being the immediate past-president of the New Jersey Dietetic Association. I'm a doctoral student at UMDNJ, and my research has been in obesity in adults.

So I've got obesity coming out of me everywhere. I am one of the few private practitioners that actually works with children, adolescents, and teens who are overweight or obese in this state, in private practice.

I can tell you that overweight and obesity are problems that may actually begin in infancy and continue to get worse throughout childhood, since overweight and obesity is a multifactoral problem which stems from what we call an *energy imbalance* between the energy in, which is food, and energy expended, which is physical activity.

Where do we start to put responsibility on this imbalance? Do we start with the parents? They're usually struggling with their own weight issues, without access to proper support to maintain an appropriate body weight. Our culture is bombarded with information in the media. The question is: Which information is correct?

The Federal Trade Commission estimates that over $30 billion is spent each year on weight loss products and programs. Funny, the obesity epidemic is getting worse, it's not getting better. Finkelstein and his researchers estimated that New Jersey will have spent $2.3 billion on obesity-attributed expenses for adults in 2003. The economic costs of an unhealthy diet and physical inactivity add up to almost $100 billion per year, or approximately 8 percent of the national health-care budget, in direct medical costs. The Centers for Disease Control reported that $31 billion of direct treatments costs for cardiovascular disease was related to overweight and obesity. This is a very expensive problem to this country.

According to Olshansky, obesity and its comorbidities may have decreased the lifespan by five to 20 years. This means that for all the

advances that we have made in medicine and science, we actually have a generation of children who may not outlive their parents.

How can we reverse this trend in children? Schools alone cannot be the answer. They can be part of the solution, but they are challenged with the need to generate revenue in food service, vending, and fundraising. Our schools are making money to sustain their existence at the expense of our children's health. Even with the school wellness policy that needs to be adhered to in New Jersey, there is still a disconnect with the access that kids have to unhealthy food during school hours.

No Child Left Behind should become "No child should be left *on* their behind." Physical education has taken a back seat to children's performance on standardized testing. Look at the cycle of physical education. From elementary school, children are lucky if they have physical education once per week. In my daughter's previous school district, she had it once every seven school days. And that's an elementary school. Then, when they get to middle school, they have it more than once per week. By the time they get to high school, it then becomes daily. But the damage is done. We cannot afford to wait until our children turn 14 and 15 to instill the behavior of daily physical activity. It needs to start in Kindergarten.

Recognize that insurance companies do not pay for the intervention that is effective -- nutritional counseling -- unless there is diabetes or kidney disease. Insurance companies do not pay for additional physical activities that children should participate in. Insurance companies would sooner pay for bariatric surgery, which is expensive, invasive, dangerous, and, over time, has not proven to be successful for sustained weight loss. Making better nutrition choices and increasing physical

activity are the least expensive, least invasive, and most effective ways to fight overweight and obesity.

I wish that I had the magical answer to make this go away. Personally, hosting my show is one way that I can hopefully bring a solution to millions of households, by turning around the lives of 13 families on national television.

I would like to tell you about some of the resources that are available in the State of New Jersey. Registered dietitians provide medical nutrition therapy and nutrition education to youth and adults in New Jersey. The New Jersey Dietetic Association has a membership of 2,300 members in New Jersey, and the American Dietetic Association has 67,000 members nationally. About 50 percent are working in the community, in government, schools, and public health, Cooperative Extension, and consultant work. The other half work in hospitals, nursing homes, and a variety of facilities. We all promote healthy eating; reducing fat, salt, and sugar in our diets for improved health.

Some examples of statewide programs that are currently going on are: Rutgers Cooperative Extension has-- They have full-day children's health summits, which focus on childhood obesity and create local grassroots networks to get the public moving and eating healthier. The next summit is at the New Jersey Hospital Association on May 24; and another one will be offered in Morris County on November 2, at the College of St. Elizabeth. Dietitians, nutritionists, public health professionals, teachers, school food service, school nurses, and administrators, along with hospital and health-care professionals, have attended these full-day events in seven counties since 2005.

Dietitians continue to work in schools, corporations, local government to provide support for walking and health-promotion programs. The New Jersey Mayors Wellness Campaign, providing school wellness trainings in collaboration with the Child Nutrition bureau and New Jersey Department of Agriculture-- All schools in New Jersey currently need to comply with the school wellness legislation.

Registered dietitians work in private practice, in school-based programs, in public health, and Cooperative Extension, along with hospitals and other facilities, to provide nutrition education and medical nutrition therapy. New Jersey Dietetic Association members are the nutrition professionals with advanced training in a variety of areas.

What we need in the state: We need grant dollars available to start up local nutrition and health programs that benefit local residents. The Department of Health should apply for Federal money from USDA, and NIH, and CDC so local New Jersey groups could apply for that money to provide local wellness programs. NJDA could provide leadership in assisting with the applications for major Federal obesity money, and assist in developing a working plan for setting up obesity intervention programs and projects in New Jersey.

Registered dietitians and nutritionists need to be hired in school districts to assist in supporting school wellness policy and to provide nutrition education classes to youth, parents, and teachers. Nutrition education needs to be taught to students at all age levels in New Jersey schools, and health needs to be taught as a core curriculum class.

We are the nutrition professionals that care about the health of New Jersey residents, and we are helping to improve the diets of our New

Jersey residents. In addition, we need licensure for dietitians and nutritionists in the state, to stop the misinformation that is out there. New Jersey is one of six states left in the United States that does not have licensure. And it is a real threat to the public health and safety when inadequately trained individuals give out inappropriate information, especially when it affects the health of our children and our families.

That's it. (laughter)

ASSEMBLYMAN PAYNE: Thank you very much.

MS. STOLER: I also just wanted to say I have access to a lot of additional resources that I can forward along to the Committee. They are just too substantial for me to duplicate. But I have access to lots of obesity information from the American Dietetic Association, from the IOM, and from the Society for Nutrition Education, as well.

ASSEMBLYMAN PAYNE: Thank you.

Are you Ms. Skinner?

MS. STOLER: Yes.

B A R B A R A   S K I N N E R: Yes.

ASSEMBLYMAN PAYNE: Yes. All right. Why don't you testify, also. And then we'll have -- see any questions from either -- for either one of you.

MS. SKINNER: Okay. Very good.

Good morning, Assemblyman Payne, Committee members, staff, and guests. Thank you for holding this important meeting to discuss the problem of childhood obesity.

My name is Barbara Skinner, and I'm a registered dietitian working in a hospital-affiliated medical practice in a predominantly

minority community in southern New Jersey. I am here to testify, also as Felicia has, as a member and past-president of the New Jersey Dietetic Association.

I'm going to be skipping over my testimony a little bit, for those who might be reading along, as some of the points duplicate what Felicia has already discussed.

Registered dietitians and the New Jersey Dietetic Association have been on the forefront of New Jersey's efforts to battle childhood obesity. Activities have included serving on the 27-member New Jersey Obesity Prevention Task Force, and planning child health summits to focus on childhood obesity, and developing grassroots networks to work on the problem. Additionally, dietitians continue to work with schools, corporations, and local governments to provide support for walking and health promotion programs, as Felicia has indicated.

Many have testified here today about the prevalence and scope of the childhood overweight and obesity problem. We know that obesity increases a child's chance of getting a chronic disease, ranging from high blood pressure to diabetes. Real and potential consequences of childhood diabetes (*sic*) cannot be ignored. As a specialty-trained dietitian and a certified diabetes educator, diabetes care and prevention is my business, and it is my passion. So I would like to talk about this for a moment.

When I was a school-aged child, I remember my grandmother taking twice-daily insulin shots, because she had old-age diabetes. Now called type 2 diabetes, this devastating disease of adults is appearing in children and adolescents. According to the Institute of Medicine, case reports from the 1990s showed type 2 diabetes accounting for twice as

many new cases of pediatric diabetes than before that time. Primarily, it was type 1 diabetes. This upward trend clearly parallels the increasing prevalence in childhood obesity.

Diabetes is more than just a touch of sugar. Some of us have experienced it personally or through our families and our friends. We know that, especially over time, it can be a debilitating disease, leading to serious, life-threatening health problems and poor quality of life. It costs our country more than $100 billion a year.

ASSEMBLYMAN PAYNE: One hundred billion, with a *B*?

MS. SKINNER: Yes.

The younger the person is when they develop type 2 diabetes, the longer the disease has to work the damage. We must do a better job at preventing it, especially in our children. And the thing is, we can.

We know that having a family member with type 2 diabetes increases a child's risk of developing the disease. In fact, 45 to 80 percent of children with type 2 diabetes have a parent with the disease; and 74 to 90 percent report at least one affected first- or second-degree relative, such as an aunt or an uncle. But for diabetes to start, it takes more than just strong genetics. It's not a natural thing that has to happen. The body must first become resistant to its own insulin. Insulin resistance can be triggered by obesity in both adults and children. The good news is that studies have shown weight loss lessening insulin resistance in both adults and adolescents. And hopefully this can help prevent or delay the onset of type 2 diabetes.

I work as a registered dietitian and diabetes educator in a community with this high prevalence of type 2 diabetes. Although my work

is primarily with adults who have this disease, I try to make my interventions family focused. Parents are the health and nutrition role models for their children. And many of the patients that I see are mothers-to-be or parents of very young children. This is because the disease is even hitting adults younger and younger.

Many of my patients have at least one child who is obese or overweight, and they're motivated to change the family's eating and exercise habits. Incidentally, sometimes their motivation is more for their family and preventing the progression of the disease through the generations than it is for themselves.

As Felicia has stated, however, there are few dietitians in the state that work specifically with children and weight issues. The focus of my nutrition counseling sessions might include topics for this patient, to help them and their family: how to keep healthier foods in the home, choosing alternatives to fast foods that are both quick and work with their time constraints, learning how to make quick and healthy meals, and fun physical activities that the whole family can engage in and enjoy.

In conclusion, nutrition professionals interact with children and caregivers of children in many different settings. We are the experts in improving the health and nutritional status of New Jersey's children. We support New Jersey's efforts for a broad-based plan to target the problem of childhood obesity.

And just as a final comment, I'd like to mention that I was also an overweight child. As I mentioned, I do have type 2 diabetes in my family. My daughter is 15-and-a-half years old, and she was on a progressive weight gain kind of trend -- and even living with a dietitian.

Okay? (laughter) Genetics are very strong. And many of us have to fight very, very hard, and continue to fight to prevent becoming obese.

I didn't bring a picture of her today, but I had this (indicating) in my purse. And I thought I would pull it out. And, of course, this has "Three a day for dairy health." But this is one of the grocery lists I keep in my house. And I encourage my daughter to write down the foods that she wants me to purchase at the grocery store. And I'd just like to mention that the first three items are carrots, grapes, and apples. (laughter) So I guess I did my job.

Thank you for your time.

And Felicia and I are here to answer any questions you have.

ASSEMBLYMAN PAYNE: Thank you, Ms. Skinner.

Anyone here--

Reverend.

ASSEMBLYMAN STEELE: I'll yield.

ASSEMBLYMAN BARONI: I've always been taught to yield to reverends. But if I might, I have a question following up on a line in your -- two lines in your testimony about insurance companies.

Obviously, I've experienced the difficulties of what is covered and what is not covered when it comes to obesity treatment. Can you give us some examples of things that are not covered, generally, in New Jersey, but are covered elsewhere?

MS. STOLER: It's, generally, a national problem. It's not specific to New Jersey. As a matter of fact, I represent the State Dietetic Association. I was just in Washington last month, going down and lobbying with our national representatives. We do-- The American Dietetic

Association does this every year to try to increase the scope of medical nutrition therapy legislation. That's pretty much what sets the example for insurance companies. Some insurance companies will pay for wellness. And what a lot of families do is, they can put money into a flex-spending program and use it.

I can tell you, as a practitioner -- I'm a solo practitioner -- I have to do fee-for-service, because otherwise I make less than minimum wage to fight the insurance companies to get reimbursed for my services.

So in terms of specifics, for obesity -- they're not paying for it. They're paying for surgery, they'll pay for medications. But they're not paying for the counseling that needs to be done.

ASSEMBLYMAN BARONI: One of the great concerns that I have is the exponential growth in childhood bariatric surgeries.

MS. STOLER: Oh, it's disgusting.

MS. SKINNER: Oh, yes.

ASSEMBLYMAN BARONI: Children who are young, who are getting bariatric surgery -- where the insurance companies will cover that surgery -- with extraordinarily high risk and high mortality rate -- but won't cover nutritional counseling, won't cover exercise counseling.

Are you seeing that elsewhere? Is this as bad of a problem as I think it is?

MS. STOLER: Yes.

MS. SKINNER: Yes. There's a young woman who is coming to me this week -- who actually works in my office -- who is 19 years old and is exploring that option. And everybody is counting on me to help turn

her around from her decision. She is trying to look nice for her wedding next year.

Okay. So one of the issues--

ASSEMBLYMAN BARONI: Wait. She is going to have bariatric surgery so she looks good for her wedding?

MS. SKINNER: She is considering it. That is one of the reasons.

So one of the issues has been that obesity, by itself, is not enough, sometimes, for insurance coverage for nutrition counseling. The standby has been -- and I think Felicia might have mentioned this. If you have a child who is obese and has asthma, if you have a child who is obese and has type 2 diabetes, if they have joint problems-- So, in other words, if the obesity has already caused a health problem for children or adults, then that is kind of the protocol that insurance companies follow.

As you know, with the bariatric surgeries, it is only -- they can be obese, and if they meet a certain standard as far as body mass index, without any comorbidities, as I mentioned, then they may be eligible for the bariatric surgery. But that standard is not the same for nutrition reimbursement.

ASSEMBLYMAN BARONI: It's just--

And, Chairman, I'll stop on this, because it's the issue of bariatric surgery and insurance companies. They're covering a surgery -- a major, major surgery -- with the expense that comes with major surgery, but they won't cover a significantly lower cost of early childhood, early adult nutrition counseling. And I wonder if the change in the Federal -- people who look at obesity in and of itself as a disease, as opposed to the

subsequent diseases of heart disease, and cancer, and etc.-- We need to focus-- And here in New Jersey, maybe we need to speak with some of our insurers -- that obesity, in and of itself, is a disease. And the way to treat it is with prevention education, not massive surgery. So we probably should move in the direction of speaking to some of our insurance companies and schooling them on -- that obesity is a disease in and of itself.

MS. STOLER: And one of the other things that we didn't discuss and get into detail about is the mechanical problems that children have, in terms of their joints -- that they're damaging their ankles, and their knees, and their hips as a result of being obese. Because their bodies -- their little bodies are just not meant to carry that much weight on them. And I've worked with a lot of sports medicine doctors that have obese kids coming in that are having issues with their joints that need to be fixed. They can't just repair a knee if there is 200 pounds on top of it.

ASSEMBLYMAN PAYNE: You're right.

Thank you.

ASSEMBLYMAN BARONI: Thank you, Chairman.

ASSEMBLYMAN PAYNE: We need to-- And the point about insurance companies will cover bariatric surgery -- massive, expensive -- but will not deal with-- It's the same thing with a lot of things in government. We will pay for -- not prevention, but for correction. We'll build more jails, but we won't improve the schools to keep-- I mean, it's just kind of backwards. So this is one of the things--

Maybe we somehow, as legislators, need to look into some possible legislative remedy to some of these things. And some of you who are testifying today might have some suggestions, some ideas on how we, as

legislators, might be able to create policy or legislation that might address these matters.

Some of the other recommendations, of course, are that our Department of Education become more proactive in these kinds of things, etc. But, certainly, the area of insurance is something we need to look at.

Thank you very much.

Are these cookies for us? (laughter)

MS. STOLER: Those were from Dr. Hoffman.

ASSEMBLYMAN PAYNE: Well, we'll hear from Dr. Hoffman now, okay?

MS. STOLER: Yes.

ASSEMBLYMAN PAYNE: Any other questions for these two?

ASSEMBLYMAN STEELE: Yes.

ASSEMBLYMAN PAYNE: Yes.

ASSEMBLYMAN STEELE: Mr. Chairman, I know that, obviously-- I don't know whether we ever take it seriously when people tell us we're overweight. They have the little chart, you know, that says that, "If you're five-whatever, the magic number should be this."

MS. STOLER: BMI, right.

ASSEMBLYMAN STEELE: Yes. I mean, what is the measuring rule that we begin to define when this person really needs to begin to take seriously their health?

MS. STOLER: Well, you know--

ASSEMBLYMAN STEELE: I mean, I guess I'm overweight according to my doctor. I should be, probably, 155 pounds.

MS. STOLER: Well, instead of using height and weight charts -- because they're based upon very limited ethnic backgrounds -- really, BMI has become the norm. So a body mass index is a ratio of your height and your weight; and it's your predictive risk for illness associated with being overweight. A BMI under 25 is considered an appropriate body mass index; a BMI of -- I believe it's -- anything above 25 to 29.99 is considered overweight; and obesity begins at 30. The caveat is that-- Generally in men that are very athletic and muscular, they can sometimes have a BMI slightly over 30 that makes them technically obese, but they are not. But that's, like, very few people that fall into that category. It's generally, that's how you do it. And then morbid obesity begins at a BMI of 40 or greater. And, I mean, I've seen people with a BMI in their 50s. So it's scary.

ASSEMBLYMAN STEELE: Thank you.

MS. SKINNER: I can add another point. In working with individuals at risk for diabetes or with diabetes, taking a look at what their risks are for different chronic diseases -- especially for diabetes, high blood pressure, cholesterol -- we also look at waist-hip ratio and just the size of the waistline. And are you an apple or are you a pear? I'm an apple. I'm from a family of people who have diabetes and heart disease. So, yes, I'm also in the overweight category of my BMI, working toward getting down to the lower level.

ASSEMBLYMAN STEELE: Okay.

MS. SKINNER: But the focus, also, is on reducing the waistline, reducing visceral fat. This is what we want to focus on if you have any of those risk factors that I mentioned.

ASSEMBLYMAN STEELE: Thank you, Mr. Chairman.

ASSEMBLYMAN PAYNE: Thank you, both. Thank you very much for your testimony.

MS. SKINNER: Thank you.

ASSEMBLYMAN PAYNE: Now, Dr. Hoffman, perhaps you can come and tell us about these chocolate chip cookies, and bring the milk to go along with them.

D A N I E L   H O F F M A N, Ph.D.: With pleasure.

Mr. Chairman, Committee members, good morning.

ASSEMBLYMAN STEELE: Good morning.

DR. HOFFMAN: I would like to introduce myself. I am Daniel Hoffman.

Is this working? (referring to PA microphone)

ASSEMBLYMAN PAYNE: Is the red light on? If it is, then it's working.

DR. HOFFMAN: Yes.

I am Daniel Hoffman, an Assistant Professor of Nutritional Sciences at Rutgers, The State University of New Jersey. I'm the Clinical Director of the New Jersey Obesity Group.

I extend my thanks to each of the Committee members for allowing me to speak to you today on the most important health issue facing our state, childhood overweight.

I will first make a statement and then be free to answer any and all questions.

It is not at all difficult to witness the trend in childhood overweight. One only has to walk into any public school, especially our urban schools, to see that the number of children who are overweight is

large. More important, however, is the fact that children are becoming more overweight at younger ages almost every year. These observations translate into poor health, increased risk for chronic diseases, social stigmatization, decreased self-esteem, poor educational outcomes, and poor employment opportunities as adults. Thus, it is imperative that the State of New Jersey take an aggressive and comprehensive approach to both preventing a further increase in the number of overweight children and reducing the number of overweight children in the state.

The key challenge is: Where and how do we begin? A good place is with the current numbers on childhood overweight. In New Jersey, it is estimated that 10 percent of adolescents are overweight and another 15 percent are at risk for becoming overweight. For younger children, approximately 20 percent of 6th graders are overweight. It is estimated that New Jersey follows national trends, with more African-American and Hispanic children, and those from lower-income families, having a greater risk for obesity compared to Caucasian children or children from higher-income families.

Still, these numbers are based on limited data, a key point that I will address later. In fact, these data are so inadequate that they were not even entered into that national "State of Your Health" report, leaving New Jersey with a *not available* marking for percent of children who are overweight.

Regardless of the validity or accuracy of the numbers being reported, most of us can find examples of how childhood overweight is fast becoming a serious public health problem. Pediatricians report a growing number of children diagnosed with type 2 diabetes, formerly known as *adult*

onset diabetes. Children are being excused from gym classes because of hypertension or risk of exertion due to excess weight. Playgrounds and yards are empty, as fewer and fewer children find the option to play outside either feasible or possible. Still, we need to find programs and cease the endless game of blaming the food industry, school food programs, urban blight, parents, children, or any other scapegoat that comes to mind. It is all of us that contribute to the conditions that make childhood overweight a problem.

Programs that have been effective in either reducing the prevalence of childhood overweight or preventing weight gain are few and far between. At the same time, numerous educational programs exist, but none of them have been properly evaluated to determine how effective or sustainable they are. One of the most comprehensive programs ever was the Pathways study. Pathways was a two-phased, school-based, randomized trial involving six American Indian Nations. This program improved the quality of food served at school, increased daily physical activity, incorporated parents, promoted culturally sensitive games, activities, and menus. The result of this five-year, multimillion dollar program was that none of the children lost body fat during the period studied. So while comprehensive programs are needed, they are not miracles on wheels that deliver simply because they are comprehensive. Programs need to be directed and aggressive on long-term objectives, rather than short-term outcomes.

Unfortunately, this is a common outcome for nutrition education and other obesity-prevention programs. There isn't time to delve into the myriad of programs that do not work. Suffice it to say that most

programs do not work. The reason lies in the cookie that was passed out to the Committee members. (laughter) If they haven't made their way around, please pass them around for the simple fact of looking at the size.

ASSEMBLYMAN STEELE: Excuse me, Mr. Chairman. Could you make sure that the Republicans get some cookies? (laughter)

DR. HOFFMAN: Yes.

I did not pass them out so you could eat them. I passed them out so you could see the size of one cookie.

A biological fact of life is that you only need to find a combination of extra calories eaten or fewer calories burned to create what we call a *positive energy balance*. One of these cookies represents a positive energy balance of 50 calories. If you change nothing else in your life except eat one of those cookies each day, you will probably gain 50 pounds over a decade.

Now, from where and why we are getting these extra calories, or not using as many calories, is the million-dollar question.

ASSEMBLYMAN BARONI: I don't want to see the cookies. (laughter)

DR. HOFFMAN: The simple fact is that we can develop a positive energy balance from any number of factors: sitting instead of standing, a little extra ketchup on a sandwich, parking closer to your office, taking the bus instead of walking, watching TV instead of going for a walk, eating a brownie instead of a piece of fruit, having butter topping on popcorn instead of plain, hiring a lawn service instead of mowing the lawn ourselves, even watching television instead of working on the computer. These factors make up a collection of dietary and activity patterns that

eventually contribute to weight gain. These are not simply avoiding fast food restaurants, or exercising 30 minutes a day, or improving safety in neighborhoods, or reinstating physical activity in schools. These solutions address the big picture, but they fail to address the small components that form the big picture.

From the sheer number and variety of such factors that all contribute to a positive energy balance, it is easy to see why so many programs fail but, at the same time, emphasize the need for comprehensive and overlapping programs that go from the dinner table to the State House, and back.

So where and how do we begin to do what is necessary to stem the rising tide of weight and poor health of our state's children? First, we need to seriously ask the question of: Who and where are the most overweight children in the state? Without a clear answer to this fairly simple question, any program has great potential to be misdirected and have funds misspent, as schools or communities without an obesity program (*sic*) receive aid or programs, while others that do have a problem fail to ever see such aid or programs.

You may be aware that the Department of Education requires each school to record the height and weight of each and every child in the State of New Jersey. While calculating the BMI percentile is a basic and imperfect indicator of being overweight, it is a necessary screening tool that is being ignored. Yet these data are never requested by the Department. It would be a great step in the right direction for the State to require that we develop a health map of our state to identify counties or cities that do have an obesity problem. We could pinpoint school districts that require

continued monitoring; we could tailor programs to where weight issues are greater in particular socioeconomic or racial groups. The real advantage to developing a health map is that no one child would be singled out, no parents would receive a BMI report card. It would simply be a master tool available to the State, nonprofit groups, or professionals who want to develop and deliver targeted obesity prevention programs.

As mentioned, programs need to be targeted at communities, schools, or racial groups that most need them. Most school districts already have standardized curricula that educate our children on healthful food choices and activity. However, with the current trend in childhood overweight, programs need to go beyond the status quo. For a program to be truly effective, it has to have a target. Using a health map is one step. But working with community groups, nonprofit groups, and others who know the community's needs, are additional avenues that can and need to be taken to deliver the programs to the neediest.

It is without a doubt that activity in schools has to become a priority. While I am not prepared to delve into the minutiae of what the State or schools define as *physical education*, I am prepared to state that it is doubtful that our children are participating in any real form of exercise during the school day. As a former high school teacher, I am aware of the demands placed on schools, especially when it comes to adding new programs. However, as a nutrition scientist, I'm also aware of the clear and unequivocal relationship between exercise and health, exercise and academic performance, and exercise and diet. I would challenge anyone to build an argument against having structured physical activity in our schools. Such

programs not only improve academic success, but they are effective in improving fitness and preventing weight gain.

In addition to school programs, it is imperative that we seek to promote and organize after-school activities that allow children to explore healthful lifestyles by providing safe and structured environments where healthful eating and activity are taught. The reason I place an emphasis on after-school is that not all children have the luxury of living in areas with safe playgrounds or have the financial means to participate in private programs. Thus, it is up to the State to support after-school programs for those most at risk for overweight, namely minority children and children from lower socioeconomic groups.

In closing, I would like to reemphasize that we are far from being in a position to begin fighting against childhood overweight. The main reason that I take this position is that we are unaware of who and where our children are most at risk for becoming overweight. Without this information, we cannot begin to direct existing programs or devise novel programs to educate children on healthful diets and physical activity. Thus, to help us plan a future where fewer and fewer of our children are becoming overweight and at risk for chronic diseases -- diseases that I remind you cost us not only in terms of early mortality, but also in decreased productivity, increased absenteeism from work, increased insurance and health-care costs -- there are four steps that need to be taken.

First, we need to know where we have the highest prevalence of overweight among children in the state. This can be done most easily with the data that already exists, that the State requires each school to record. It just needs an organizational structure in which to be analyzed -- one that I

have personally proposed to the State but have yet to receive a productive response.

Second, we need to identify existing programs that promote healthful diets, and direct these programs to the areas with the greatest need.

Third, having schools dedicate time and space to allow for real physical activity is key to allowing children to have the opportunity to engage in some form of activity most days of the week.

Finally, we need to reevaluate our approach to urban planning and ensure that every community in our state has well-lighted walkways, safe playgrounds, safe sidewalks, and access to healthful food.

These four steps, however, need to be coordinated. Thus, we need to establish a true partnership between State government, our public academia, and community groups to organize these efforts. It is only through coordinated efforts that bridge basic research, community outreach, and policy that we can ever hope to successfully address the problem of childhood overweight in New Jersey.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much, doctor.

Mr. Barnes -- Assemblyman Barnes.

ASSEMBLYMAN BARNES: Mr. Chairman, thank you.

I want to congratulate our colleague, Mr. Baroni. I read about your story even before you testified -- commented on it today.

This witness has given us some very specific guidelines -- very specific. And I'd like to hear from Mr. Baroni on what you, yourself, have done, sir, in terms of your lifestyle changes. What made you lose all that

weight? Was it a combination of diet and exercise? And what specific things did you do differently, on a daily basis, that changed the -- your weight gain and, actually, tremendous weight loss, from what I understand.

ASSEMBLYMAN BARONI: Well, with your permission, Mr. Chairman. I stopped eating those little chocolate chip cookies that witnesses bring to hearings. (laughter)

I was very--

I'll be very brief with the answer. I'm more than happy to discuss it with you further.

Fifteen years ago, in December of 1994, I went to Duke University's Diet and Fitness Center. I spent a month there, learning how to eat, and exercise, and fundamentally change everything about what I ate and how I worked out. And I went from a kid who never worked out to somebody who works out every day. And I went from a kid who ate four square meals a day to counting calories and eating healthy. And I can assure you, it was nothing to do with surgery. It wasn't a pill, a shake, a bar. It wasn't some fad diet at 2 a.m. on the TV station -- that I could pay $39.95, and lose all the weight in the world, and become a famous movie star.

It is the single hardest thing any human being can do, which is to take a disease-- You know, folks who are alcoholic, folks who have drug dependency problems, face critical and very difficult lives ahead -- people who try and get off of drugs and to fight alcoholism. But, conceivably, although very difficult, somebody could live without alcohol or drugs. It's hard, but it's-- One cannot live without food. So when one has to continue

to use something that one has a difficulty-- It is a lifetime battle. And there are people who have battled it far better than I, and continue to.

But thank you for your question.

It is the hardest thing one can do.

And I'm grateful for academics like you, Professor, and your colleagues at Duke, and Yale, and other places around the country who have dedicated their lives to helping people like me.

ASSEMBLYMAN PAYNE: Thank you very much.

Thank you.

Doctor, you made some specific recommendations.

Do we have copies of your testimony?

DR. HOFFMAN: Yes, you do. I've provided one.

ASSEMBLYMAN PAYNE: Could you-- We do have it?

DR. HOFFMAN: Well, there's one copy of it.

ASSEMBLYMAN PAYNE: One copy.

If you can e-mail, e-mail. If we can e-mail -- or have a copy of it for us, we'd appreciate it very much.

ASSEMBLYMAN STEELE: I think he provided a copy with--

ASSEMBLYMAN PAYNE: Yes, if we can have copies of it for all of us, that would be very good. I'd like to have our staff have copies of it too.

ASSEMBLYMAN BARONI: Mr. Chairman, may I ask the witness one question?

ASSEMBLYMAN PAYNE: Surely.

ASSEMBLYMAN BARONI: When I look back on my education time, and you think of the diseases that children face --

everything from measles, mumps, rubella, to chicken pox, to scoliosis, and the-- Is there any childhood disease that you can think of -- in the academic research, or what -- that we have done a worse job in preventing than obesity?

DR. HOFFMAN: I would say no.

ASSEMBLYMAN BARONI: I agree.

ASSEMBLYMAN PAYNE: Thank you.

Let me ask you a question about genetics.

Ms. Skinner, I believe it was, said that genetics is not necessarily one of the more important things. I think it was--

Did you mention that?

MS. SKINNER: Yes, yes. About diabetes, yes.

ASSEMBLYMAN PAYNE: Yes.

I'd like to have some further discussion on that. Because I called Jenny Craig this morning, and I'm going to get that package that they send out, or whatever it is. (laughter) But there is a-- There are those who say that genetics has a very strong role to play in this. And I think you said that's maybe one of them but not that significant.

I really would like to have--

If you're going to say anything, please come to the table so we can have you recorded. Please come to the table so we can record you. Okay?

Stay there.

DR. HOFFMAN: I can respond to it also.

ASSEMBLYMAN PAYNE: Fine. I want all of you to-- I would like all of you to respond to it, please, if you don't mind. Because I would really like to hear about this genetic problem.

I was a mentor for a young fellow for about 11 years who was very large.

DR. HOFFMAN: If I could begin, there are-- Specific genes have been identified, that are transmitted through families, that are associated and maybe part of the causal pathway for obesity or other chronic diseases.

The fact remains, though, that these genes have existed in our bodies for centuries. So the overriding question is: What is causing these genes to now manifest themselves in chronic diseases? And it's without a doubt the environment that has allowed these genes to modify the human biology. So it's not as though the genes of people have changed in the past 50 years. We can identify a multitude of environmental changes: the food industry, supersizing, the decrease in physical activity. All these factors contribute to allowing these genes -- which have been identified -- but they are not the single factor. There is no one, single factor.

ASSEMBLYMAN PAYNE: Would you, Ms. Skinner, like to have any comments on this?

MS. SKINNER: Yes, I would agree. And when I said that genetics was not the only factor--

ASSEMBLYMAN PAYNE: Is your red light on? (referring to PA microphone)

MS. SKINNER: Yes.

You could take, for example, a family where you have five siblings. Mine, for example-- My brother got diabetes at age 47. My mother is 85 years old, and she is probably in the process of developing it. They don't have the same exact genetics, because they don't have the same father. But you can look at different lifestyles, and how people eat, their weight, their physical activity level. And I'm not saying that diabetes -- if there is a genetic component, that the person will never get it. But we can certainly do better, I believe, in delaying it -- even if it is a very strong genetic tendency -- by what we do, in terms of watching our weight and exercising.

ASSEMBLYMAN PAYNE: Yes.

Yes, you'd like to say something?

MS. STOLER: Yes, I was going to add-- In addition to what Dr. Hoffman and Barb Skinner just said is, it takes many generations of evolution to see a real change in genes. So I like to say, "You don't have to wear the genes that were handed down to you," that it is a multifactoral problem. And we have to look at everything. It is definitely-- What science has shown, and research has shown, is that there is an imbalance. It's a discrepancy between food taken in, and all of the calories and the types of calories that are taken in, in relation to the physical activity. It's a really simple equation. It hasn't changed. You know, there's never going to be a magic pill that's going to make it go away. So it's looking at our lifestyle, and our behaviors, and what we've become accustomed to.

ASSEMBLYMAN PAYNE: You know, it's still-- People don't just eat, eat, eat to get the size they are, in many instances, I don't think. Because there are those who try to stop, etc. But there are some folks that I

can't believe it's just a matter of -- they've gotten to be 400 pounds -- I don't know, maybe you can answer -- simply because they've eaten so much, or simply because they've taken in all these calories -- I mean, because there's that imbalance between that which is taken in and energy used to burn it. I don't know.

Bill.

ASSEMBLYMAN BARONI: Yes, I agree with you, Chairman.

Clearly, genetics is one of the factors. And it's interesting, because both my sister and myself were adopted. So we do not share common genes, and we do not share them with our parents. So my sister and I largely ate the same things growing up, essentially. My sister was rail-thin and, you know, had no weight issues; and I was 300 pounds and had a lot of weight issues. So, clearly, genetics is a factor. But as all of our witnesses, and as you, Chairman, point out, there are so many factors -- which is, of course, one of the things that drives me crazy every time there is a new discussion about some new fandangled way to lose weight.

We've all gained weight -- all of us who battle weight -- in an infinite number of different ways, yet somehow we keep trying to search for the one way to reverse it. There is no one way to reverse it, because there was no one way to get it. And it's not like polio, where we'll have a vaccine. It would be great, but it's not going to be that way.

And as you point out, Chairman -- correctly so -- it's going to take a lot of different ways -- as you call it, a *Manhattan Project* -- and that's exactly the right approach to this. Because there's a lot of different ways it's going to have to be addressed. And maybe more exercise is good for one person, but maybe better eating is good for another. Or maybe it's a genetic

component, or maybe there's an infinite number of different ways to do it. And that's why this hearing is so important, Chairman, is that it's not just that heavy people like me-- And you hear it, and some of it was the insurance companies. "Oh, they just eat too much." "Oh, if they'd just eat a little bit less, or don't have dessert." Let me tell you, if it was just don't have dessert, we wouldn't have heavy people. It's a thousand, thousand different ways that people get heavy.

And Chairman, by your calling a Manhattan Project, and by focusing the attention on this, I think it brings up the point that -- the witnesses add to this -- that there's a lot of ways that we have to address this. And we'd better get started, and that's why this hearing is so important -- we'd better get started addressing these things. Because in 20 years, five other legislators are going to be sitting here saying, "How could the Legislature, knowing this was a problem, having really smart people testify, sit there and say, 'Pass the cookies.'" (laughter)

DR. HOFFMAN: Which I did not say. (laughter)

ASSEMBLYMAN BARONI: That's right. Well, we did. You didn't say it.

ASSEMBLYMAN STEELE: Well, I mean, only two out of the rest partake of them, so (indiscernible) two. (laughter)

ASSEMBLYMAN BARONI: Somebody needed to check them.

ASSEMBLYMAN THOMPSON: Assemblyman Steele and I thank you for the cookies.

ASSEMBLYMAN STEELE: Yes, absolutely. We didn't want your cookies to go in vain.

ASSEMBLYMAN PAYNE: Thank you very much.

ASSEMBLYMAN STEELE: Mr. Chairman, I think you raised a good issue though. I mean, if genetics is -- you know, sometimes that whole belief is that it's in the genes. You know, it's important for people to know that so they do not succumb to that and think, you know, it's just going to happen to me. So I think it's very important that that kind of dynamic takes place, so that people can begin to understand that -- do we eat to live, do we live to eat? So that we can really begin to look at all of the dynamics and factors involved, and hopefully that we could come up with a healthier person with a healthier lifestyle.

ASSEMBLYMAN PAYNE: Thank you, Reverend.

Dr. Hoffman, one thing I noticed -- you didn't use the word *obesity* too much. You kept saying *overweight*. You didn't really zero in on the--

DR. HOFFMAN: Because we're talking about children, and it's kind of an unwritten, somewhat unofficial, rule: Do not address children as being obese.

ASSEMBLYMAN PAYNE: I noted that you didn't address that, use that word.

Okay, thank you.

We do have some other folks to testify on the area of asthma.

But we talk about the lack of-- For instance, when we were in school, I know most of us, there was physical education every day, daily. I mean, it was part of it. It became part of it. Someone suggested that we should have teaching health as one of the core curriculum content standards. But the question I have is, why have we in our public school systems eliminated the regimen of having gym every day? I mean, I-- And

we recognize that this is one of the contributing factors of this. But we just don't do this. And it's just amazing to me that we don't. And I guess we have to, obviously, redirect it. If we find things that seem to be -- at least might have some contribution toward eliminating this problem. Is it funds? I don't understand the reasons why, you know.

ASSEMBLYMAN BARONI: It's the worst of both worlds. And I apologize for being passionate about this. But you may want Michael Patrick back next time, but-- (laughter) I can tell you, it's a combination of two things: one, because of the reduced funding of education, both on the national level and the State level over the last few years, just over time schools were forced to get cheaper food. So they were serving cheaper and fattier and less healthy food. At the same time, those reduced cuts were forcing school districts to do more with less time, including the No Child Left Behind. Therefore, you had gym/physical education instructors having less time to teach. And in the time they were teaching, they were doing less aerobic activity. You know, I can tell you, as the kid who didn't like playing crab soccer -- you know, it was not exactly a great aerobic workout. And it's the school systems that are addressing those two issues that are serving healthier food and healthier choices for kids in the cafeteria, and at the same time increasing aerobic activity as part of physical education. I, like -- having been forced to take gymnastics in school, this body, then or now, ain't ever getting over one of those horses. But every year they forced me to try. It was, like, great, let's get the heavy kid to try and jump over the horse. (laughter)

We need to do more. But in the end, our school districts haven't received the funding they need, so they make cuts. And where do

you cut? You cut the food you serve and you cut the number of faculty you need. That has been the problem in the education community. The teachers want to teach more. And they want to teach phys ed; and the cafeteria workers want to -- and our folks working in the cafeteria want to serve healthier food. But unless we give them the resources to do it, it's our fault. Not our fault, but it's the public policymakers fault. A third grader who chooses the nachos -- it's, that's what they're getting served.

ASSEMBLYMAN STEELE: That's true.

ASSEMBLYMAN PAYNE: It's pennywise and pound foolish.

ASSEMBLYMAN BARONI: Absolutely right. Absolutely.

ASSEMBLYMAN PAYNE: We save money by cutting out some of these things, and then health costs for taking care of folks once they become less healthy -- it's astronomical.

ASSEMBLYMAN BARONI: The cost of a salad bar in a school is far less than one student's -- just one in that school's lifetime -- dependence on insulin. And no one has, until this Committee -- people aren't really thinking about those things.

ASSEMBLYMAN PAYNE: Thank you. Thank you very much.

I appreciate those of you who have come and testified. It's been something of a concern of mine for some time. And I hope that we -- and I expect that we will be able to come out with some very positive kinds of action items, initiatives that we can take with the Department of Education. I think we'd like to start there and with others. And being a member -- Mr. Baroni is a member of the Education Committee, I believe. Are you a member of the Education Committee too?

ASSEMBLYMAN STEELE: No, sir.

ASSEMBLYMAN PAYNE: Then we could certainly begin to do some of the positive things that we need to do. And we appreciate your testimony here. And hopefully, in five years we won't be back here saying the same things.

Thank you.

Now, I'd like to have Bill Whitlow here, please, from the Rutgers University, to testify on the other area of concern -- and that is the asthma problem.

Well, if the red light is on, you're set to go. (referring to PA microphone)

J. W. "BILL" WHITLOW, Ph.D.: Good morning, Mr. Chairman and Committee members. It's a great pleasure to be here and an honor to have a chance to talk about asthma.

My name is Bill Whitlow. I'm a Professor of Psychology at Rutgers University in Camden. I've been involved in efforts to reduce asthma in Camden City since about 2000 -- it started the millennium. You're probably wondering what a Professor of Psychology would have to say about asthma. And the answer is that asthma is a serious medical condition, but the management of asthma is something that involves primarily education.

I've been very heartened by the Chairman's characterization of our focus on the Manhattan Project, because the message that I'd like to relay today is the importance of a team effort to address asthma, just as a team effort is necessary to address obesity. My focus, then, has been on education. I started a program called AMULET, Asthma Management and Urban Lead Education and Training, for Camden, because those are two

health problems that impact particularly on low-income and minority children, and they're preventable, as is obesity.

Asthma is a chronic disease. It's like hypertension, and like hypertension in an important way -- which is that the definition in management of asthma depends upon monitoring how your body is functioning in ways that you may not yourself be aware of. So someone who has asthma has a particularly sensitive respiratory system, and their air passages are likely to be inflamed or likely to get inflamed quickly -- more quickly than someone who doesn't have asthma. And so they have to manage that in the same way that someone with high blood pressure needs to manage their blood pressure.

There are triggers that produce what's called an *asthma attack*, and that's what is an acute episode of asthma. And that's what some people think of as being the primary concern with asthma, but that, of course, is not the case. The goal of asthma management, the goal of education about asthma is to make sure that people are controlling asthma so that it doesn't get to the level of being an acute episode.

As I'm sure the Committee knows, asthma has increased steadily over the past 30 years. No one really knows why that's the case. In New Jersey currently, it's estimated by the Department of Health and Senior Services that about 8 to 9 percent of all residents have asthma. Those rates are higher in children than they are in adults, they're higher in minority populations than they are in white populations, and they're higher in poor people. It's estimated, for example, that one-in-eight African-American children in the State of New Jersey have asthma. That's a large number of children.

Camden City, as I'm sure you know, is one of the poorest cities in the country. It has predominantly minority population, and it's a city of children. About 35 percent of the population are under the age of 18, according to the 2000 census. And for children, as the Chairman has already pointed out, asthma is the leading cause of school absenteeism attributed to chronic conditions. It's one of the most common chronic conditions in childhood. And in Camden City, asthma in children is the leading reason for multiple visits to emergency departments in hospitals. And that's, from the point of view of medical professionals, a misuse of the emergency department -- that asthma should be manageable. So having children go to the emergency department is a bad outcome. It means that someone is not managing it properly, and the use of the emergency room is being drawn from other things that it really needs to focus on.

How do we reduce the burden of asthma? It's a team effort. And that's recognized in New Jersey. You'll hear testimony from the Pediatric/Adult Asthma Coalition that's been mentioned already, and they've done a fantastic job of organizing groups of people in the state to confront the issue of asthma.

What I'd like to do is to just talk a little bit about a particular project that I've been involved in, because it's going to take it down-- One of the points the Chairman raised is that there are plans, and then the plans may or may not get implemented. I just want to make a point about the difficulties of bringing these plans to the level of the individuals who are affected by it, to the homes -- talk about obesity, and where are the parents, where are the families. The same can be said of asthma, where are the

parents, where are the families? They're there, but they need information, and getting that information is often difficult to do.

In Camden, I've worked with a number of groups. The Camden AHEC, the Area Health Education Centers, have been an important team member -- Linda Boclair at that office, in Camden, has worked with me; and the Camden County Health Department has helped -- worked on this project; as has New Jersey DEP. So there's already efforts to bring groups of different institutional organizations together.

And the answer to how to reduce asthma -- it's a little bit better in some ways than obesity, in that the answer of how to reduce asthma is -- or the burden of asthma is fairly well-known. There are two things that one needs to have. One component is a medical component. There needs to be an action plan for what someone does to treat their asthma. And the Pediatric Asthma Coalition has developed such an action plan. You'll hear more about that. But the action plan involves making sure people know about the two kinds of medications. There are two things you need to do. You need to have treatment for the chronic condition. So you need to make sure a person who has the susceptibility is taking medications that keep that under control, the same way with high blood pressure. If you have high blood pressure, you need to take medications every day. It doesn't matter how you feel. You take the medication, and that's providing you with a safe baseline.

In addition, you need medications in the case of asthma. If you have an attack, then all of a sudden you can't breath. And at that point, you need something more serious than just day-to-day maintenance. And that's where you have other medications, bronchial dilators, that open up

the passage ways and let you breath, so you're there for another day. But that's not a solution. You need to manage it. And if you get to the point of needing your bronchial dilators, it means that things have gotten out of control, and you don't really want to let them get out of control.

ASSEMBLYMAN PAYNE: Excuse me?

Are some people predisposed to this condition?

DR. WHITLOW: There is some predisposition. There seems to be a lot of reason. You mentioned the diesel fuel issue. There seems to be a lot of reason that -- it's an impact from environmental factors that are creating more and more incidences of it. But it is the kind of thing, if your parents had asthma, your grandparents had asthma, then you know that you should pay attention to it. But it can be managed.

So one component is the medical component -- how to keep it under control. And the other component is how to prevent people from being exposed to triggers. Because if you have this condition, then you're susceptible to triggers that produce an attack. Some of that is external, so things in the air -- try to implement controls, of improving air quality. But what has been more important, and especially for children, is the internal environment. The environment in the home, the environment in schools, the environment in day-care centers. And the goal is to try to educate everyone -- the parents, the caregivers, the schools, the day-care centers -- to educate people about what those triggers are and how to reduce them.

The single, most-important trigger, of course, is what's called *environmental tobacco smoke*, second-hand smoking. Tobacco smoke is an incredible irritant that's a very easy trigger for many people. But there are other things, too. Mold you've heard of. Mildew, kinds of conditions

where houses get damp, or day-care centers get damp, or schools get dampness. And that means if there's flooding in the school, then there needs to be a concern about possible mildew and mold after that.

There are other kinds of things that can be done. And the purpose of our program was to go to homes and talk to parents about what they could do in their home to try to reduce the exposure of their children to those kinds of triggers. These aren't always easy issues. One of the prime sources are things like rugs and pets. We go to a home and tell a parent that their child can't have the dog, that's not an easy decision sometimes. Not because the parent couldn't get rid of it, but because the child was attached to the dog or the cat. We go to families--

ASSEMBLYMAN PAYNE: Don't roaches also trigger--

DR. WHITLOW: Roaches are also a source of asthma triggers. And so one of the things that you can do, that's less of an issue, is to help people improve their control of pests. But again, in cities like Camden, there are harder -- it's easier in some places than it is in others to control pests. But in addition to controlling them-- So roaches are a source of triggers, but then pesticides are a source of triggers. So to be effective you need to try to reduce the pests not just by spraying everywhere, but by making their lives unpleasant. So you take away their food sources, take away their moisture sources, keep your house clean. That reduces the incidence of pests without pesticides.

So those are the kinds of things that we've done to try to educate parents about ways to make their house more friendly to their children. But what I would say -- so the process of doing that, just to come back to the point I made at the beginning about the difficulties with AHEC

and DEP-- New Jersey DEP actually got a grant from EPA, which is concerned with air quality, and they made it available through AHEC to work with Rutgers to train some parents in how to provide better environments. And we also worked, through the County Health Department, to talk to day-care center providers and workers about this. So we had a person who was in the community go and talk to parents. And she visited houses -- this had to be at their invitation. You can't just go to somebody's house and say, "This house is a mess. You need to clean it up." If you want them to do something, you need to have them say, "I'm concerned about my house. Would you come and help me do this?" So there needs to be buy-in from the parents in that. Our worker did that. She got the trust of the parents. She was invited to go to their houses. She met with them, she talked to them, she went back and talked to them again. But it's a difficult task where people have lots of concerns.

There are lots of problems that parents in Camden have, besides asthma attacks for their children. So that they have to choose between going to an interview for a job, or getting another child to another hospital problem. It's difficult. So I just wanted to make a point that going house to house and talking to parents has taken approximately a year-and-a-half, to reach out to about 40 families. It's an intensive thing, and it requires concentrated effort. It's not an easy task. There are lots of--

ASSEMBLYMAN PAYNE: Is it ongoing? You say they received a grant to do this from--

DR. WHITLOW: From-- Well, we got it through DEP. That grant has now expired, and so we are still meeting with parents, but we're

not recruiting additional parents into that. And the issue is funding that provides a way to get to that level of intervention.

ASSEMBLYMAN PAYNE: What about the Department of Ed, their School Board, are they working with -- in conjunction with this program?

DR. WHITLOW: We did not work with the School Board on this particular program. There are programs, and the Pediatric Asthma Alliance has addressed school issues. But we took one problem at a time on this.

ASSEMBLYMAN PAYNE: You know, the Bible says "the poor will always be with us," and I guess this is the case. You get 40 families in a year-and-a-half, and there's about 5,000 other families waiting to be visited, etc., etc. We get a grant, try it out, and then the government doesn't give us any more money. So we're right back where we started from. Again, we need, you know-- And then, of course, Camden, one of the poorest cities in the entire country, is impacted with all of these problems, and we get limited-- You know, it's ridiculous. It makes no sense to me at all. And that's where we need to continue to try to keep the focus on these kinds of things. People and kids are impacted by these things that are preventable. We know they're preventable.

I have a piece of legislation in now to retrofit diesel engines, etc., because the pollution from diesel fuel creates problems, and I have the industry fighting against it. The bill is supposed to come up, but they're fighting -- "No, we don't want to do that for the kids." It's just absolutely ridiculous. We have a playground alongside of a highway where diesel trucks are going by and spewing out -- in a two-hour period, 340 trucks go

by spewing this stuff. And kids playing baseball, thinking they're doing a healthy exercise, and the pollutants are coming in, you know. So I have legislation now that's trying to stop this, and I'm getting, you know, people fighting it. You've got school buses that pollute kids while they ride the buses, for crying out loud. I mean, it's asinine. And so these are things that we're concentrating on.

Of course, when I went up for office, I never got any support from these people, but that's okay as long as the kids are healthy. But we have to have some kind of consistency on these things. We have to get angry about it; we have to do something about it. My god, we're talking about getting guns off the streets. Let's get guns off the streets, but let's also get the pollutants out of the air. Let's start putting the cement factories in Camden, for instance. That kind of stuff, you know.

DR. WHITLOW: Absolutely. And speaking back to the obesity issue, I mean, what's a parent supposed to do. They don't, in Camden, want their child to go out and play because it's not a healthy environment, as well as not necessarily a safe environment. So that's only adding to those woes.

ASSEMBLYMAN PAYNE: I'm sorry to go--

DR. WHITLOW: That's quite all right. No, your efforts on behalf of the retrofitting is excellent, and one of the things that we wholeheartedly support -- that sort of reduction and--

ASSEMBLYMAN PAYNE: And I want to add pesticides to it. It just passed out of the Environmental Committee today. There's people opposed to that, too. But the eliminating of the pesticides, you know--

Poor people have to get lobbyists, too. That's what it is, you know? And I guess that's what we are.

DR. WHITLOW: Yes. That's what you are. Yes.

ASSEMBLYMAN PAYNE: But continue. I'm sorry.

DR. WHITLOW: Really, that summarizes much of what I want to say -- is that the efforts of AHEC, the efforts of Camden County Health have been instrumental in the kinds of things -- working with schools to certify schools as being healthy environments, and working with day cares as being healthy environments are important elements of that process. But making sure that parents know what they can do and providing resources to help them do that, because it's not just a matter of giving them a flyer. A flyer is just one more piece of trash that has to be disposed of. But getting people who can actually work in a consistent way with the community. And there are members of the community to do that -- having what are called *health advocates* or something like that. It's just that that's not an insurance company focus, that's not a State focus, those are-- At the local level, it's just hard to find a mechanism for that kind of support.

ASSEMBLYMAN PAYNE: Thank you very much.

DR. WHITLOW: Yes. Thank you very much for the opportunity to speak today.

ASSEMBLYMAN STEELE: Mr. Chairman, I just wanted to commend the witness for his intention of going into the homes and things. That's really where we have to actually begin the education and continue the education process. And hopefully, the 40 families will have made a difference because you've been there. And I'm sure that, even though that

number does not seem like a large number, but I think it's a big problem for you to take on that kind--

DR. WHITLOW: It's a start. You have to start and work beyond that.

ASSEMBLYMAN STEELE: Absolutely.

ASSEMBLYMAN PAYNE: Thank you very much.

DR. WHITLOW: Thank you. Thank you.

ASSEMBLYMAN PAYNE: May we have now Maris Chavenson.

MARIS CHAVENSON: You did very well on that.

ASSEMBLYMAN PAYNE: Thank you.

MS. CHAVENSON: That's a compliment.

ASSEMBLYMAN PAYNE: Close, huh?

MS. CHAVENSON: Yes. Maris is correct.

Good afternoon. And I know it's been a long, very informative morning, and I'll do my best to be brief. And I want to thank you very much for inviting us today. Again, my name again is Maris Chavenson. I'm the Associate Coordinator for the Pediatric/Adult Asthma Coalition of New Jersey. We're sponsored by the American Lung Association of New Jersey. And Linda Holmes made a reference to the work that we're doing. We are supported by the Department of Health and Senior Services.

May is Asthma Awareness Month, so this is perfect timing. Governor Corzine actually made a proclamation that May is Asthma Awareness Month for the State of New Jersey, so this is very, very timely and it speaks very close to the work that we're doing. And you've heard a

lot of this before, and I'll go briefly through some of the information that was outlined earlier.

Asthma is one of the most common chronic diseases affecting children, and results from the 2003 National Survey of Children's Health suggests that about 255,000 New Jersey children, 12 percent, have a history of asthma. And the survey also suggests that 180,000 children in New Jersey, 9 percent of the pediatric population, currently have asthma. When uncontrolled, asthma can result in activity limitations, missed school days, emergency department visits, hospitalization, and even deaths.

The burden of asthma is outlined in the attached notes. You all have a copy of what we brought here. But I want to highlight some key concerns that we have as a Coalition.

Seven years ago, the American Lung Association of New Jersey and its medical arm, the New Jersey Thoracic Society, sent out a call across the state to those interested in changing the way asthma is managed in New Jersey to come together as a coalition for statewide change. The Pediatric/Adult Asthma Coalition of New Jersey, PACNJ, was formed, with over 130 interested parties representing schools, child care, physicians, health insurers, communities, and environmental agencies. Funding for our statewide initiatives came from the Centers for Disease Control and Prevention, through the New Jersey Department of Health and Senior Services, the United States EPA Region 2, foundations, and corporations. Maintaining a statewide coalition that targets communities most in need with new programs, and then expands those programs for statewide change, is becoming more difficult each year. Funding allocated annually to sustain

a statewide coalition to continue the work with schools, child-care communities, physicians, and environmental agencies is sorely needed.

The National Heart, Lung and Blood Institute has issued guidelines for best practice in asthma management, and the Coalition saw the need to ensure that physicians, schools, and families were following those guidelines. Experts in the field of asthma and representatives from those systems that impact on children were enlisted to participate on six task forces to bring people together in a coordination of care to focus on statewide system change.

I outline in the notes here a lot of the statistics that you've heard already. But bottom line, children are strongly impacted much more than adults. They're hospitalized more, they're in the emergency department more; and the under-5 population are even more severely affected. And then the minority populations -- black children and Hispanic children are also disproportionately affected by the burden of asthma.

In addition, May -- we're in right now -- and the Fall are spikes for asthma, when children are in school and in child care. So if the schools and child care are involved as a team in managing asthma with the children, we can make an impact for their lives. Again, they're in school during these peak seasons for hospitalizations. PAC addressed asthma management in the schools in an effort to change the system from being a reactive response to an emergency, to a proactive, preventive approach that addressed triggers and recognized the early warning signs of an asthma episode so a child could get help before there was an emergency. To achieve this statewide system change, PAC developed free educational materials and tools, and implemented them statewide.

This was made possible because New Jersey has one of the most comprehensive laws in the nation on asthma management in the schools. This law went into effect in September 2001, and requires asthma education for school nurses, annual asthma education for school faculty, that there be a nebulizer in every school, and that the child has an asthma action plan that also lists the triggers -- for children who carry an inhaler in school.

This is an outstanding law and PACNJ developed those tools needed to facilitate schools complying. Then we created the PAC Asthma Friendly School Award to recognize those schools that not only complied with the law and provided the education, but also went above and beyond by taking the New Jersey Department of Environmental Protection Agency's "No Idling Pledge," that speaks to the school buses you're talking about, saying that they may not turn on their buses when they're picking up the children and they're waiting to take them at the end of the day. All these schools also have participated in the U.S. EPA Indoor Air Quality Tools for Schools training and formed a team for their school.

Two weeks ago, we had our third award ceremony, and we acknowledged, up until this time, since last Spring, 262 schools that serve over 150,000 children have received our Asthma Friendly School Award. We're currently partnering with the Newark Public Schools so that all 84 of those schools can receive our award. We're hoping for next Fall. We've done a training with all their school nurses. We're going to work with their maintenance staff on indoor air quality issues.

ASSEMBLYMAN PAYNE: Great.

MS. CHAVENSON: We would like to recommend that, to expand this statewide effort for system change and to continue to motivate schools to remain proactive in their approach to asthma management, that policies be established to offer those schools who are recognized as complying with the law and being asthma friendly -- that they receive priority when State funding is made available to schools.

We've also done work in the child care community to reach the under-5 population. We've partnered with the child-care health consultants who are in each of the 21 counties, and part of the resource and referral agencies in all the counties, to develop asthma trainings -- a bilingual asthma education video kit. And then, in addition, a program called "Policies and Practices for Asthma-Friendly Child Care," that targets the directors of family child care and child-care settings. And we've trained all those consultants to be facilitators so that they can create these trainings statewide.

We're also working with Professional Impact New Jersey to establish these trainings as part of their Directors' Academy, so directors and centers can get asthma training that they can then take back to their centers.

We're also about to work with the Newark Preschool Council, the Head Start Program there, to provide asthma training for their 300 providers and 30 directors.

Again, emergency room visits are a real serious problem for children, especially in the minority community. The burden of asthma is disproportionately distributed throughout the state, with Essex County experiencing the highest age-adjusted hospital discharge rate for asthma.

As mentioned before, in addition to schools and child-care providers, PAC is working with physicians, communities, health insurers, and environmental agencies for statewide system change. It's this approach that's aimed at reducing emergency room visits.

This year PAC worked with the New Jersey Chapter of the American Academy of Pediatrics to develop an asthma education program for system change in physicians' offices. This program is being piloted here in Trenton with 11 physician practices, and involves all office personnel and medical staff in the establishment of systems that improve asthma care. This requires a shift from an acute-care perspective to a chronic-care model, and can be expanded to other cities, with appropriate funding.

The NHLBI identified, in their Guidelines for best practice in asthma management, the importance of an asthma action plan, for communicating between the physician and the patient and their family. This tool has been developed by PACNJ and tracked for effectiveness through the school nurses. It's now being revised in response to a school nurse survey that identified problems with physicians and implementation. We've partnered with the New Jersey Primary Care Association to link with the New Jersey Federally Qualified Health Centers participating in the Asthma Collaborative to test this tool with their patients.

And as Linda Holmes mentioned, New Jersey is part of the Agency for Healthcare Research and Quality -- a program to address disparities in pediatric asthma. Our Coalition has participated on the AHRQ team and, as a result, all of the PAC asthma educational materials were reviewed for cultural competency. This was a unique opportunity. Currently, the AHRQ is developing guidelines for PAC, and others in the

state, for us to use in developing asthma tools that are culturally competent for diverse populations. The tools will include patient cultural beliefs and folk remedies associated with asthma that can be a barrier to patient compliance. The AHRQ is also developing a protocol for convening focus groups on asthma for these target populations that are hardest hit by the disease.

PAC has a unique opportunity to implement these tools through our community task force and to revise our current materials to more fully meet the needs of children and their families with asthma.

The New Jersey AHRQ team is also looking at asthma morbidity at the city level, and is finding that certain cities experience disproportionate hospitalizations and emergency department visit rates for asthma. The team is planning an emergency department intervention to target Trenton and Camden, with the hopes of raising awareness, garnering support, and extending the program to other affected cities, including Newark.

We also have maintained a Web site that increasingly serves as a statewide resource for all of our materials and links to many resources statewide. We anticipate that soon it will be necessary to revise all of our materials to stay current with changes in asthma management, including cultural competency and guidelines.

We need your help to sustain our statewide Coalition that targets communities most in need with new programs, and then expands those programs for statewide change. Funding -- allocated annually to continue the work with schools, child care, communities, physicians, environmental agencies -- is needed. And as stated before, policies need to

be established to offer those schools who are recognized as complying with the school law -- as being asthma friendly -- to get priority when State funding is made available to schools.

Thank you again for the invitation to speak with you about the burden of asthma; our effort to impact, statewide, with sustainable change for managing asthma; and the need for funding to support this effort.

ASSEMBLYMAN PAYNE: Thank you very much for your comprehensive testimony -- and obviously very, very informative and helpful. And I'm glad to hear about some of the work that AHRQ is doing. There's a lot more that needs to be done. And as you recommend, that funding needs to be allocated to continue the work with the schools, etc., etc. Funding seems to be at the core of a lot of these things. But I think that if we continue to be strong advocates for these health issues, that we should be able to increase -- not only sustain the funding we have, but perhaps increase it. Because if we can get across to our government, our State, to our citizens that it's much cheaper for prevention on the front end, then I think that we may be able to begin the thinking on the part of the people -- the people that serve in the Legislature and the budget process, etc.

Thank you very much.

I don't know whether there's any questions, specific questions that we have. But I want to thank you very much for your testimony.

MS. CHAVENSON: Thank you very much.

ASSEMBLYMAN STEELE: Just one question for a point of information. The Paterson school system, are they--

MS. CHAVENSON: Paterson is also targeted for the Asthma Friendly School Award Program. We're working very closely with the school nurses there, and they have begun implementing. There are six steps that are required for the law, and they've begun implementing some of those steps. So we are targeting Paterson as well.

ASSEMBLYMAN STEELE: Right. If I can be of any assistance, let me know.

MS. CHAVENSON: Oh, wonderful.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

We really appreciate it. We had one other person that signed up, but I don't see Dave here.

So if there are no other folks who are here to testify, I just want to say that it's my hope that we'll be able to, certainly, arouse the attention and bring about more support for this area. Certainly we know that some of these areas are preventable asthma. Certain legislation that we are able to get through the Legislature will have an impact on the health of our children. And the important thing is: If we can just utilize some common sense, utilize some of the programs that have been shown to be successful, we can improve the health of our young people. But not only that, we also can hope to improve the bottom line of the State of New Jersey by prevention, as opposed to correction after it's too late.

And I just have to point out that there have been some organizations -- Horizon has been working along with Rutgers University to create a program called *Shape It Up* program -- from 2004 to 2006, and had a program to help draw attention to the needs for many of the programs

we're talking about. And we want to make sure that there are other organizations in the private sector and in the public sector to work together as a team.

As I said earlier, we need to have a Manhattan Project to address these things, and we need to have coordination. There are a lot of different disparate programs that are working in these areas. We need to try to have some kind of uniformity so that we all know what we're doing, and I think we'd be much more effective.

Thank you all for coming here today. And it's my hope that we will be able to show some meaningful progress in the area of obesity and asthma.

Thank you.

Thank you, members of the Committee.

Thank you.

(MEETING CONCLUDED)

APPENDIX

Testimony of Eddy A. Bresnitz, MD, MS
Deputy Commissioner/State Epidemiologist
New Jersey Department of Health and Senior Services
Assembly Regulatory Oversight Committee
Monday, May 21, 2007

Issue: Childhood Obesity

Good morning Mr. Chairman and members of the Assembly Regulatory Oversight Committee.

I appreciate the opportunity to provide the Committee information on the important issue of excess weight, specifically childhood obesity and overweight.

Excess weight is a public health crisis, often starting in childhood. It is a growing global public health problem and New Jersey is not exempt.

A CDC-sponsored survey in 2005 reported 37.1% of adults are overweight and 22.1% are obese in New Jersey

Excess weight is the nation's second leading cause of death after smoking contributing to as many as 300,000 deaths annually.

In the last 30 years, the percentage of overweight youth has doubled nationally for ages 6-11, and tripled for ages 12-19.

According to a national Survey (NHANES), 15 percent of children aged 6-11, and 12-19, are obese, estimated to rise to 20% by 2010.

The DOE and DHSS conducted a retrospective records survey of ~2400 6th graders in 2003 - 2004 selected randomly from 40 schools from varying socio-economic groupings found that 20 % were obese and 18 % were overweight, higher than the national average.

Higher obesity levels were observed among poorer school districts and among all racial/ethnic groups.

The state's African-American and Latino youth are more likely to be overweight than are white youths.

New Jersey has the nation's second highest obesity rate for WIC children of those states and US territories that report this data.

The prevalence of obesity among Hispanic children exceeds national rates. Results from the 2005 New Jersey Student Health Survey indicate that about three in 10 middle- and high- school students, based on self-reporting of their height and weight were either overweight or at risk of being overweight.

An ongoing plan to review and analyze student health records for height and weight data is critical in order to measure the State's progress in reducing childhood obesity.

The problem of overweight in childhood is known to persist into adulthood because the food and physical activity choices learned in early childhood will continue throughout life.

And obesity is costly, with New Jersey's share of the annual national total in 2003 estimated to be $2.3 billion.

According to one estimate, insured children treated for obesity are approximately three times more expensive than the insured child without obesity, costing the US approximately $750 million per year.

For adults, obesity-related health conditions cost the nation $75 billion a year in medical expenses in 2003, with taxpayers paying half those costs through the Medicare and Medicaid programs.

Early intervention is needed so that overweight/obese children do not become overweight/obese adults.

There are numerous physical consequences that place children at risk for life-long health problems.

Increases in blood pressure and cholesterol levels due to obesity, place children at-risk for early heart disease.

Excess body fat increases resistance to insulin causing Type II diabetes.

Other physical problems include asthma, sleep apnea, menstrual abnormalities, and orthopedic problems.

In addition to physical health problems, there are emotional and social consequences including depression, being bullied and poorer academic performance.

Obesity results from an imbalance of consuming more calories than the amount of calories expended.

The causes are multi-factorial and for some, are genetically or physiologically determined.

However, childhood obesity is largely the result of a decrease in regular physical activity and poor eating habits.

Other factors come into play and can be broadly defined into three groups: demographic, cognitive and behavioral and community.

Demographic include socioeconomic status and race/ethnicity.

Cognitive and behavioral factors include attitudes, beliefs, and perceptions and sedentary behaviors – for example, watching television, playing video games and computer use.

Community factors include decreased school-based physical activity as well as an inadequate "built" environment- the way that land and buildings are designed and used and a transportation system that provides or limits opportunities for physical activity and travel-

The "built environment" is an increasingly emerging focus for health interventions.

It involves how community designs impact physical activity and how neighborhood factors influence eating patterns.

Some key factors are availability of sidewalks, bike paths, recreational spaces, safety of communities, types and numbers of restaurants and grocery stores in neighborhoods, and sprawl.

And earlier this year, Governor Corzine unveiled a $74 million comprehensive pedestrian safety initiative that provided funds to local governments for the creation of safer walkways, bikeways and street crossings and other measures that will promote more exercise in the community.

In addition to this initiative by the Governor, allow me to mention just a few of the other initiatives of our Department.

The overarching goals of Healthy New Jersey 2010 are to increase the quality and length of healthy life; and eliminate disparities in health outcomes based on race and/or ethnicity.

To this end, the Department has and continues to undertake activities to prevent obesity and promote physical activity and nutrition including:

- Convening of a New Jersey Childhood Obesity Roundtable in June 2002 and a follow-up Summit in December 2003 that brought together key stakeholder groups to share information and make recommendations to combat the obesity problem. The attendees focused on what could be done in: Schools, Community, Industry/worksites, Insurance/ HMOs, Legislative/policy, Advertising/advocacy, Government, Research and 'other' areas.

- The Department staffed the activities of the Obesity Prevention Task Force established by the Legislature in 2003.

- Creation of an Office of Nutrition and Fitness to implement Task Force's recommendations outlined in its report, *The New Jersey Obesity Prevention Action Plan.* Five key areas for intervention will be- increased physical activity; decreased screen time (television, video games, and computer use); improved nutrition, in particular the increased consumption of fruits and vegetables; and exclusive breastfeeding of infants. The report mentioned that special efforts are needed to reduce the disproportionate rates of overweight and obesity in African Americans, Latinos and low-income people. The coordination of initiatives is imperative to maximize resources and minimize duplication of services.

We have implemented many educational programs to encourage physical activities.

Examples:

- *Kid Strong (Inside and Out)* and its follow-up curricula, *Jump Start Your Bones* were distributed to 1500 New Jersey public schools and focuses on healthy eating and regular physical activity for bone health in 10-14 year olds.

- Four Community Partnership for Healthy Adolescents grantees and several individual schools have implemented either in- or out- of school pedometer projects.

- Availability of mini-grants from the New Jersey Council on Physical Fitness and Sports, *Leaders' Academy for Healthy Community Development* (20 mini grants of $2500 were offered in FY 2007; to be repeated in FY 2008) to communities to improve the health and wellness of the community through projects focused on increasing access to walking and biking opportunities.

- DHSS, Rutgers University and the PLAY Task Force are developing a workshop *for Preschoolers* for a near future statewide launch to impact childhood obesity. This effort is based on a number of strategies recommended in the *Obesity Prevention Action Plan.*

- Collaboration with Rutgers Cooperative Extension through a multi-year memorandum of agreement (MOA) on a statewide obesity prevention campaign: *Get Moving, Get Healthy New Jersey* (GMGH NJ). Through their County-based network of offices, two goals will be realized:

    1. New Jersey youth and families will make healthy eating and physical activity choices as part of their daily lives.

    2. The Department of Health and Senior Services and Rutgers Cooperative Extension will be recognized as the state leadership facilitating the collaboration of public and private partnerships to create a healthier New Jersey.

Other programs that address nutrition and physical activity throughout the lifespan include:

Our WIC Program (with DOA) to promote healthy eating and good nutrition:

- New Jersey 5 A Day, Fruits and Vegetables – More Matters is coordinated through the WIC Program in cooperation with the NJ Department of Agriculture and many other partners that promote nutrition and physical activity to reduce obesity. For example, the WIC Farmers Market Nutrition Program provides select groups of WIC participants with four - $5.00 vouchers for the purchase of fruits and vegetables at approved farmers markets.

- The New Jersey State WIC Program provides on-going promotion and support of breastfeeding, increased fruit and vegetable consumption, nutrition education for growth and development, and age-appropriate education on physical activity.

Child Health Regional Network training of professional staff

- Through the Child Health Regional Network (CHRN), health professionals working in local health departments participate in trainings that update their knowledge and skills in a variety of topics including nutrition and childhood obesity and oral health.

Oral Health Program

- The Oral Health program developed an Oral Health and Nutrition Resource Guide for school-based personnel working with youth in the State's 31 special needs districts. These manuals were distributed in 2002 to WIC

Coordinators, NJ State School Nurses, each College of Nursing in the State that has a School Nurse Certification Program and CHRN program attendees.

-Family Planning agencies distribution of educational materials

- Brochures and training materials with specific nutrition and physical activity recommendations are disseminated through Family Planning agencies.

We have many programs targeted at adults

- The Division of Aging and Community Services (DACS): Project Healthy Bones (PHB) is a 24-week exercise and nutrition education program for older adults at risk, or who have osteoporosis. The program is offered at 125 community sites throughout the State. PHB is designed to improve strength, balance and flexibility. More than 1400 seniors participate in the peer led program.

- The Senior Nutrition Program is partnering with HealthEASE, a project funded by the Robert Wood Johnson Foundation in 2002, on a physical activity initiative called "Steps to Healthy Aging" being offered at local senior nutrition centers. The program includes the use of pedometers and education on healthier eating.

- A "Live Long, Live Well" statewide walking program for older adults is being co-sponsored with the New Jersey Commission on Aging. A New Jersey walking recognition award is a component of the initiative.

- The Office of Cancer Control and Prevention (OCCP) has collaborated with Family Health Services and other key stakeholders in the development of two work products: the nutrition and physical activity chapter of the Comprehensive Cancer Control Plan (CCCP). The chapter, compiled by an expert sub-committee, focuses on increasing fruit and vegetable consumption, reducing obesity and overweight and increasing leisure time physical activity. The document, *Nutrition and Physical Activity Programs in New Jersey,* published in 2002 was recently updated and provides information on current activities, program gaps and facilitate dissemination of successful programs available to New Jersey residents.

Other State Departments are also addressing childhood obesity. Some highlights include:

- Department of Education - revised core curriculum content standards for health and physical education and requires 150 minutes per week of health, physical education and safety.
- Department of Agriculture - has mandated that each school have a School Wellness policy that shall be implemented by September 2007
- Department of Transportation - has launched *Safe Routes to School* with federal grant funding
- Department of Community Affairs - through their Office of Recreation, is working with local parks and recreation departments to support local initiatives.

Let me conclude by stating that leading experts have indicated that for the first time in recorded public health history, that if we don't address the problem of excess weight head on in a multi-pronged approach, the current generation of youth will live shorter and sicker lives than their parent's generation. Addressing overweight and obesity NOW will improve the quality of life for our future generations and will strengthen the health of our nation. Thank you.

Testimony of Linda Holmes
Executive Director – Office of Minority and Multicultural Health
New Jersey Department of Health and Senior Services
Assembly Regulatory Oversight Committee
Monday, May 21, 2007

Issue: Health Disparities

Good Morning Mr. Chairman and members of the Assembly Regulatory Oversight Committee. I appreciate the opportunity to provide the Committee information on the important issue of health disparities.

As we have often heard Dr. Fred Jacobs, M.D., J.D., Commissioner of Health and Senior Services, say reducing and ultimately eliminating disparities in health outcomes is the core mission of the Department of Health and Senior Services. This remains the one of department's top priorities.

Over the years, the Department has worked to reduce disparities through various initiatives such as Rapid HIV testing and the Cancer Education and Early Detection Program, both of which target minority population at risk.

A year ago when providing testimony to this committee, I indicated that the Department was working on a Health Disparities Plan. Today I can say, for the first time, the Department of Health and Senior Services has developed a Strategic Plan for Eliminating Health Disparities in New Jersey, released in March. The plan is now being implemented.

The Department's Plan makes a number of recommendations for strengthening programs and developing new initiatives that will help the Department reduce and ultimately eliminate health disparities among various racial and ethnic groups.

In addition, this plan establishes goals for strengthening the infrastructure of the Department. For example, the Plan recommends increasing the number of minorities in management positions through a new mentoring program. This initiative is being directed by Human Resources.

Other steps we are taking to address strengthening the department's infrastructure include making certain that health education information that is culturally and linguistically sensitive is increasingly available on the Office of Minority and Multicultural Health website. Standardizing the collection and reporting of race/ethnicity data across the Department is another priority. We do not know if there is equity in the delivery of health care services without race and ethnic specific data to measure the quality of those services.

This plan lists actionable strategies for the Department to follow in order to eliminate health disparities. For example, in addressing disparities in asthma, the Department has examined our best practices and created a framework for eliminating asthma disparities in New Jersey.

The Commissioner's Annual Asthma Summit provides opportunity for collaboration among national and local experts in designing strategies to reduce asthma disparities.

The first summit in September 2005 allowed health care providers to exchange ideas on how to: (1) implement new asthma interventions in minority communities and low-income populations; (2) incorporate best practices as the basis of asthma management; and (3) develop partnerships with public and community health systems.

The Pediatric/Adult Asthma Coalition of New Jersey (PACNJ), partially supported by NJDHSS, continues to serve as the statewide coalition on asthma awareness. PACNJ, with over 150 participating member organizations and six active task forces, is undertaking the following initiatives: (1) school nurse asthma trainings; (2) asthma-friendly childcare trainings; (3) distribution of personalized *Asthma Action Plans* for individual children to manage their asthma; (4) train-the-trainer programs; (5) Asthma Friendly School Awards; and (6) annual media campaigns.

Other initiatives in the Department include Educating Physicians in partnership with the New Jersey Academy of Pediatrics; and the Partnership with the Trenton Childhood Asthma Program. Additionally, AHRQ selected New Jersey as one of six states to participate in the *Learning Partnership to Decrease Disparities in Pediatric Asthma* project.

Also, this year, the Office of Minority and Multicultural Health will be awarding small grants to faith based and community organizations to support efforts to empower communities with health information about how to be more effective in self management of chronic diseases. This will be the theme for our upcoming minority health month activities in September.

The strategic Plan for Eliminating Health Disparities will not "sit on a shelf". This Disparities Plan is the roadmap that the Department will use over the next three years to make a difference in the health of New Jersey minorities. The Department will measure progress against the goals outlined in the Plan. A department-wide Health Disparities Group, including Senior Staff and program directors, will meet quarterly to track progress made.

The time is now, but there is more work to do. While the current plan addresses eight medical areas (asthma, cancer, cardiovascular disease, diabetes, obesity, HIV/AIDS, infant mortality and unintentional injuries), we will be updating the plan this year to include kidney disease Hepatitis C, immunizations, violence, and sexually transmitted diseases.

To reach our goal, continued collaboration with academia, community based organizations, faith based groups, health care providers including federally qualified health centers, elected officials and the media are key.

Testimony of Felicia D. Stoler, MS, RD
NJ Dietetic Association, Host of TLC's Show *Honey We're Killing the Kids!*
May 21, 2007

Thank you for the opportunity to speak. First, I would like to tell you that the members of the NJ Dietetic Association are the premiere resource for nutrition information in the State of NJ. I am here wearing many hats... I host a reality show on the Learning Channel about unhealthy kids and their families, I am a mother, a registered dietitian & exercise physiologist, a member of the NJ Council on Physical Fitness & Sports, in addition to being the immediate past-president of the NJ Dietetic Association. I am a doctoral student @ UMDNJ & my research has been in obesity in adults. I am one of the few private practitioners that works with children, adolescents & teens who are overweight or obese in the state.

I can tell you that overweight and obesity are problems that may actually begin in infancy, and continue to get worse throughout childhood. Since overweight and obesity is a multifactoral problem – which stems from what we call an energy imbalance... between energy in (food) & energy expended (physical activity). Where do we start to put responsibility on this imbalance?

Do we start with the parents? They are usually struggling with their own weight issues... without access to the proper support to maintain an appropriate body weight. Our culture is bombarded with information in the media – the question, which information is correct? The Federal Trade Commission estimates that over $30 billion is spent each year on weight loss products & programs. Funny, but the obesity epidemic is getting worse, not better. Finkelstein et al estimated that NJ will have spent $2.3 billion on obesity-attributable expenses for adults in 2003. The economic costs of an unhealthy diet and physical inactivity add up to almost $100 billion per year or approximately eight percent of the national health care budget in direct medical costs. The CDC reported that $31 billion of direct treatments costs for cardiovascular disease was related to overweight and obesity.

According to Olshansky et al, "obesity and its comorbidities may decrease the adult lifespan by five to 20 years" – this means that for all the advances we have made in medicine & science, we actually will have a generation of children who may not out live their parents. How can we reverse this trend in children? Schools alone cannot be the answer – they can be part of the solution, but they are challenged with the need to generate revenue in food service, vending and fundraising. Our schools are making money to sustain their existence, at the expense of our children's health. Even with the school wellness policy that needs to be adhered to in NJ... there is still a disconnect with the access that kids have to unhealthy food during school hours.

No child left behind, should become, no child should be left ON their behind. Physical education has taken a back seat to children's performance on standardized testing. Look at the cycle of physical education, from elementary school – children are lucky if they even have physical education once per week... then when they get into middle school, they have it more than once per week... by the time they get to high school it's daily – but by then, the damage is done... we cannot afford to wait until our kids turn 14 & 15 to instill the behavior of daily physical activity... it needs to start in kindergarten.

Recognize that insurance companies do pay for the intervention that is effective – nutritional counseling, unless there is diabetes or kidney disease. Insurance companies do not pay for additional physical activities. Insurance companies would sooner pay for bariatric surgery... which is expensive, invasive, dangerous and over time has proven to NOT be successful for sustained weight loss. Making better nutrition choices and increasing physical activity are the least expensive, least invasive and most effective way to fight overweight and obesity.

I wish I had the magical answer to make this go away. Personally, hosting my show is one way that I can hopefully bring a solution to millions of households – by turning around the lives of 13 families on national television. I would like to tell you about resources that are available in NJ.

Registered dietitians provide medical nutrition therapy and nutrition education to youth and adults in NJ. The NJ Dietetic Association has a membership of 2,300 members in NJ and ADA has 67,000 members. About 50 % working in the community in government, schools, public health, Cooperative Extension and consultant work. The other half work in hospitals, nursing homes, and a variety of facilities. We all promote healthy eating, reducing fat, salt and sugar in our diets for improved health. Some examples of state-wide programs that are currently going on:

- Rutgers Cooperative Extension is working with counties to deliver full-day "Children's Health Summits" which focus on Childhood Obesity and create a local grassroots network to get the public "moving and eating healthier". The next summit is at the NJ Hospital Association on Alexander Rd in Princeton, NJ on May 24th. Another will be offered in Morris County on November 2nd at College of St. Elizabeth. Dietitians, nutritionists, public health professionals, teachers, school food service, school nurses and administrators along with hospital and health care professionals have attended these full-day events in 7 counties since 2005. (See http://www.njaes.rutgers.edu/ for more info.
- Dietitians continue to work with schools, corporations, local government to provide support for walking and health promotion programs, NJ Mayor's Wellness Campaign, providing "School Wellness Trainings" in collaboration with Child Nutrition Bureau and NJ Dept of Agriculture. All schools in NJ currently need to comply with the school wellness legislation.
- Registered Dietitians work in private practice, in school-based programs, in public health and Cooperative Extension along with hospitals and other facilities to provide nutrition education and Medical Nutrition Therapy. NJ Dietetic Association members are the nutrition professionals with advanced training in a variety of areas.

We need:

- Grant dollars available to start up local nutrition and health programs that benefit local residents.
- Dept of Health should apply for federal money from USDA and NIH/CDC so local NJ groups (non-profits, schools, colleges, local governments) could apply for that money to provide local wellness programs.

- NJDA could provide leadership in assisting with the applications for major federal obesity money and assist in developing a working plan for setting up obesity intervention projects in NJ.
- Registered dietitians/Nutritionists need to be hired in school districts to assist in supporting school wellness policy and to provide nutrition education classes to youth, parents and teachers. Nutrition education needs to be taught to students at ALL age levels in NJ schools and "health" needs to be taught as a core curriculum class.
- Dietitians continue to work with MDs to teach individuals about their risks for disease due to obesity. We provide MNT so clients/patients reduce their risk factors for major diseases. Our members help New Jersey residents understand the science behind healthier eating and the importance of being physically active and fit. For every dollar spent on nutrition education, $ 6.00 is saved as documented by the federally-funded Expanded Food and Nutrition Education Program (EFNEP)
- We are the nutrition professionals that care about the health of NJ residents and we are helping to improve the diets of our NJ residents.
- We need licensure for dietitians/nutritionists in the state to stop the misinformation that is out there. NJ is one of 6 states left in the US that does not have licensure and it is a threat to public health and safety when inadequately trained individuals give out inappropriate information – especially when it affects the health of our children and their families.

For further information, please feel free to contact me by email fsoler@att.net or by telephone 732-946-4436.

Good morning, Assemblyman Payne, committee members, staff and guests. Thank you for holding this very important hearing to discuss the problem of childhood obesity.

My name is Barbara Skinner, and I am a registered dietitian working in a hospital-affiliated medical practice in southern New Jersey and am here to testify as a member and past president of the New Jersey Dietetic Association.

The New Jersey Dietetic Association has a membership of 2,300 nutrition professionals working in the community in government, schools, public health, Cooperative Extension and consultant work. Others work in hospitals, nursing homes, and a variety of facilities. We all promote healthy eating, physical activity and lifestyles for improved health. Good nutrition is our business.

Registered dietitians and The New Jersey Dietetic Association have been on the forefront of New Jersey's efforts to battle childhood obesity. Activities have included serving on the 27-member New Jersey Obesity Prevention Task Force, and planning Child Health Summits to focus on childhood obesity and develop grassroots networks to work on the problem.

Additionally, dietitians continue to work with schools, corporations, and local governments to provide support for walking and health promotion programs, as well as the NJ Mayor's Wellness Campaign, and "School Wellness Trainings" in collaboration with the Bureau of Child Nutrition Programs and the NJ Dept of Agriculture.

Many will testify (have testified) here today about the prevalence and scope of the childhood overweight and obesity problem. It is alarming that over the past three decades, the childhood obesity rate has more than doubled in just about every age category, from preschoolers to school-aged children between the ages of 6 and 19 years.

Obesity increases a child's chance of getting a chronic disease, ranging from high blood pressure to diabetes. Real and potential consequences of childhood obesity cannot be ignored. As a specialty-trained dietitian and certified diabetes educator, diabetes care and prevention is my business and passion, so I would like to talk about this for a moment.

When I was a school-aged child, I remember my grandmother taking twice daily insulin shots because she had "old-age diabetes". Now called Type 2 diabetes, this devastating disease of adults is appearing in children and adolescents. According to the Institute of Medicine, case reports from the 1990s showed type 2 diabetes accounting for twice as many new cases of pediatric diabetes than before that time. This upward trend clearly parallels the increasing prevalence in childhood obesity.

Diabetes is more than just "a touch of sugar". Some of us have experienced it personally, or through our families and friends. We know that especially over time, it can be a debilitating disease leading to serious, life-threatening health problems and poor quality of life. It costs our country more than $100 billion per year.

The younger the person is when they develop type 2 diabetes, the longer the disease has to work its damage. We must do better at preventing it, especially in our children - and we can.

We know that having a family member with type 2 diabetes increases a child's risk of developing the disease. In fact, 45–80% of children with type 2 diabetes have a parent with the disease, and 74–90% report at least one affected first- or second-degree relative. But for diabetes to start, it takes more than strong genetics. The body must first become resistant to its own insulin. Insulin resistance can be "triggered" by obesity, in both adults and children. The good news is that studies have shown weight loss can lessen insulin resistance in both adults and adolescents, and hopefully prevent or delay the onset of type 2 diabtes.

I work as a registered dietitian and diabetes educator in a community with a high prevalence of type 2 diabetes. Although my work is primarily with adults who have this disease, I try to make my nutrition interventions family-focused. Parents are health and nutrition role models for their children, and many of my patients are mothers-to-be or parents of young children.

Many of my patients have at least one child who is obese or overweight, and are motivated to change the family's eating and exercise habits. The focus of our nutrition counseling sessions might include topics that help the patient and their family - keeping healthier foods in the home, choosing alternatives to fast foods, learning how to make quick and healthy meals, and fun physical activities for the whole family.

In conclusion, nutrition professionals interact with children and caregivers of children in many different settings. We are the experts in improving the health and nutritional status of New Jersey's children.

The New Jersey Dietetic Association is interested and willing to continue leading and assisting in developing and implementing future plans for obesity treatment and prevention projects in New Jersey. To this end, we recommend that dietitians and qualified nutrition professionals:

- Continue to work with healthcare providers to teach individuals about how to lessen their risk for obesity-related diseases such as diabetes.
- Be hired to work in school districts, with active involvement in school wellness policy and in providing nutrition education classes to youth, parents and teachers.

Finally, we support nutrition education being to be taught to students at ALL age levels in NJ schools.

Thank you for this opportunity to address the committee today.

Respectfully,
Barbara Skinner, MS, RD, CDE
Registered Dietitian and Certified Diabetes Educator
NJ Dietetic Association

New Jersey State Legislature
Assembly Regulatory Oversight Committee
May 21, 2007

Testimony

Maris Chavenson, Associate Coordinator
The Pediatric/Adult Asthma Coalition of New Jersey
Sponsored by the American Lung Association of New Jersey
1600 Route 22 East, Union, NJ 07083, 908-687-9340, www.pacnj.org

Dear Assemblyman Payne and Committee Members:

Asthma is one of the most common chronic diseases affecting children and results from the 2003 National Survey of Children's Health suggest that about 255,484 New Jersey children (12%) have a history of asthma. This Survey also suggests that 180,159 children in New Jersey (9% of the pediatric population) currently have asthma. When uncontrolled, asthma can result in activity limitations, missed school days, emergency department visits, hospitalizations and even deaths.

The burden of asthma is outlined in the attached notes we are submitting but in speaking with you today, I want to highlight some key concerns.

Seven years ago the American Lung Association of New Jersey and its medical arm the New Jersey Thoracic Society sent out a call across the state to those interested in changing the way asthma is managed in New Jersey to come together as a coalition for statewide change. The Pediatric/Adult Asthma Coalition of New Jersey (PACNJ) was formed with over 130 interested parties representing schools, child care, physicians, health insurers, communities, and environmental agencies. Funding for statewide initiatives came from the Centers for Disease Control and Prevention through the NJ Department of Health and Senior Services, the United States Environmental Protection Agency, Region 2, Foundations, and Corporations. Maintaining a statewide coalition that targets communities most in need with new programs and then expands those programs for statewide change is becoming more difficult each year. Funding allocated annually to sustain a statewide coalition to continue the work with schools, child care, communities, physicians and environmental agencies is needed.

The National Heart, Lung, and Blood Institute had issued Guidelines for Best Practice in asthma management and the Coalition saw the need to ensure that physicians, schools, and families were following those guidelines. Experts in the field of asthma and representatives from those systems that impact on children were enlisted on six task forces to design education programs and materials to bring people together in a coordination of care. PACNJ focused on **statewide system change.**

Asthma Hospitalizations:

- Children are more likely to be hospitalized with asthma than adults. In 2004, there were 5,175 asthma hospitalizations for children in New Jersey, and children under 5 years of age have the highest hospitalization rate for asthma.
- In 2004, black children in New Jersey were over 3 times more likely to be hospitalized with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.
- Hospitalizations for asthma demonstrate seasonal patterns among children in New Jersey. These seasonal peaks are most apparent among school age children. For example among

elementary school age children, the May asthma hospitalization rate is over 41/2 times the July asthma hospitalization rate and the September and October rates are over 5 times the July asthma hospitalization rate.

Children are in school during their peak seasons for hospitalizations. PACNJ addressed asthma management in the schools in an effort to change the system from a **reactive response** to an emergency, to a **proactive preventive approach** that addressed triggers and recognized the early warning signs of an asthma episode so a child could get help before it became an emergency. To achieve this statewide system change, PACNJ developed all the educational materials and tools and implemented them statewide.

This was made possible because NJ has one of the most comprehensive laws in the nation on asthma management in the schools. This Law that went into effect in September 2001 and requires asthma education for school nurses, annual asthma education for school faculty, a nebulizer in every school, and an asthma action plan that also lists triggers for every child that has permission to carry an inhaler.

This is an outstanding law and PACNJ developed the educational tools needed to facilitate schools complying. Then we created the PACNJ Asthma Friendly School Award to recognize those schools that not only complied with the NJ Law and provided the education, but also went above and beyond by taking the NJ Department of Environmental Protection Agency "No Idling Pledge" and participating in the USEPA Indoor Air Quality Tools for Schools Training, forming and IAQ team.

- 262 New Jersey schools serving over 150,000 children have received the PACNJ Asthma Friendly School Award
- We are currently partnered with the Newark public schools and are working to have all 84 schools receive the award

PACNJ would like to recommend that to expand this statewide effort for system change and continue to motivate schools to remain proactive in their approach to asthma management, that policies be established to offer those schools who are recognized as complying with the Law and being asthma friendly receive priority when state funding is made available to schools.

To reach the under five population PACNJ worked in partnership with the child care health consultants from the 21 resource and referral agencies throughout the state to develop two levels of asthma education to impact statewide on asthma management.

- PACNJ developed a bilingual asthma video resource kit "Steps to Controlling asthma in the Child Care Setting" for child care providers and this was piloted in Camden Trenton and Burlington. The 21 Child Care Health Consultants were trained to continue offering the program in their counties across the state and over 500 child care providers have received the training.
- PACNJ recently developed a training for child care center directors and family home providers, "Policies and Practices for Asthma Friendly Child Care" for those who establish policies at their centers. That program was piloted in Newark, Plainfield and New Brunswick. All 21 Child Care Health Consultants were trained to facilitate this program and continue to conduct it across the state. Over 200 directors have received the training at local sites and statewide conferences since September 2006.
- PACNJ is currently working with Professional Impact NJ to establish these trainings as part of their Directors Training Academy so that it will be sustained as an on-going

training program statewide for Child Care Center Directors and Family Child Care Providers.

- PACNJ is partnering with the Newark Pre-School Council Head Start program to provide both training programs to their 300 child care providers and 30 center directors.

The next step in establishing this system change to reach over 9000 child care settings in New Jersey is to establish an incentive program with an Asthma Friendly Child Care Center Award. PACNJ would like to recommend that funding be targeted to continue this effort and that PACNJ continue in the role of bringing the partners together to facilitate progress.

Emergency Room Visits:

- Children are more likely to visit the emergency department for asthma when compared to adults. In 2004 alone, there were 19,160 emergency department visits for asthma among children in New Jersey.
- In 2004, black children in New Jersey were over 3 times more likely to visit the emergency department with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.
- The burden of asthma is disproportionately distributed throughout the state with Essex County experiencing the highest age adjusted hospital discharge rate for asthma and the highest age adjusted Emergency Department Visit Rate for asthma. For example, the age adjusted ED visit rate for asthma in Essex County (1370 visits per 100,000 population) was more than 6 times higher than the Hunterdon County rate (215 per 100,000 population) in 2004.

As mentioned before, in addition to schools and child care providers, PACNJ is working with physicians, communities, health insurers and environmental agencies for statewide system changes. It is this approach that is aimed at reducing emergency room visits.

Physician Education for System Change

This past year PACNJ worked with the New Jersey Chapter of the American Academy of Pediatrics to develop an asthma education program for system change in physician's offices. This program is being piloted in Trenton with 11 physician practices and involves all office personnel and medical staff in the establishment of systems that improve asthma care. This requires a shift from an acute care perspective to a chronic care model and can be expanded to other cities with appropriate funding.

The National Heart, Lung and Blood Institute identified in their Guidelines for Best Practice in asthma management the importance of an asthma action plan for communicating between physician and patient. This tool has been developed by PACNJ and tracked for effectiveness through the school nurses. It has now been revised in response to the school nurse survey that identified problems with physicians in implementation. PACNJ has partnered with the New Jersey Primary Care Association to link with the New Jersey Federally Qualified Health Centers participating in the Asthma Collaborative to test this tool with their patients.

Communities for Change:

New Jersey was selected as one of six states to participate in a national initiative by the Agency for Healthcare Research and Quality (AHRQ) to address disparities in asthma. PACNJ has participated on the AHRQ team and as a result, all the PACNJ asthma educational materials were reviewed for cultural competency. Currently the AHRQ is developing guidelines PACNJ and others in the state can use for developing asthma tools that are culturally competent for the

diverse populations in New Jersey. The tools will include patient cultural beliefs and folk remedies associated with asthma that can be a barrier to patient compliance. The AHRQ is also developing a protocol for convening focus groups on asthma from the target populations hardest hit by the disease. PACNJ has a unique opportunity to implement these tools through our Community Task Force and revise our current materials to more fully meet the needs of the children and their families with asthma.

The New Jersey AHRQ team is also looking at asthma morbidity at the city level and is finding that certain cities experience disproportionate hospitalization and Emergency Department visit rates for asthma. The team is planning an Emergency Department intervention to target Trenton and Camden with the hopes of raising awareness, garnering support, and extending the program to other affected cities including Newark.

PACNJ has maintained a website that increasingly serves as a statewide resource for all our materials and links to many resources statewide. We anticipate that soon it will be necessary to revise our materials to stay current with changes in asthma management including cultural competency, changes in the NHLBI Guidelines, and changes in medication.

We need your help to sustain our statewide coalition that targets communities most in need with new programs and then expands those programs for statewide change. Funding allocated annually to continue the work with schools, child care, communities, physicians and environmental agencies is needed. And as stated before, policies need to be established to offer those schools who are recognized as complying with the Law and being asthma friendly to get priority when state funding is made available to schools.

Thank you again for the invitation to speak with you about the burden of asthma, PACNJ's effort to impact statewide with sustainable system change for managing asthma and the need for funding to support this effort.

New Jersey Asthma Statistics

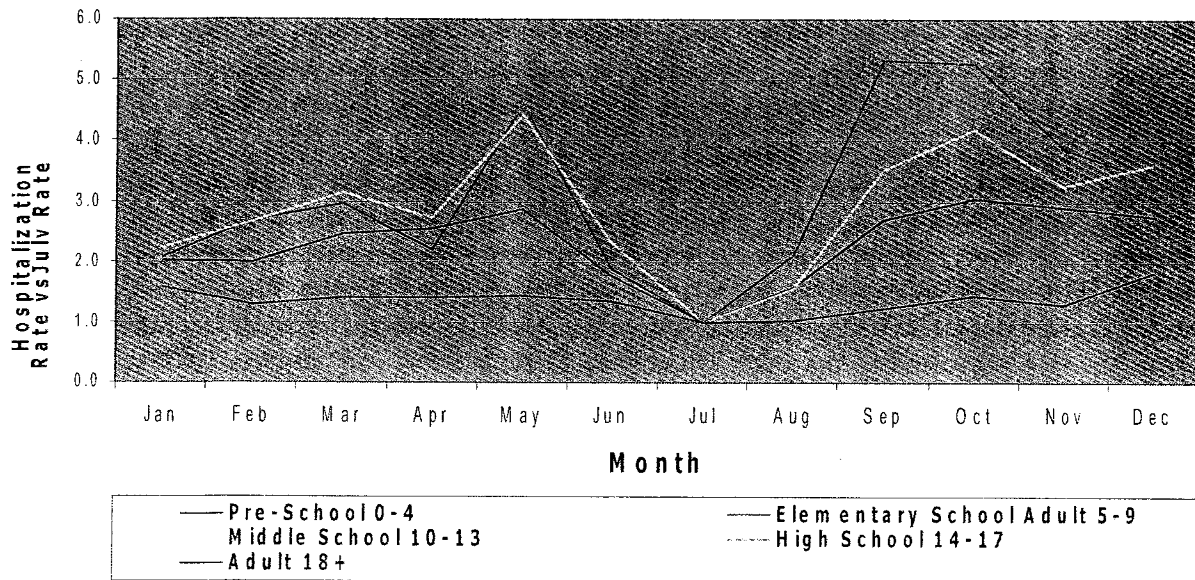
Asthma is a one of the most common chronic diseases affecting children:

- Results from the 2003 National Survey of Children's Health suggest that about 255,484 children in New Jersey (12% of the pediatric population) have a history of asthma.
- Results from the 2003 National Survey of Children's Health also suggest that about 180,159 New Jersey children (9% of the pediatric population) currently have asthma.

Asthma has a widespread impact on children:

- When uncontrolled, asthma can result in activity limitations, missed school days, emergency department visits, hospitalizations and even death.
- According to national estimates from CDC, asthma accounts for about 14 million lost days of school annually.
- National data from the 2005 Youth Risk Behavior Surveillance System suggest that about 38% of high school students with current asthma experienced an episode of asthma or asthma attack in the prior year.
- Children are more likely to be hospitalized with asthma than adults. In 2004, there were 5,175 asthma hospitalizations for children in New Jersey.

- Children are more likely to visit the emergency department for asthma when compared to adults. In 2004 alone, there were 19,160 emergency department visits for asthma among children in New Jersey.
- Hospitalizations for asthma demonstrate distinct seasonal patterns among children in New Jersey. Rates are lowest during the summer and highest during the spring and fall months. These seasonal peaks are most apparent among school age children. For example among elementary school age children, the May asthma hospitalization rate is 4.6 times the July asthma hospitalization rate and the September and October rates are 5.3 times the July asthma hospitalization rate.



Black and Hispanic residents are disproportionately affected by asthma:

- Childhood asthma prevalence varies by race/ethnicity with Hispanic and black children experiencing higher rates when compared to non-Hispanic and white children.
- In 2004, black children in New Jersey were over 3 times more likely to be hospitalized with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.
- In 2004, black children in New Jersey were over 3 times more likely to visit the ED with asthma when compared to white children. In the same year, Hispanic children in New Jersey were more than 1 ½ times more likely than non-Hispanic children to be hospitalized for asthma.

Geographic disparities exist throughout the state:

- The burden of asthma is disproportionately distributed throughout the state with Essex County experiencing the highest age adjusted hospital discharge rate for asthma and the highest age adjusted Emergency Department Visit Rate for asthma. For example, the age adjusted ED visit rate for asthma in Essex County (1370 visits per 100,000 population) was more than 6 times higher than the Hunterdon County rate (215 per 100,000 population) in 2004.

- The New Jersey AHRQ team is looking at asthma morbidity at the city level and is finding that certain cities experience disproportionate hospitalization and ED visit rates for asthma. The team is planning an ED intervention to target Trenton and Camden with the hopes of raising awareness, garnering support, and extending the program to other affected cities including Newark.

Respectfully Submitted by,
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The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, is supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 1U59EH000206-1. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA97256707-0, XA98284401-2 and CH97268901-0 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this document is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, patients should seek medical advice from their health care professional.

Horizon Blue Cross Blue Shield of New Jersey

April 21, 2007

Dear [School Name],

Horizon Blue Cross Blue Shield of New Jersey and Rutgers, the State University of New Jersey, thank you for your active participation in the *Shape it Up!* program from 2004 through 2006.

We have received the results from this past year's surveys and have attached a summary of the findings. The Eagleton Institute of Politics measured the impact of the program using pre- and post-surveys completed by elementary students throughout New Jersey.

The results indicate a good understanding of the tested healthy behaviors in elementary school children. We encourage you to continue this program annually to further promote regular exercise and healthy eating habits. If you plan to conduct this program in the future, we will be happy to provide you with the materials used (i.e., posters and booklets).

We appreciate the positive feedback we received from several schools. We are excited to learn that many schools have implemented similar programs. It is encouraging that many schools have taken the initiative to conduct programs addressing the obesity epidemic by focusing on healthy food choices and exercise. As you know, developing healthy eating and exercising habits as children is crucial in developing good eating and exercising habits as adults.

Thank you again for inviting Horizon BCBSNJ and Rutgers to your school. We hope the results help you realize the impact of the program and the need for continued obesity intervention.

Sincerely,

Saira A. Jan

Saira A. Jan, M.S., Pharm.D.
Director, Clinical Pharmacy Program Management
Horizon Blue Cross Blue Shield of New Jersey

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Blue Cross and Blue Shield Association

Horizon Blue Cross Blue Shield of New Jersey

Shape It Up! Summary

Shape It Up! is a childhood obesity prevention program developed and implemented by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) in collaboration with Rutgers University's Ernest Mario School of Pharmacy with funding from Sanofi-Aventis pharmaceutical company. The key program objectives are to promote exercise and healthy eating habits among New Jersey elementary school children. Program activities and materials include an interactive workshop, an activity book and family guide, posters, a Web site and educational field days.

Shape It Up! presented workshops to 89,736 children at 257 New Jersey elementary schools during the 2004-2005 and 2005-2006 school years. To evaluate the intervention, 6,419 students at 49 schools were asked about their satisfaction with the program and answered questions about their knowledge and attitudes towards exercise and healthy eating before and after the *Shape It Up!* Program. School administrators also completed a follow-up survey.

Key *Shape It Up!* findings:

- 94 percent of children correctly answered a question about the role of dietary fat in clogging arteries after the intervention compared to 62 percent before.
- 90 percent of children responded correctly to a question about healthy portion size after the intervention compared to 15 percent before.
- 89 percent of children responded correctly to a question about the sugar content of soda after the intervention compared to 58 percent before.
- 97 percent of children agreed with the statement that exercise makes your heart strong after the intervention compared to 93 percent before.
- 86 percent of children registered favorable attitudes towards health eating and exercise after the intervention from 83 percent before the intervention.
- 92 percent of children gave *Shape It Up!* a positive rating.
- 84 percent of 44 New Jersey school administrators reported that *Shape It Up!* helped create dialogues about healthy eating within their school community.

For additional information, please visit the *Shape It Up!* Web site at **<www.HorizonBlue.com/shapeitup>**.

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Blue Cross and Blue Shield Association

CHILDHOOD OBESITY

"SHAPE IT UP"

Saira A Jan, M.S., Pharm.D.

Director of Clinical Programs, Pharmacy Management, Horizon Blue Cross Blue Shield of New Jersey.

Associate Professor, Ernest Mario School of Pharmacy, Rutgers State University of New Jersey

Definition of Obesity

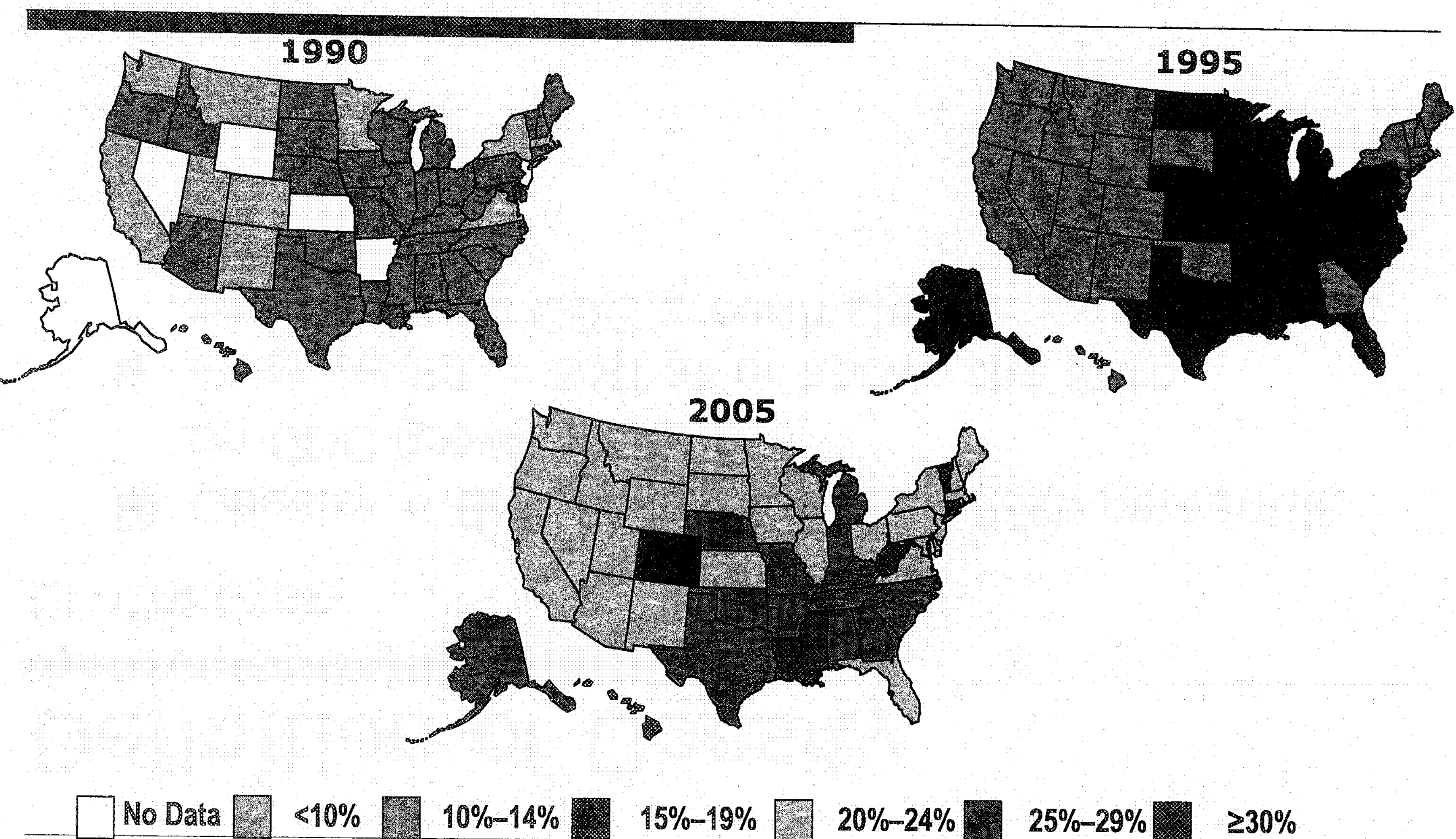
- Adults
  - BMI (Body mass Index) 25-29 overweight
  - BMI 30+ obese
  - BMI 40+morbid Obesity
  - BMI 30 Approximates 30 pounds of excess weight
  - 66% of US adults are obese (32%) or overweight
  - 32% of NJ adults are obese (22%) or overweight (BRFSS, 2005)

Definition of Obesity

- Children
  - Obesity = BMI at or above the 95th percentile on CDC growth charts
  - Overweight = BMI at or above the 85th percentile on CDC growth charts

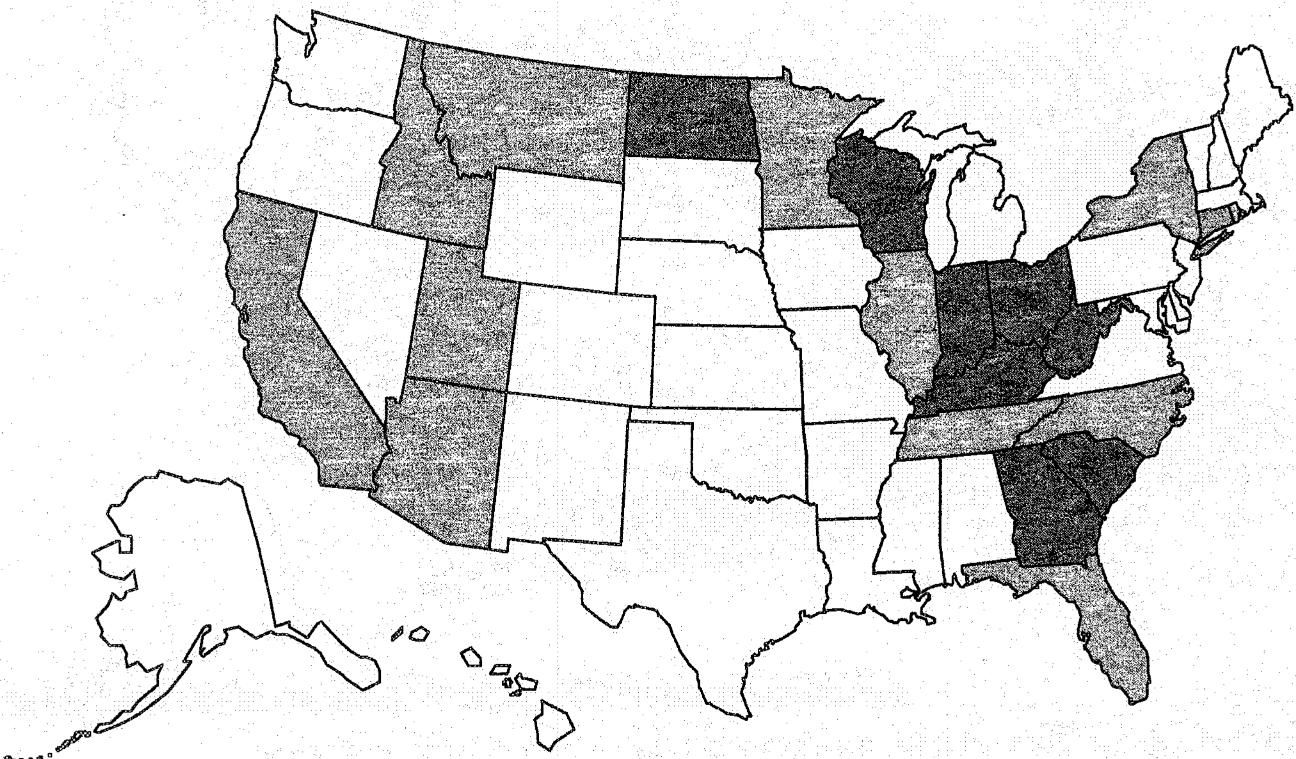
Obesity Trends* Among U.S. Adults BRFSS, 1990, 1995, 2005

(*BMI ≥30, or about 30 lbs overweight for 5'4" person)



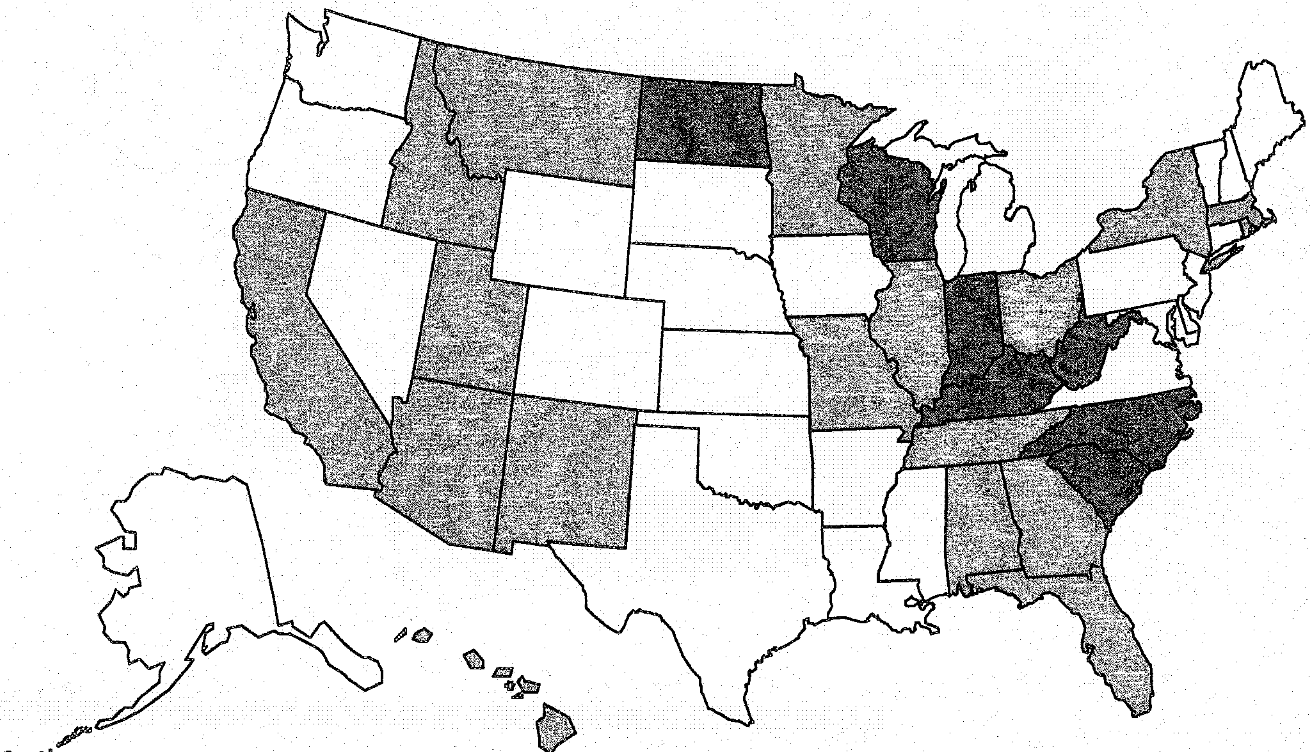
Obesity Trends* Among U.S. Adults
BRFSS, 1985

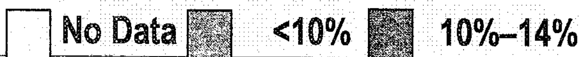
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



Obesity Trends* Among U.S. Adults
BRFSS, 1986

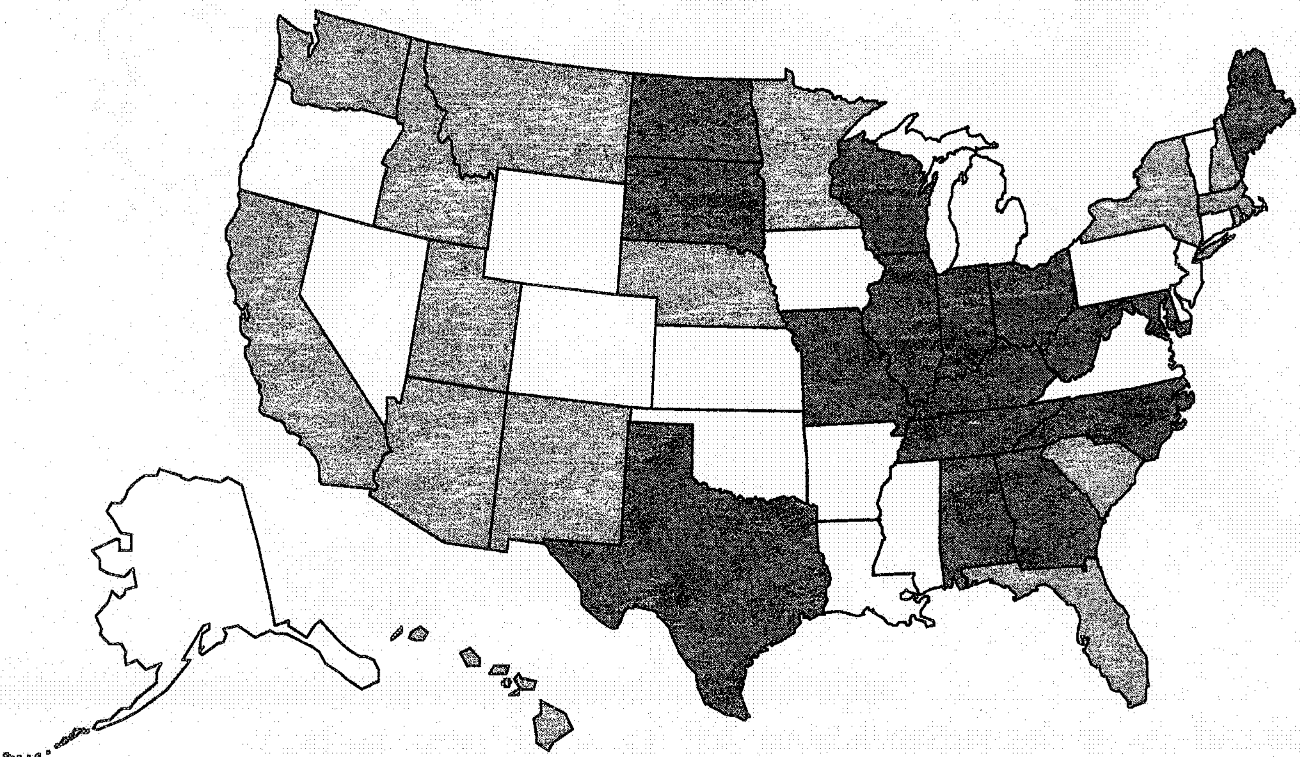
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)





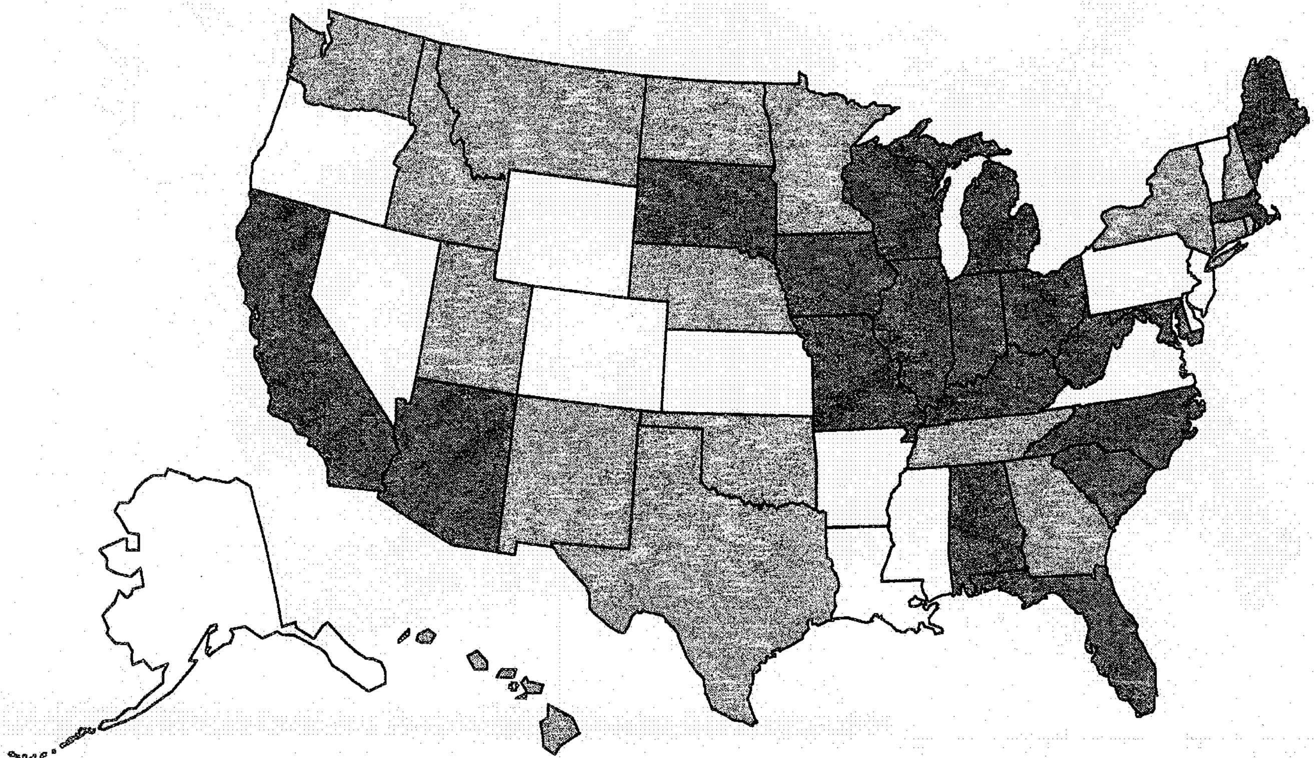
Obesity Trends* Among U.S. Adults
BRFSS, 1987

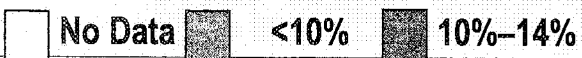
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



Obesity Trends* Among U.S. Adults
BRFSS, 1988

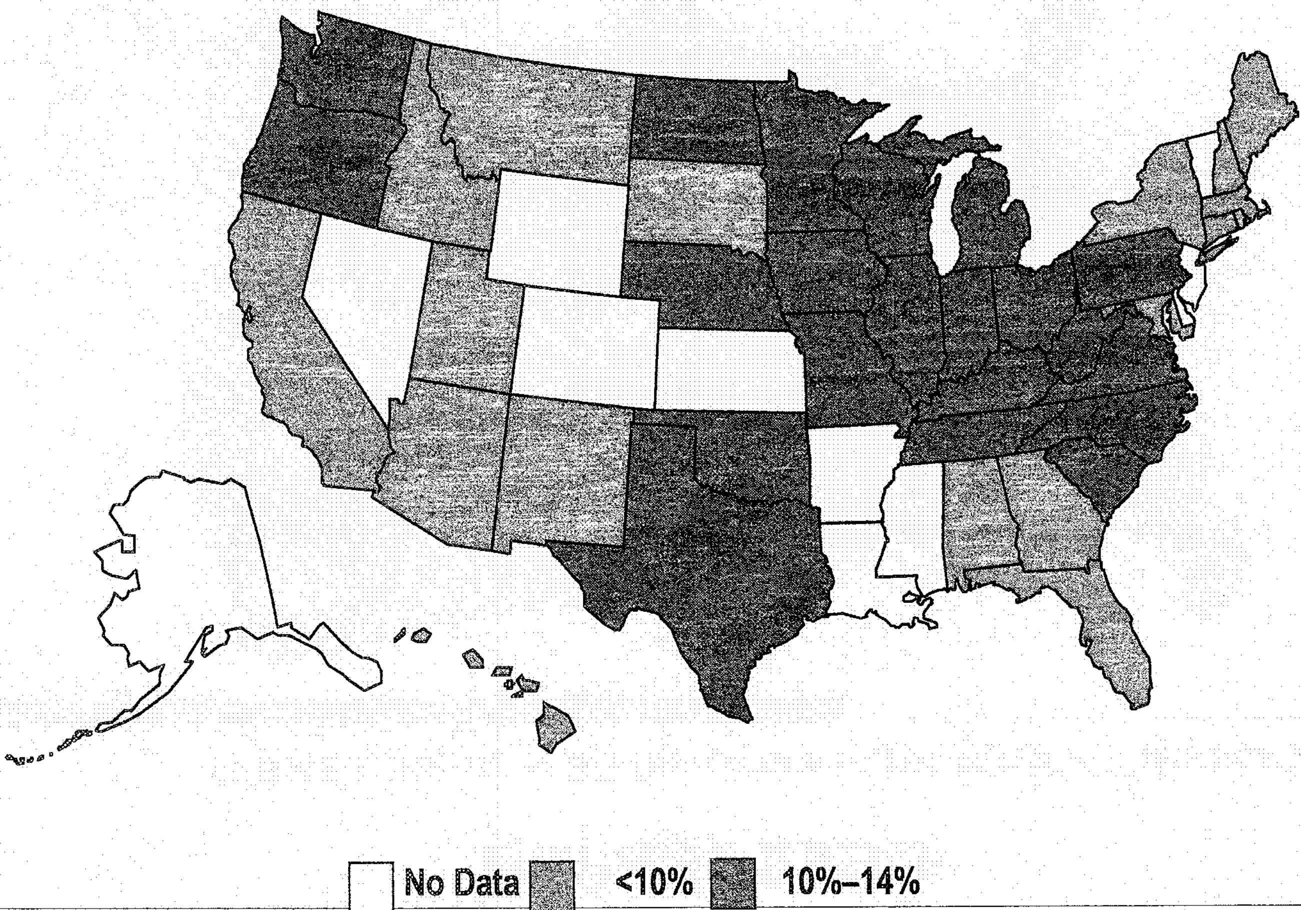
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)





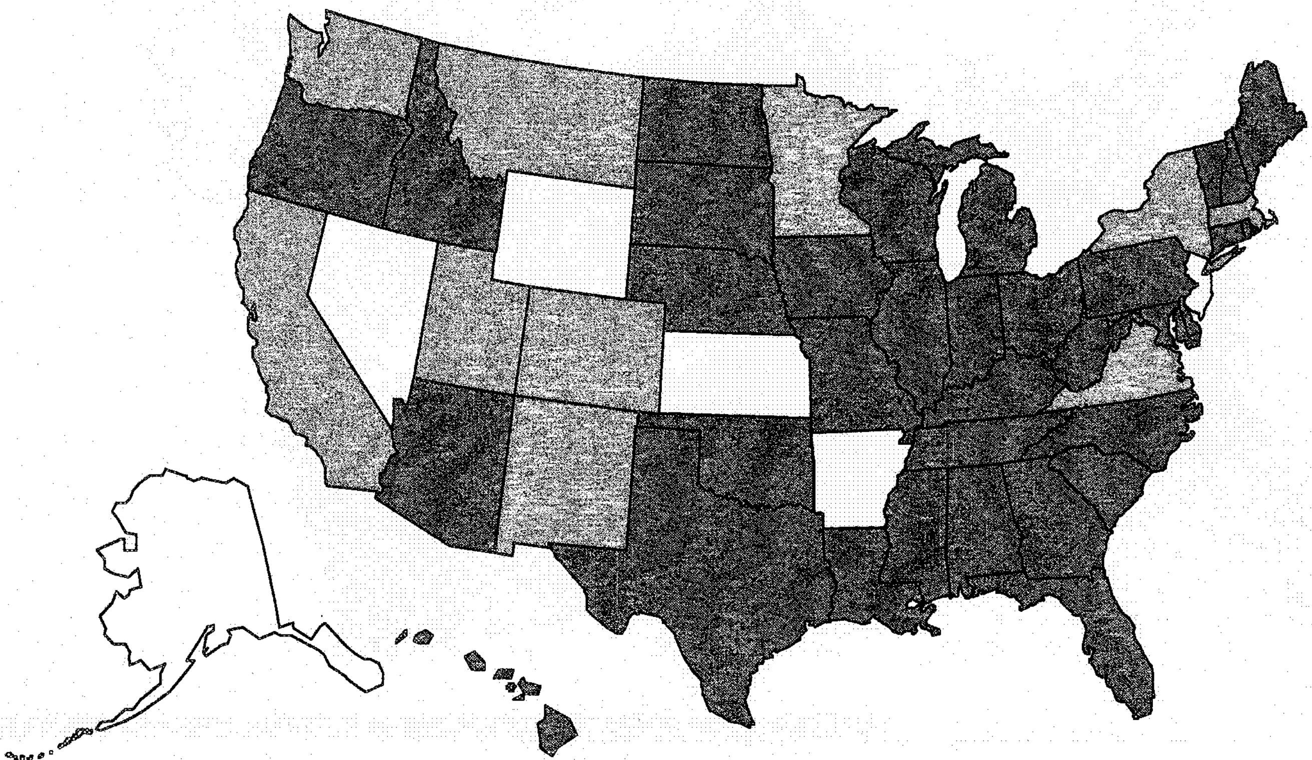
Obesity Trends* Among U.S. Adults
BRFSS, 1989

(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



Obesity Trends* Among U.S. Adults BRFSS, 1990

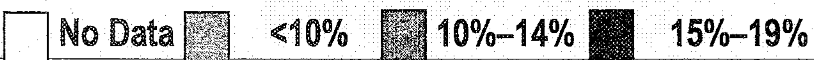
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)

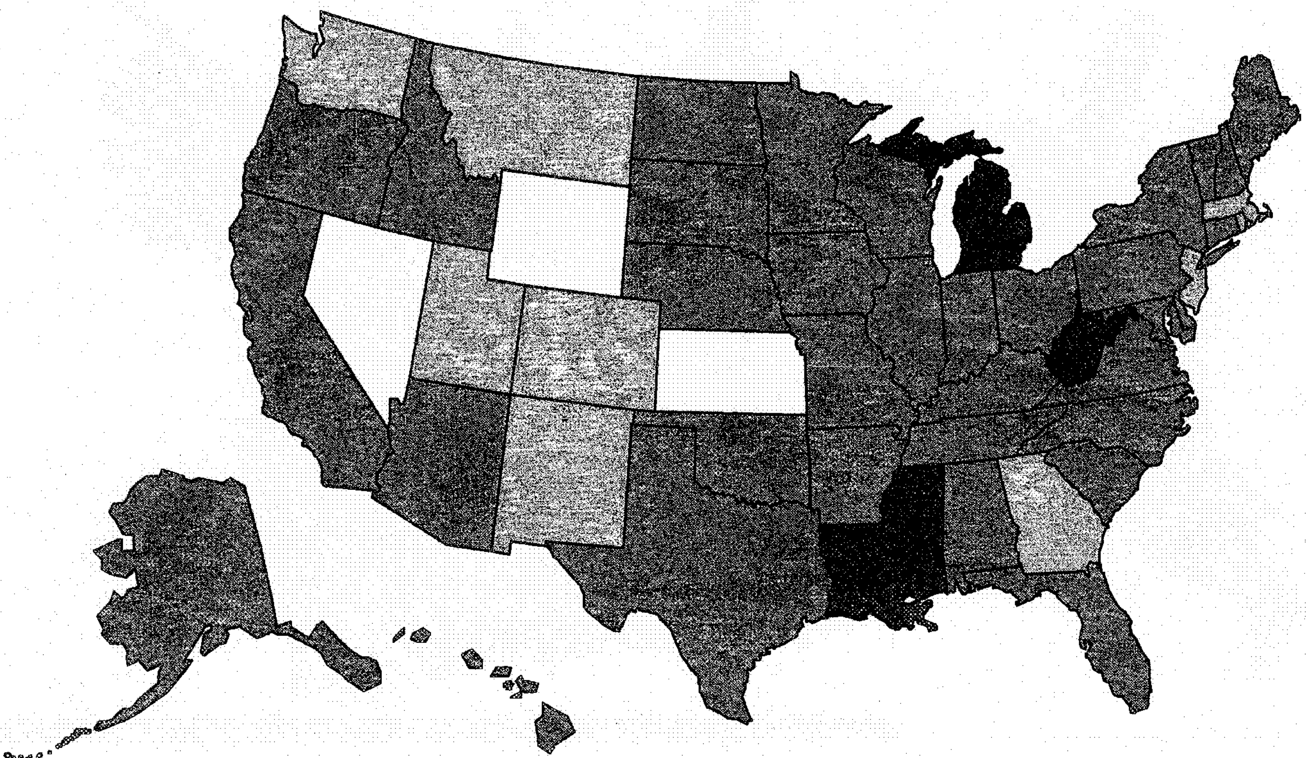


No Data <10% 10%–14%

Obesity Trends* Among U.S. Adults
BRFSS, 1991

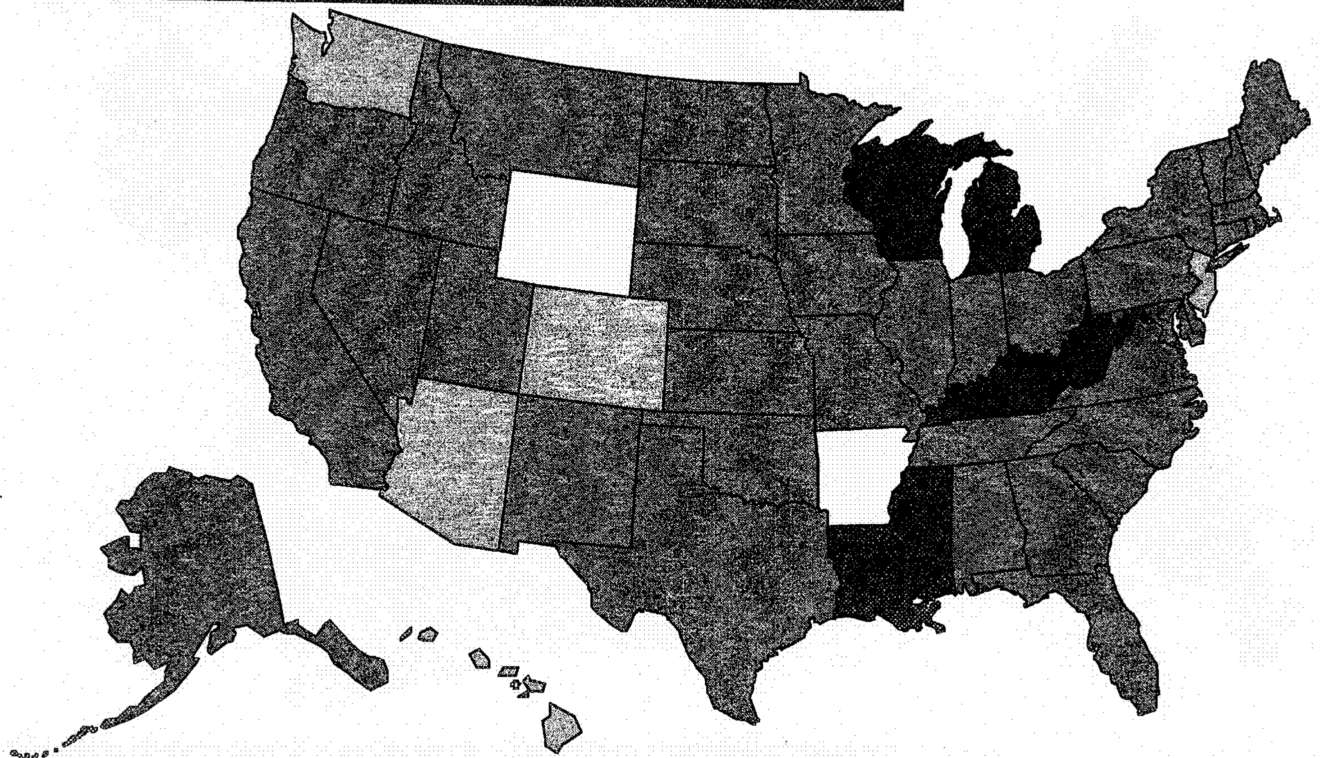
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)

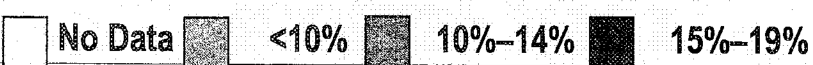




Obesity Trends* Among U.S. Adults
BRFSS, 1992

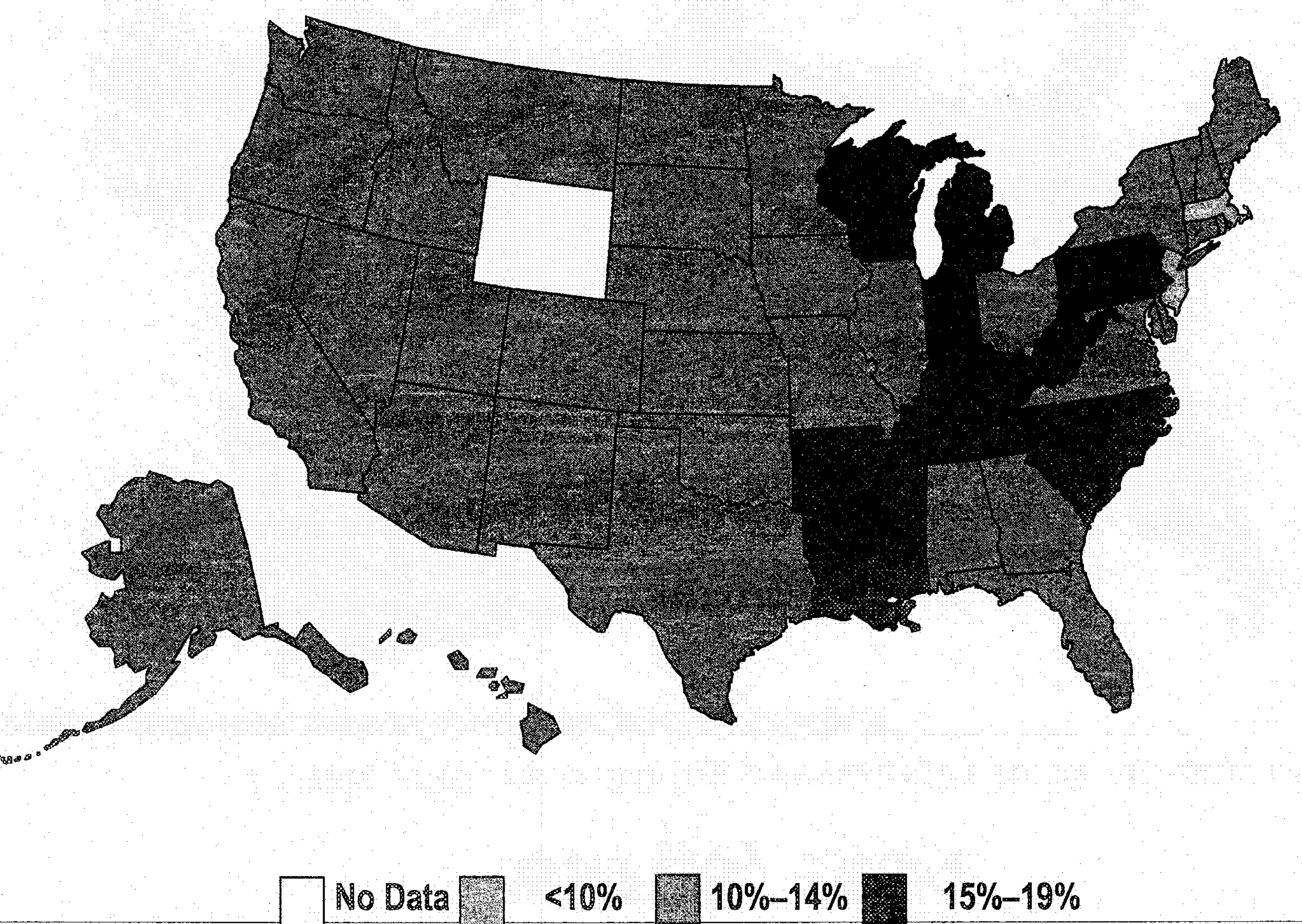
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)





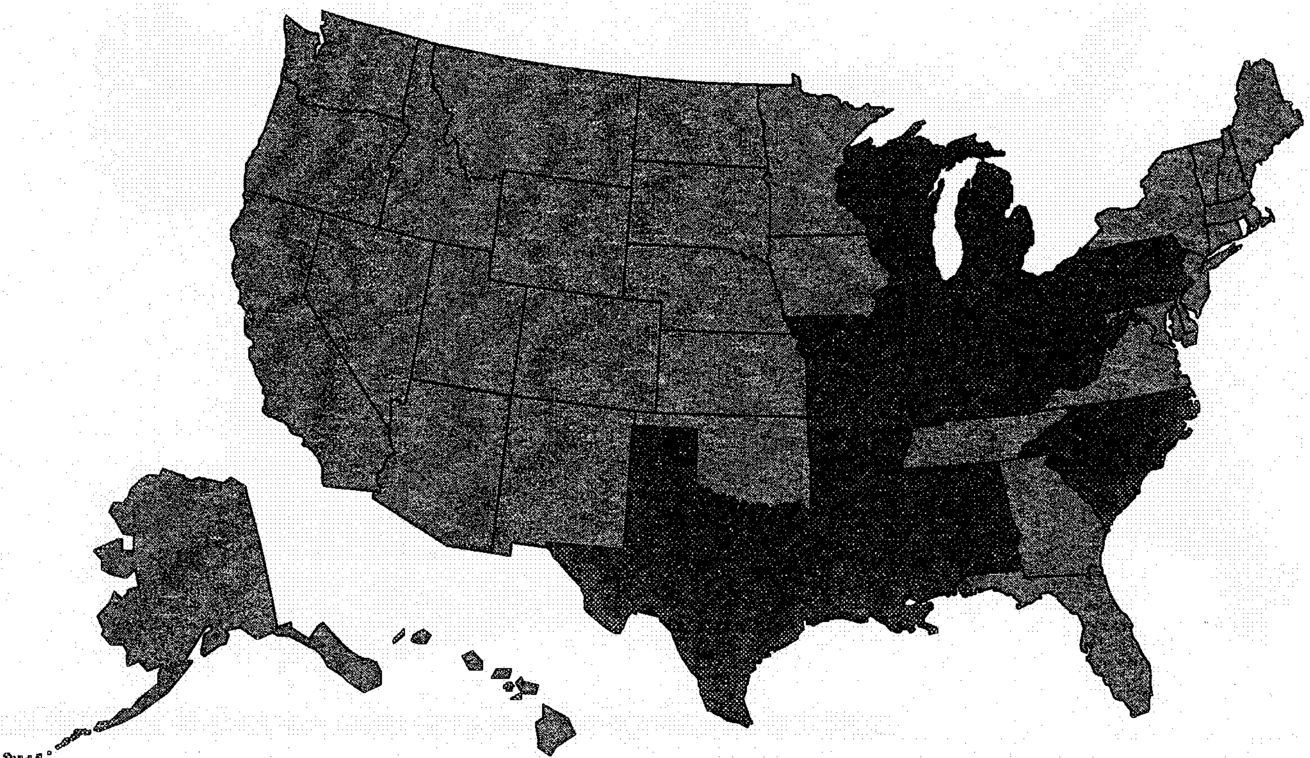
Obesity Trends* Among U.S. Adults
BRFSS, 1993

(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



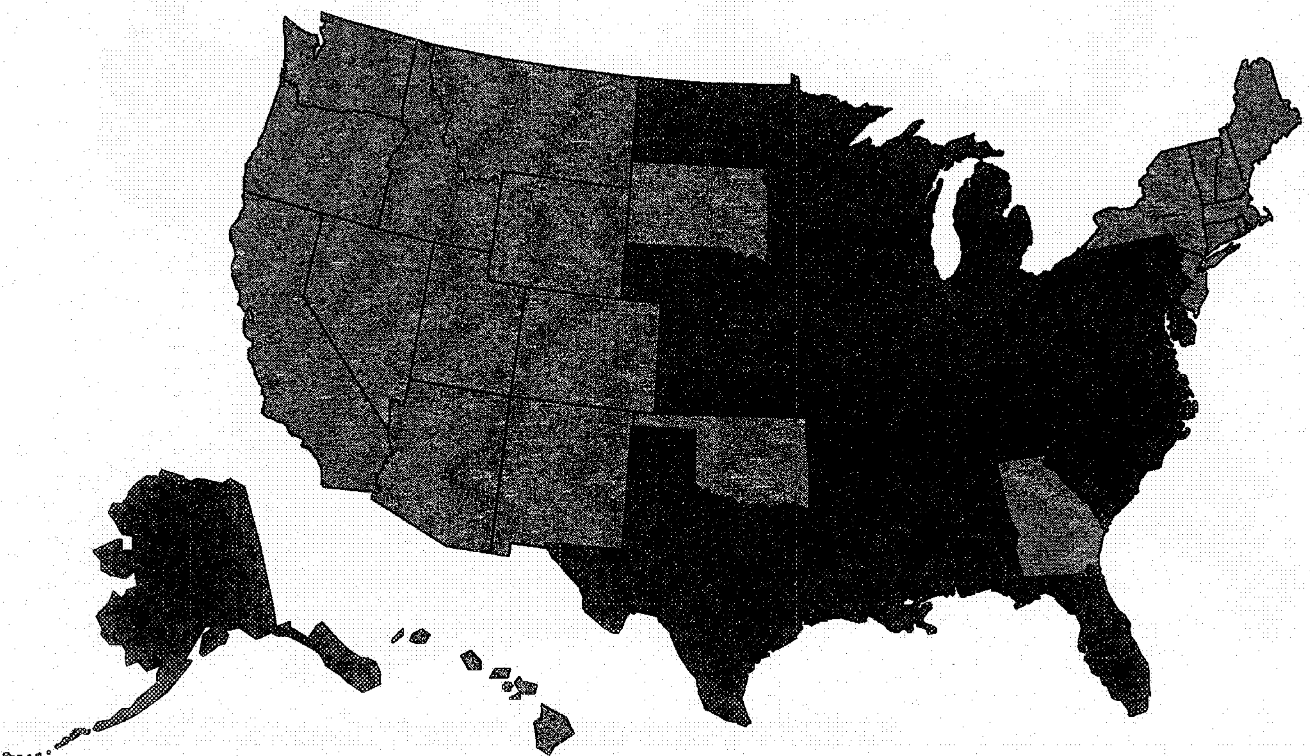
Obesity Trends* Among U.S. Adults
BRFSS, 1994

(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



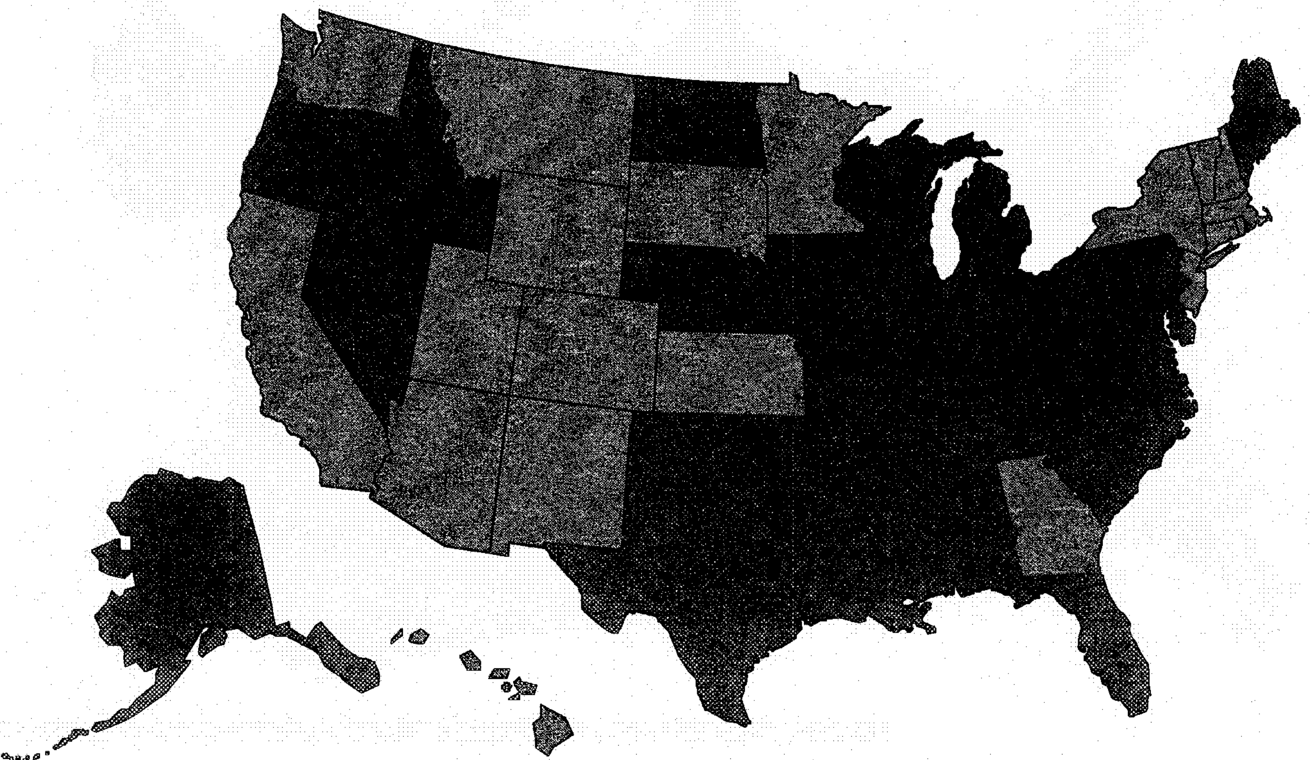
Obesity Trends* Among U.S. Adults
BRFSS, 1995

(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



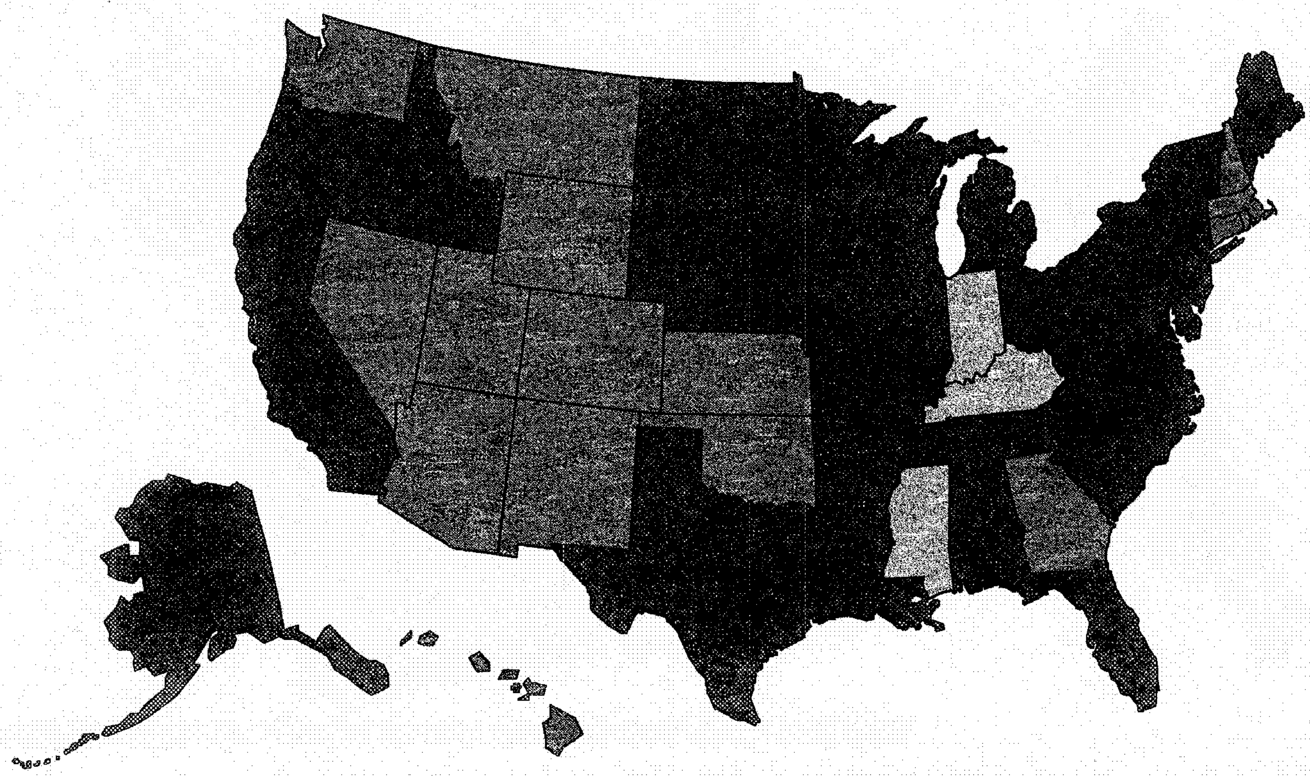
Obesity Trends* Among U.S. Adults BRFSS, 1996

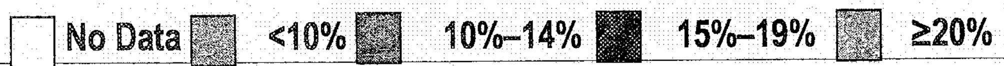
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



Obesity Trends* Among U.S. Adults
BRFSS, 1997

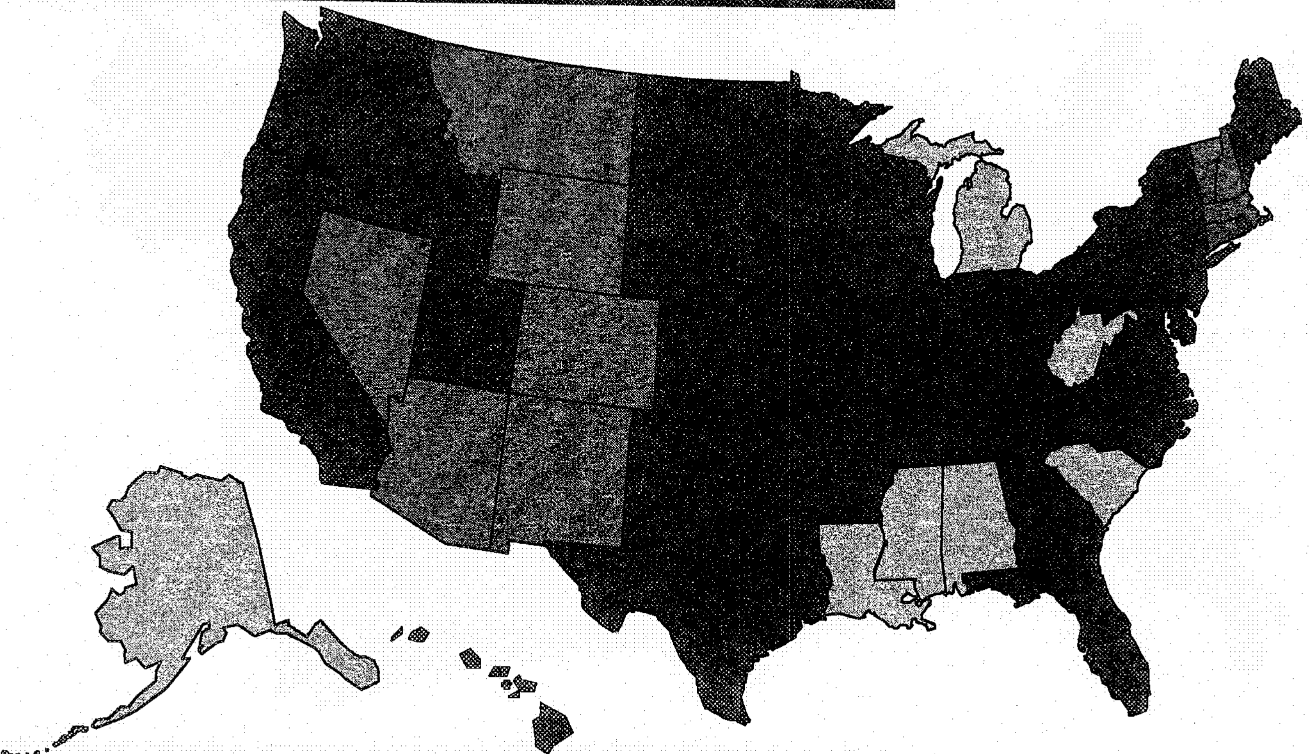
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)

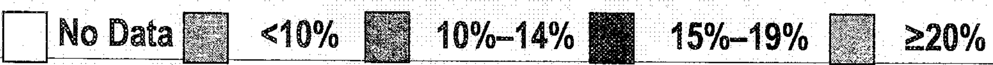




Obesity Trends* Among U.S. Adults BRFSS, 1998

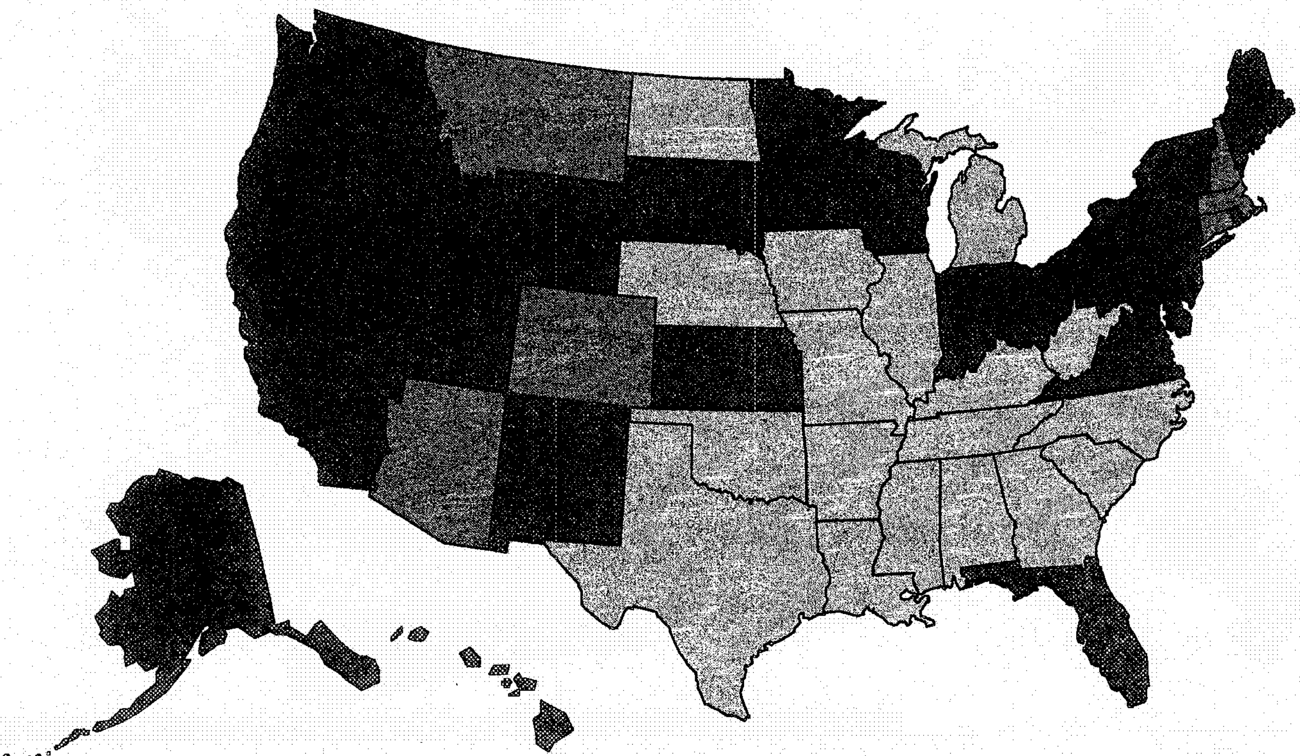
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)





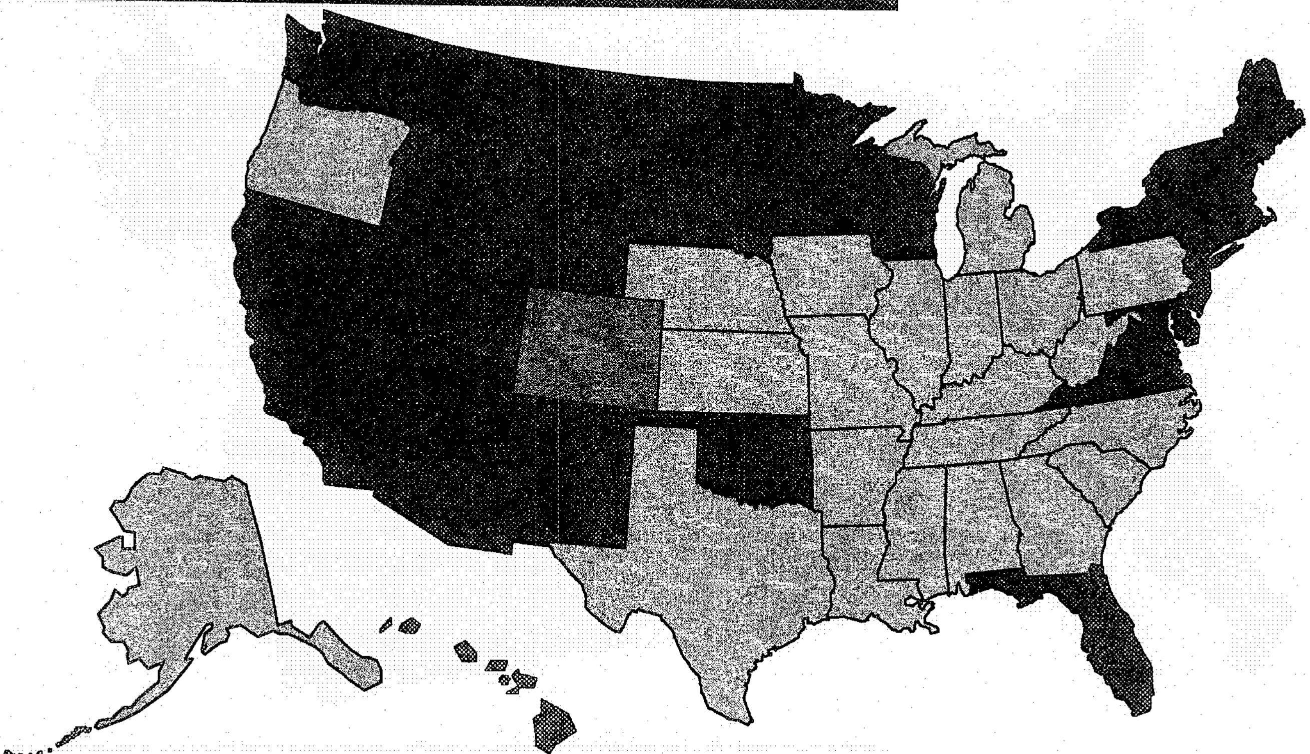
Obesity Trends* Among U.S. Adults
BRFSS, 1999

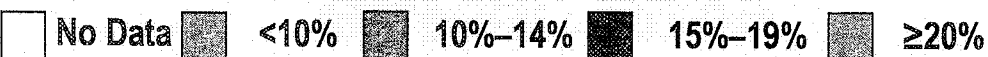
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)



Obesity Trends* Among U.S. Adults
BRFSS, 2000

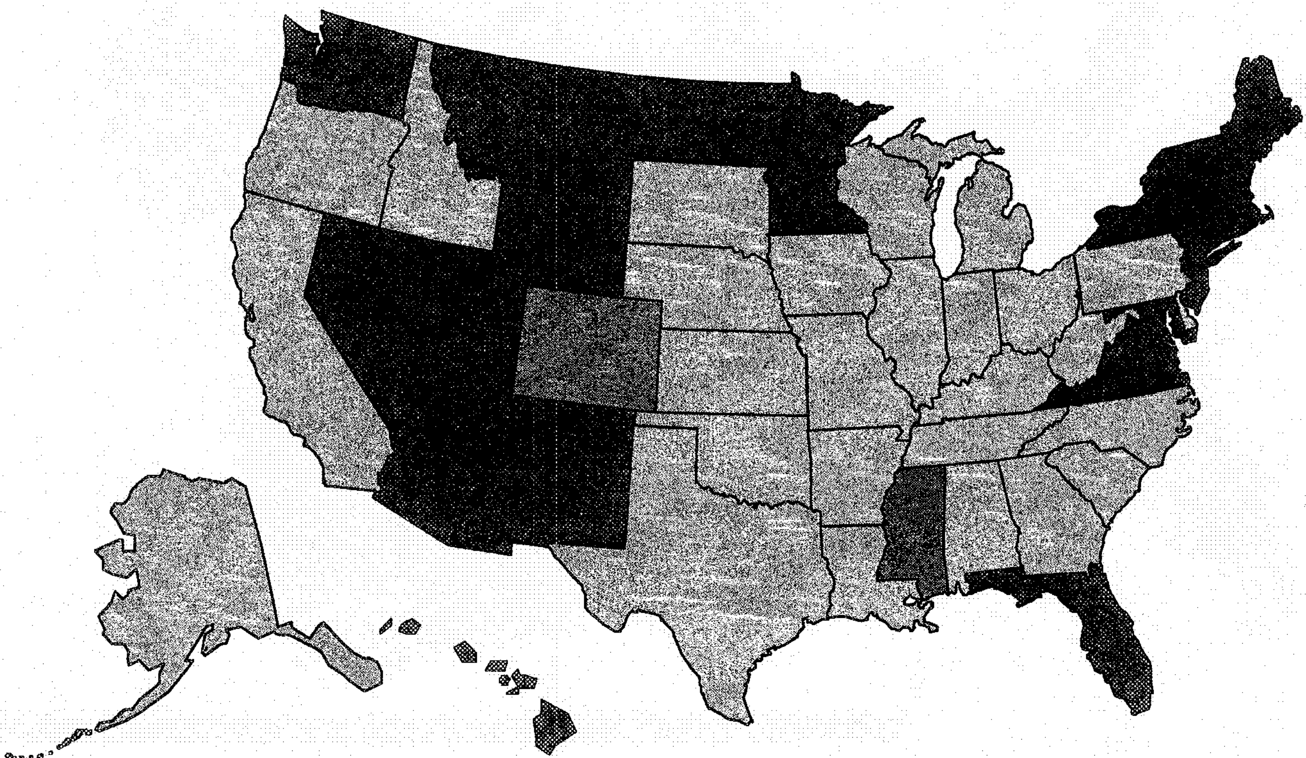
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)

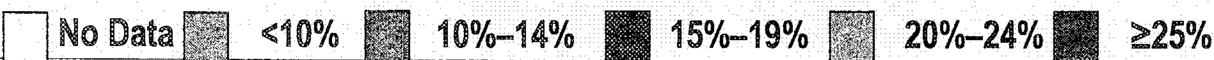




Obesity Trends* Among U.S. Adults
BRFSS, 2001

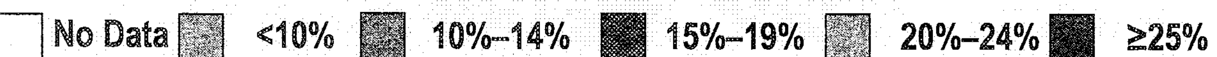
(*BMI $\geq$30, or ~ 30 lbs overweight for 5′ 4″ person)

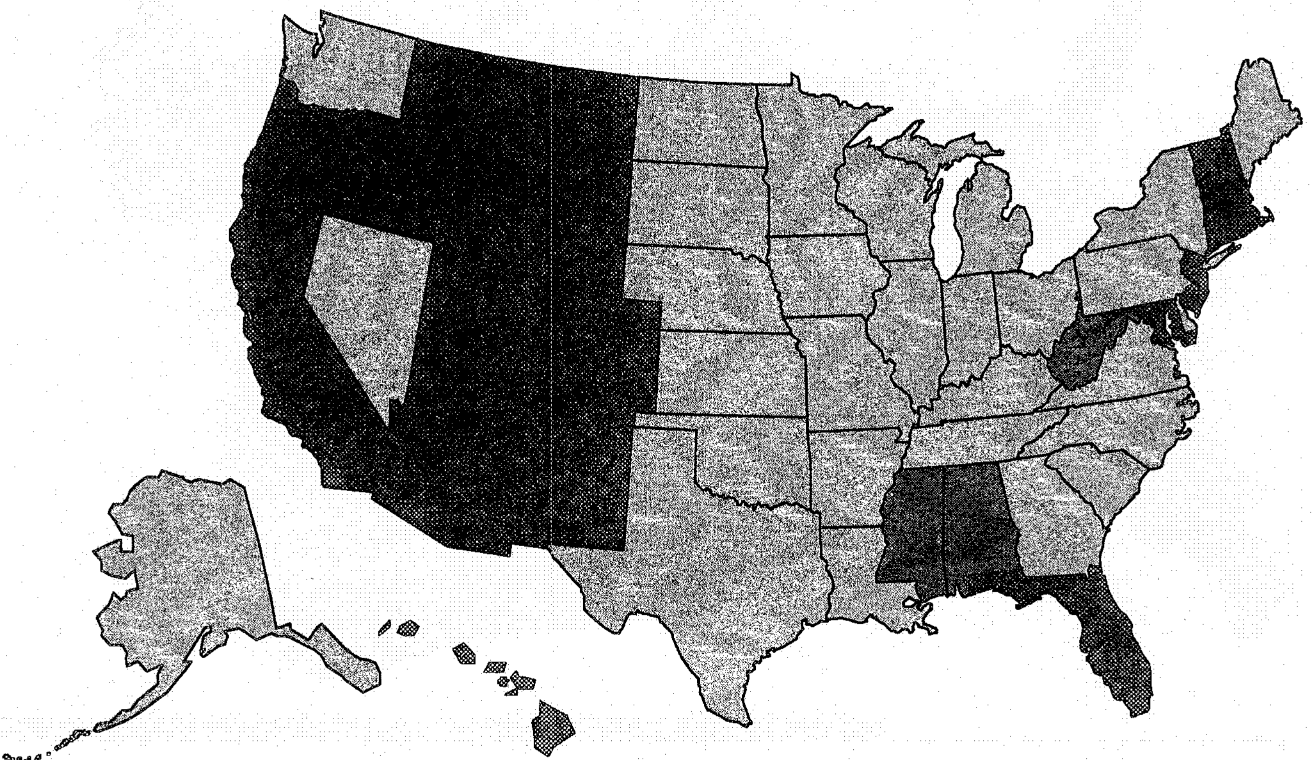




Obesity Trends* Among U.S. Adults
BRFSS, 2002

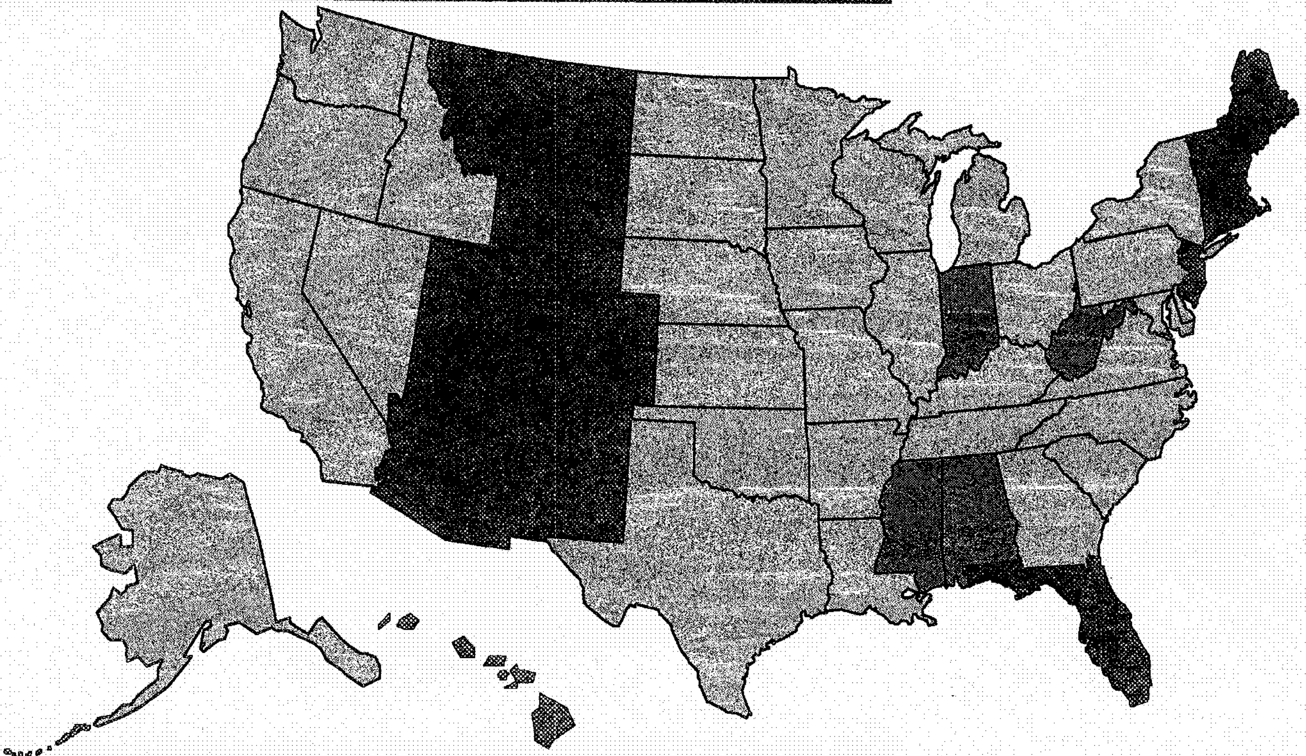
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)

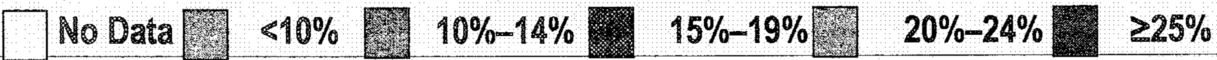




Obesity Trends* Among U.S. Adults
BRFSS, 2003

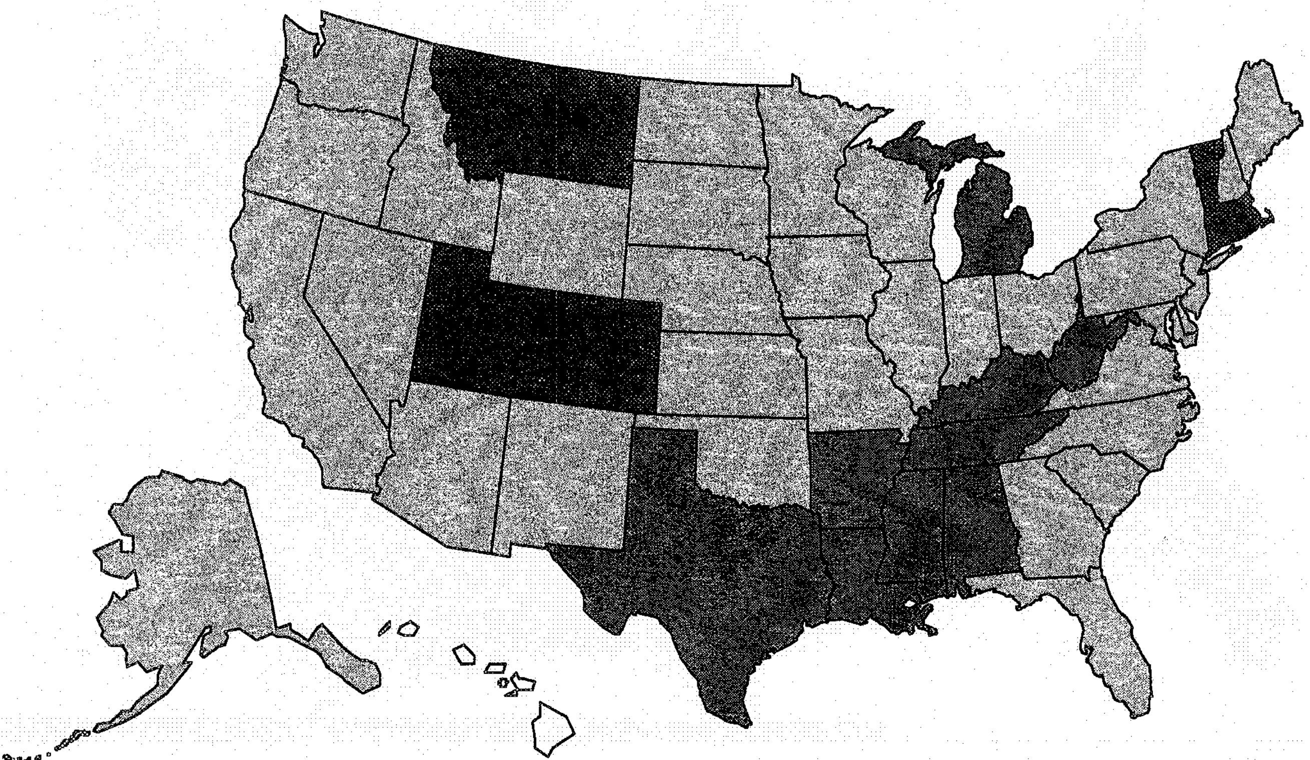
(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)

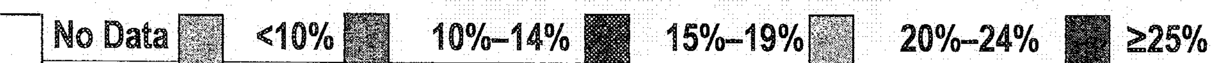




Obesity Trends* Among U.S. Adults BRFSS, 2004

(*BMI ≥30, or ~ 30 lbs overweight for 5′ 4″ person)





Obesity Trends* Among U.S. Adults
BRFSS, 2005

(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)

No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Childhood Obesity Trends

- Between 1963 – 2004 obesity rates quadrupled in US children ages 6-12yrs
- Overweight adolescents have a 70% chance of becoming overweight or obese adults.
- 25% of NJ high school students overweight/obese, 38% of 6th grade children are overweight/ obese

- Ref: 2003 NJ student health survey, NJ Dept of health and senior services and Education Survey

Risk Factors for Childhood Obesity

1. Lack of Physical Activity
2. Sedentary behavior
3. Socioeconomic status
4. Eating Habits
5. Environment
6. Physiological
7. Genetics
8. Race/Ethnicity

Health Consequences of Childhood Obesity

1. Type 2 diabetes Disease
2. High Cholesterol Problems
3. High Blood Pressure
4. Heart Disease
5. Sleep Apnea
6. Liver
7. Orthopedic
8. Asthma
9. Depression
10. Cancer

Economic Costs Related to Obesity

1. 36% increase inpatient and outpatient spending
2. In New Jersey estimated annual costs exceed $2 billion
3. 77% increase in use of medications
4. National health care expenditure related to obesity and overweight (2004 dollars) range from $98 billion to $129 billion (IOM 2005)
5. Obesity associated annual hospital costs for children rose from $35 million in 1979 – 81 to $127 million in 1997-99 (IOM 2005)

Childhood obesity – Advancing Effective Prevention and treatment: An Overview for Health Professionals. Apr. 9, 2003.
Prepared for the National Institute for Health Care Management Foundation Forum.

Shape it Up

- Collaboration between:
  - Ernest Mario School of Pharmacy , Rutgers State University of New Jersey
  - Horizon Blue Cross Blue Shield of New Jersey
    - Analysis conducted by Eagleton Institute of Politics, Rutgers State University of New Jersey
  - Grant from Sanofi-Aventis

Shape it Up

- ☐ New Jersey Elementary School Based Obesity program presented to 89,739 students during school year 2004-2005, 2005-2006 academic years

Shape it Up Goals

1. Raise awareness about healthy eating and exercise in New Jersey
2. Promote healthy eating and exercise behaviors among New Jersey elementary school children
3. Develop and implement an age appropriate program that meets the requirements of the New Jersey Core Health Curriculum
4. Provide a training program to the teachers

Shape It Up Objectives

A 45-minute interactive workshop designed to educate children in grades K through 6 how to:

1. Determine healthy portion sizes

2. Eat a variety of fruits and vegetables

3. Improve health via exercise

Shape It Up Objectives

4. Improve understanding of the Food Pyramid

5. Understand the disadvantages of excessive soda intake

6. Understand the impact of a high-fat diet

Shape It Up

Program Segments

1. Serving Size & Food Pyramid

2. Fun with Fruit

3. Soda and Water

4. Heart Rate

5. Healthy vs. Unhealthy Artery

Shape It Up

Instructors

1. Pharm. D. Candidates
2. Pharmacy Faculty
3. Pharm. D. Fellows and Residents
4. Horizon Faculty
5. Pharmacy student volunteers

Workshops

1. 60 minute session at elementary schools throughout NJ
2. Interactive
3. Auditorium and Classroom settings
4. Monthly instructor workshops to reinforce the lesson plans

Shape It Up

Educational Materials

1. Students - Activity book, food journal.
2. Parents - Healthy meal plan handouts
3. Schools - Laminated Posters
4. Website - Educational materials for kids, parents, teachers

Shape It Up Days

- Educational field trips for schools that participated in the 2004 – 2005 academic year
- Held 3 events: Trenton Thunder, Atlantic City Surf and Summerset Patriots
- Activities reinforcing Shape It Up presentation including: Food Group Frisbee Toss, Balance your diet, Tooth loss bean bag throw and Food Pyramid relay
- A review of the "Healthy vs. Unhealthy Artery segment was presented
- Each child received a goodie bag at each event

Shape It Up Total Participation
(2004-2005, 2005–2006)

New Jersey Elementary school children : **89,739**

Elementary school children: **257**

Program sessions: **466**

Eagleton Evaluation Study

1. Evaluate the effectiveness of the Shape It Up Program in:
    a)Increasing student knowledge about nutrition and exercise
    b)Creating more positive attitudes about nutrition and exercise
2. Provide a snapshot of related behavioral trends among New Jersey students

Research Methods

1. Pretest questionnaire for students
2. Workshop
3. Post-test questionnaire for students
4. Follow-up questionnaire for school administrators

Survey Participation

1. 11,088 students in grades 1-6 participated in the pretest survey, and 11,001 participated in the post-test survey
2. 7,951 students completed both surveys

Pretest Questionnaire

1. 16 closed-ended items
2. Attitudes toward exercise and healthy eating
3. Knowledge measures
4. Behavioral measures
5. Demographic measures

Post-test Questionnaire

- Post-test questionnaire had the same measures of attitudes and knowledge
- Questionnaire also had two evaluative questions concerning Shape It Up

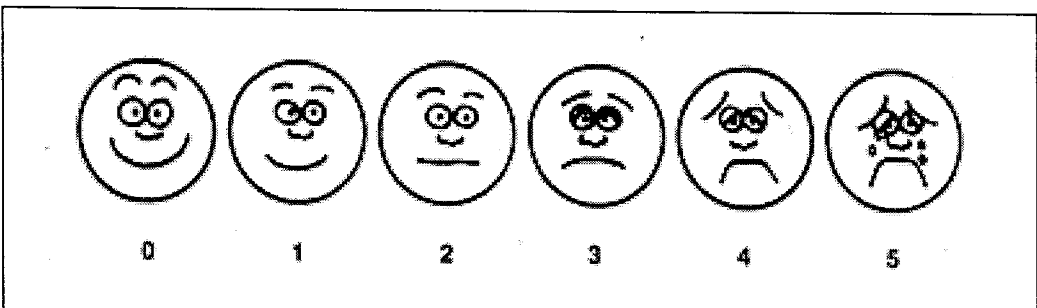
Attitude Questions

1. How do you feel about eating fruit?
2. How do you feel about eating vegetables?
3. How do you feel about doing exercise?

Attitude Scale

Attitudinal scale for healthy eating, exercise

Range of 0 for most positive to 5 for most negative



Knowledge Questions

1. The fat in food can clog the blood flow in your arteries
2. A healthy serving size of food is the size of a tennis ball
3. A can of regular soda has one teaspoon of sugar
4. Exercise makes your heart strong
5. Milk and water are better for you than soda
6. How many servings of fruits and vegetables should you eat a day?

Behavior Questions

1. How many days a week do you exercise (play sports, dance, swim, ride your bike, take a walk)?

   Response range of none to five or more days per week

Behavior Questions

2. On most days, how many sodas (cans, bottles, or cups) do you drink?

   Response range from none to four or more sodas a day

Behavior Questions

3. On most days, how many hours do you watch TV, videos, or DVDs?

   Response range of none to four or more hours per day

Behavior Questions

4. On most days, how many hours do you play video games or computer games?

   Response range of none to four or more hours a day

Behavior Questions

5. Do you eat breakfast every day?

   Yes

   No

Demographic Measures

1. Are you a boy or a girl?

2. What grade are you in?

Results: Behavioral Snapshot: Eating and Exercise

- 51% exercise less than 5 times a week and 20% exercise 2 days a week or less
- 60% consumes one or more sodas on most days
- 81% eat breakfast, ranging from 94% in Grade 1 to 62% in Grade 6

Behavioral Snapshot : Screen Media

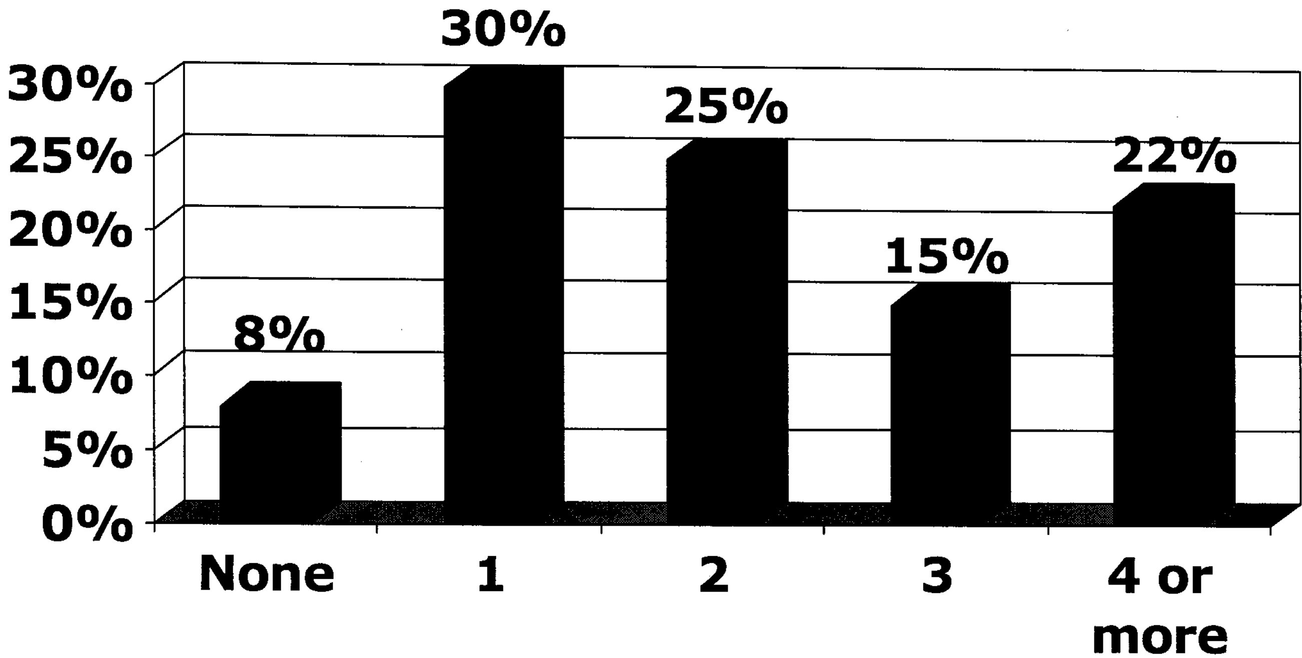
- 92% watch at least 1 hour of TV/Video/DVDs per day,62% watch at least 2 hours , 37% watch at least 3 hrs and 22% watch 4 or more hours per day

- 79% play video or computer games for at least 1 hour per day, 43% play for at least 2 hours, 26% for at least 3 hours and 17% play for 4 hours or more per day

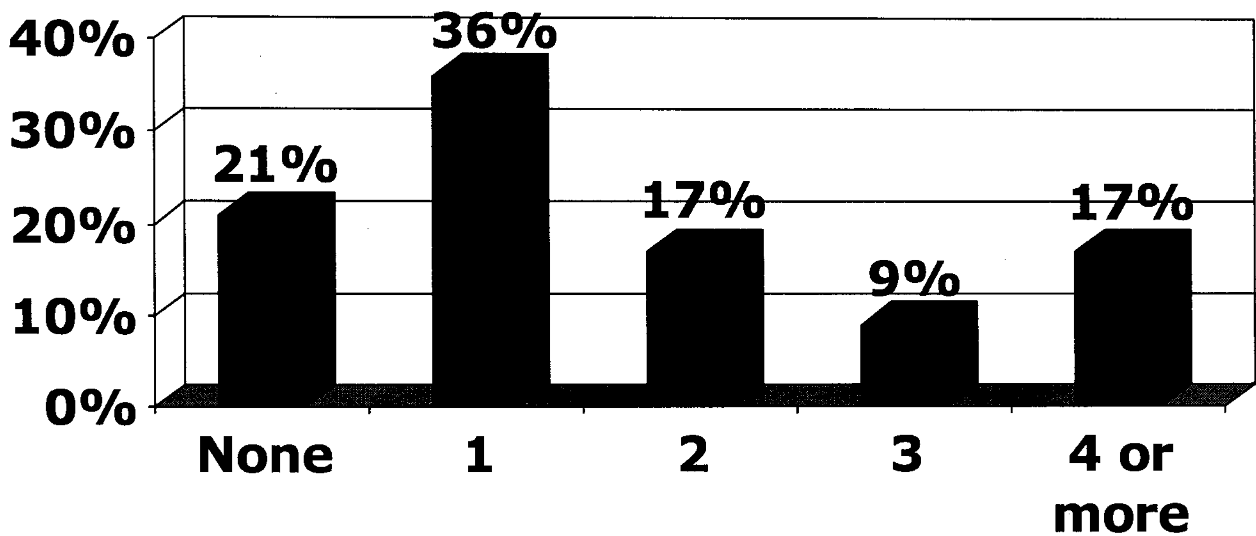
- 26% of boys watch 4 or more hours of TV/Videos/DVDs per day compared with 19% of girls

- 25% of boys play video/computer games 4 or more hours per day compared to 8% of girls

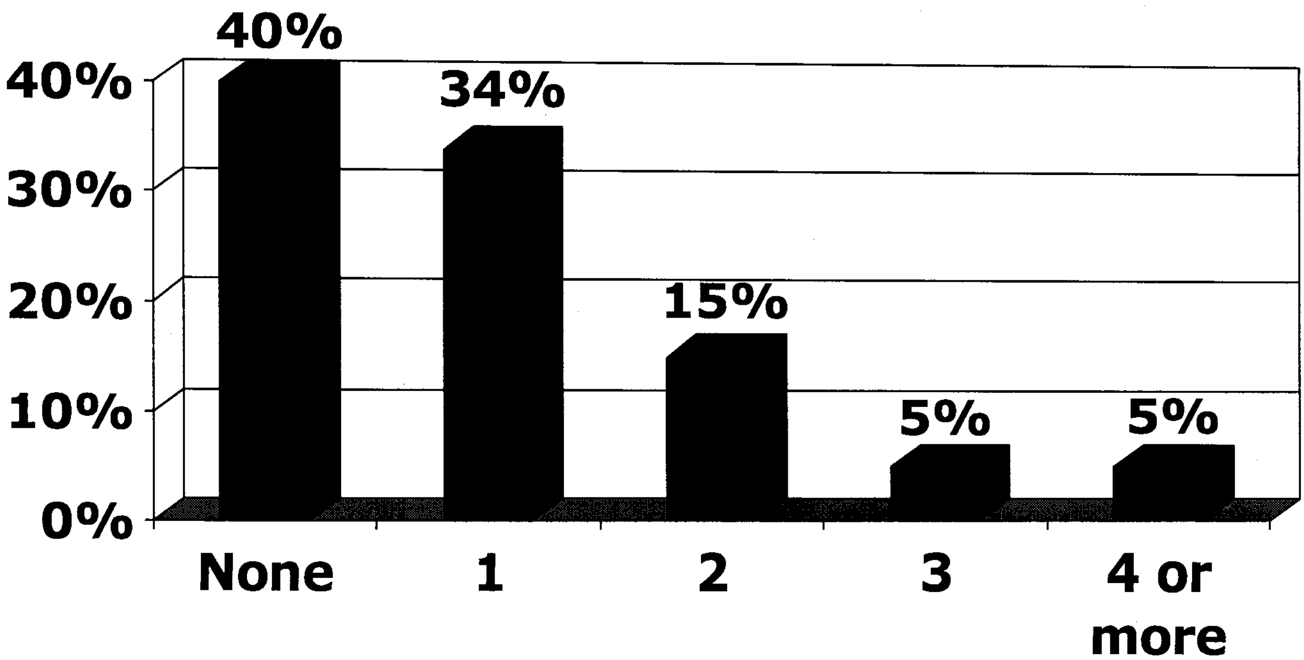
Results – Behavioral Snapshot



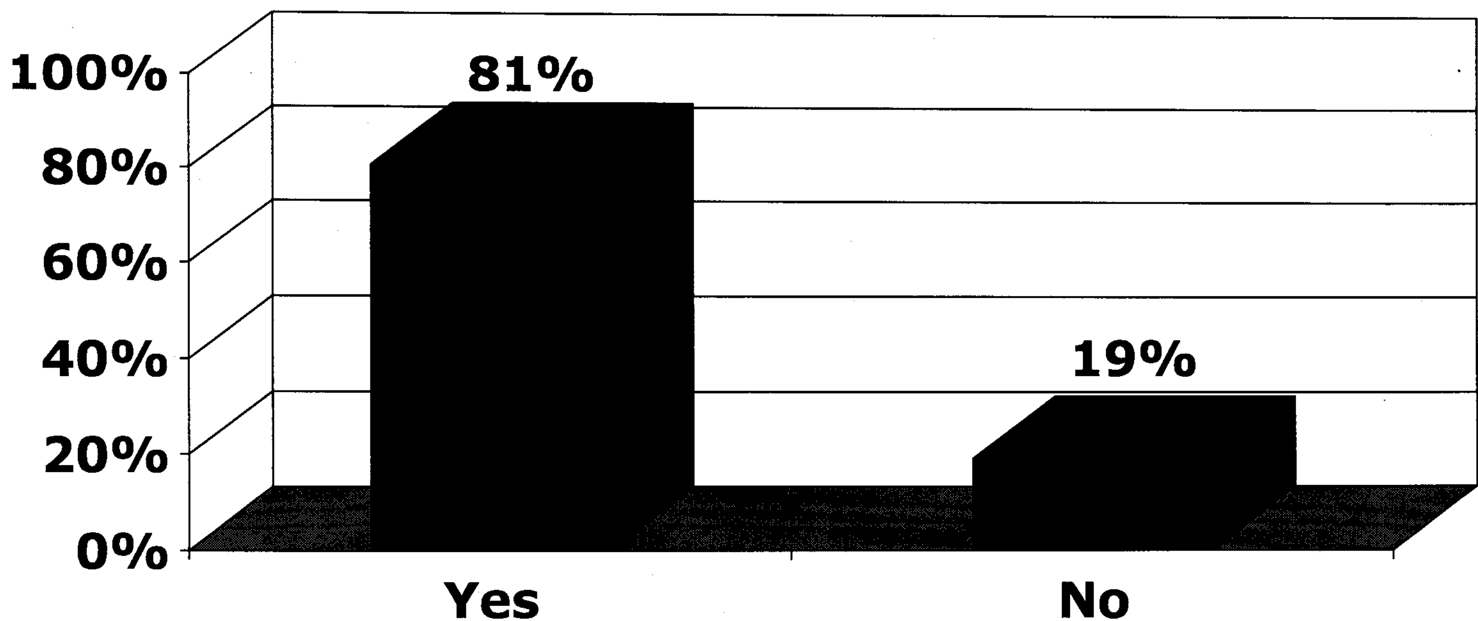
Results – Behavioral Snapshot



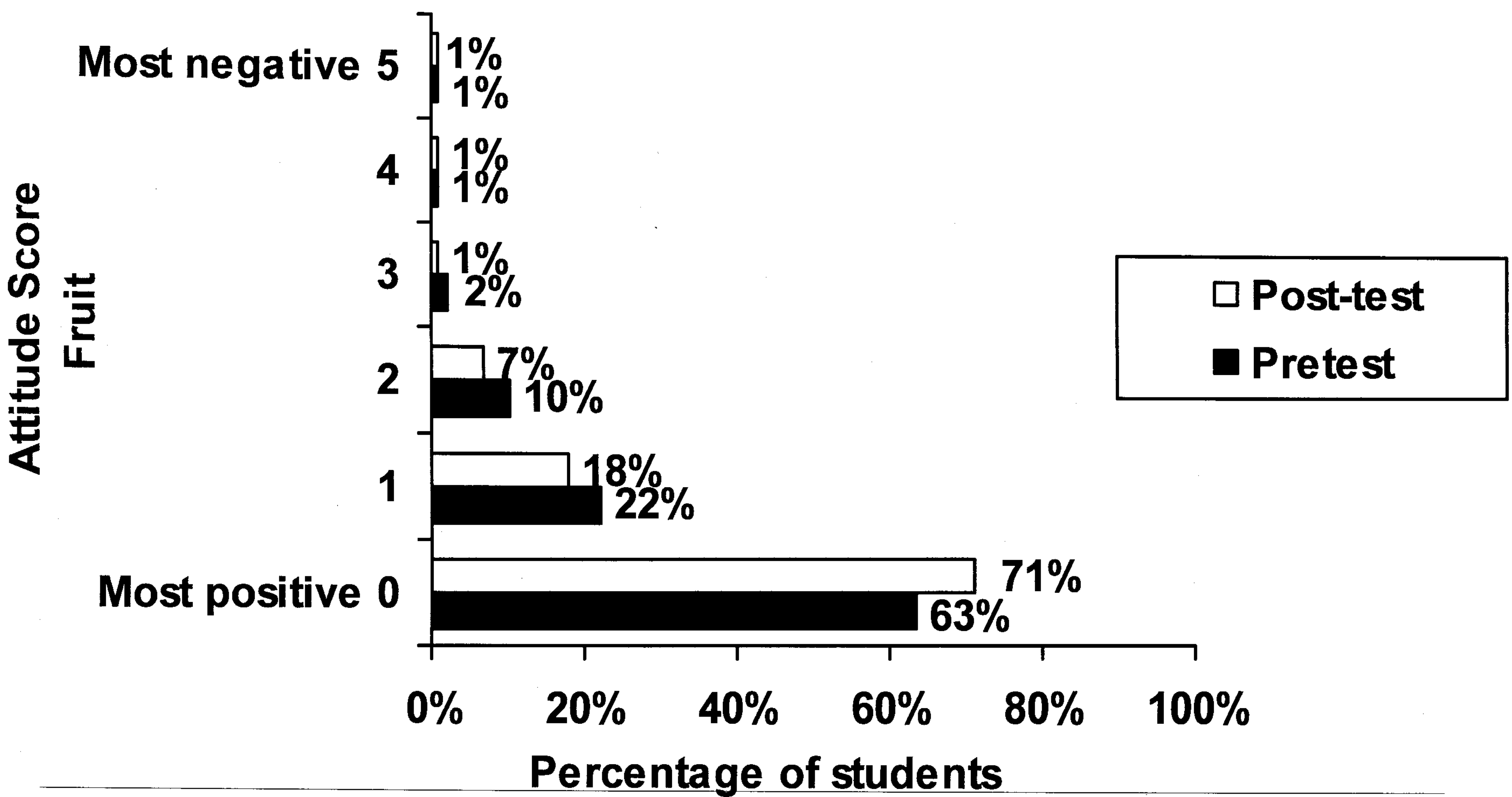
Results – Behavioral Snapshot



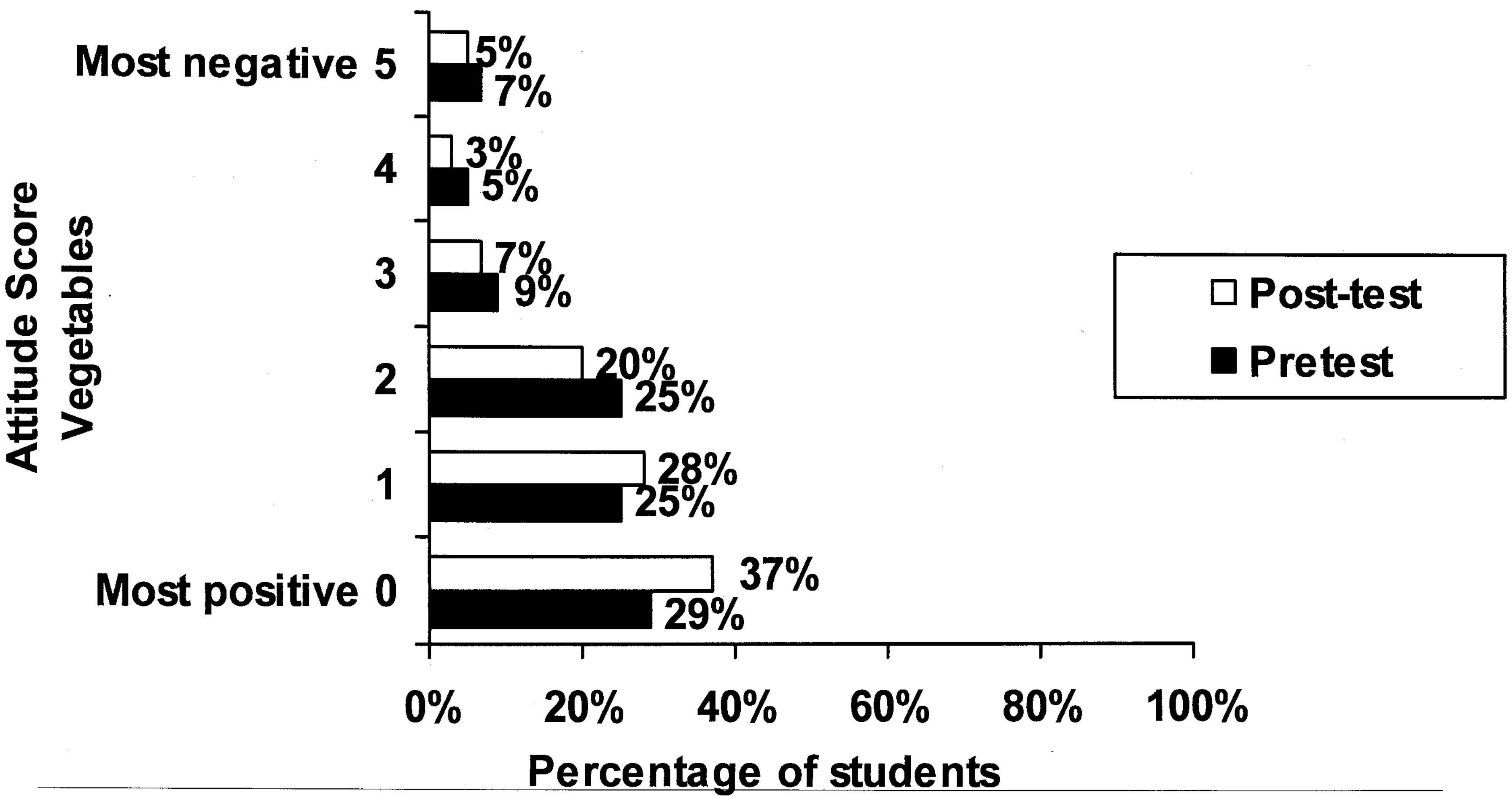
Results – Behavior Snapshot



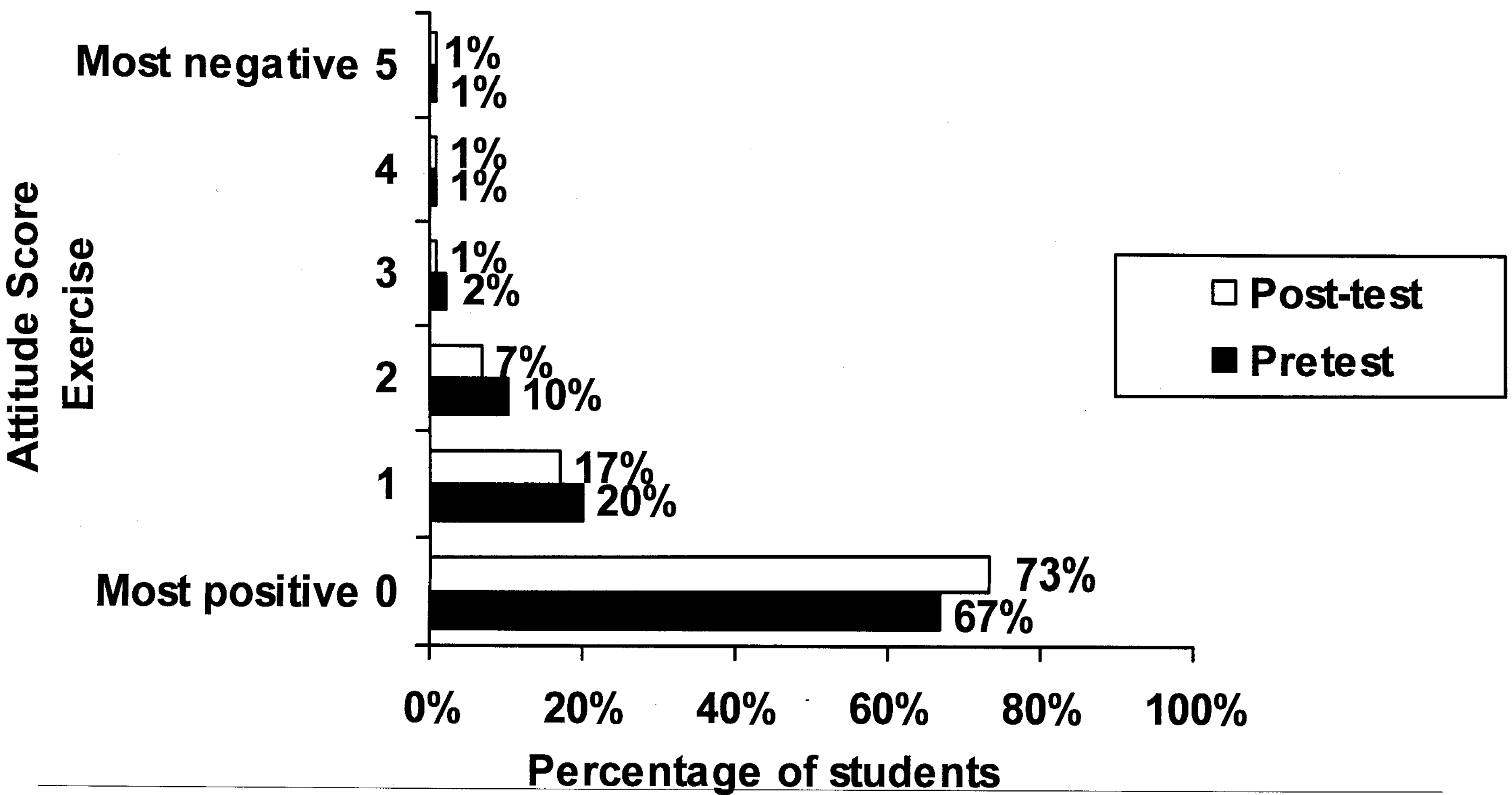
Results – Differences in Attitudes



Results – Differences in Attitudes



Results – Differences in Attitudes



Student Knowledge Results

Percent correct responses to 5 knowledge questions:

Pretest	Posttest	Gain
58.5%	81.1%	22.6%*

* $p<.01$

Results – Differences in Knowledge

- ☐ The response increase was higher in students who said that they did not eat breakfast everyday
- ☐ Females demonstrated an additional increase of correct responses

Results – Predictors of Knowledge

Multivariate model found the following were <ins>positive</ins> predictors of knowledge:

- Hours of exercise (pre- and post-test)
- Eating breakfast each day (pretest)
- Gender (males in pretest, females in post-test)
- Grade level (pre- and post-test)

Results – Predictors of Knowledge

Multivariate model found the following were negative predictors of knowledge:

- Sodas consumed per day (pre- and post-test)
- Hours watching TV, videos, DVDs (post-test)
- Hours playing video and computer games (post-test)

Student Satisfaction Results

(N=7,951)

- 91% gave the program a positive rating
- Of those, 55% gave the program the highest rating possible on the scale provided

School Administrator Survey (N=44)

Shape It Up Helped Our School/Teachers

- 91% Encourage students to participate in exercise
- 84% Create dialogues about healthy eating
- 68% Create lesson plans on health eating

School Administrator Comments

"The interactive nature of your program was effective…Students still talk about it."

"The program was instrumental in helping our entire school community think of making better choices about snacks and meals"

"Your program reinforced lessons that we have been teaching."

Key Findings

1. Positive attitudes about fruits, vegetables, and exercise increased after the Shape It Up workshop
2. Students demonstrated greater knowledge about healthy eating and exercise after the Shape It Up workshop
3. Knowledge gains were slightly greater for those who did not eat breakfast every day
4. Knowledge gains were slightly greater for females

Limitations of the Study

- Study design did not have a control group it was a single sample design with a pre and post measures
- The duration of the positive impact is difficult to determine from this analysis

Case Study I: Shape It Up

- CMC created Shape It Up characters and educational materials.

Food Guide Pyramid

Eating foods from the Food Guide Pyramid will help you grow healthy and strong.

Fats, Oils & Sweets

Eat Less

Use Sparingly

Milk, Yogurt & Cheese Group 2-3 Servings

Meat, Poultry, Fish, Eggs & Nuts Group 2-3 Servings

Vegetable Group 3-5 Servings

Fruit Group 2-4 Servings

Bread, Cereal, Rice & Pasta Group 6-11 Servings

Horizon.

Sanofi-Synthelabo is a proud supporter of Shape It Up.

Shape it Up

RUTGERS

Horizon.

RUTGERS

Shape it Up

Activity Book

Horizon.

Sanofi-Synthelabo is a proud supporter of Shape It Up.

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Making Healthcare Work®

Home : *Shape it Up*

- About the Program
- Healthy Eating Tips
- Target Heart Rate for Children
- Healthy Food Chart
- Program Materials
- Helpful Links

Horizon Blue Cross Blue Shield of New Jersey and the Ernest Mario School of Pharmacy at Rutgers, the State University of New Jersey, have developed *Shape it Up*, an age-appropriate program designed to educate New Jersey elementary school students and their families about the importance of good nutrition and being physically fit. Students will learn proper eating habits and get tips for increasing their physical activity. *Shape it Up* will also increase childhood-obesity awareness and prevention by helping parents become proactive about their children's eating habits.

THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS

John Colaizzi

Helpful Links

About the Program

Shape it Up educates students about proper eating habits and being physically active, and raises awareness of obesity-related health problems.

Schedule of Events

Click here for a listing of schools that are scheduled to begin the program this fall.

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Asbury Park Press (Neptune, NJ)
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Date: Tuesday, September 28, 2004

Pupils learn fighting obesity is elementary

'Shape it Up' program to tour 150 N.J. schools

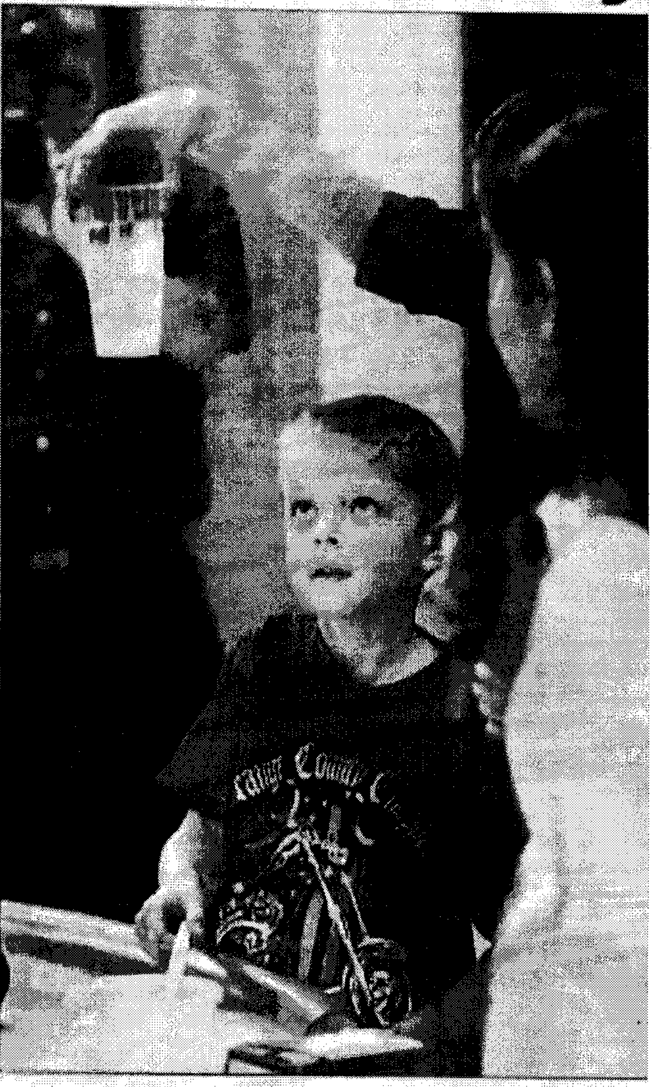
By KIRK MOORE
STAFF WRITER

How do you make soda pop seem disgusting to a crowd of elementary school children? Just bring in Rutgers University pharmacy students to do a little basic chemistry demonstration.

"One, two, three . . . 10, 11, 12!" Olivia Wang of Howell led the children of West Dover Elementary School in Dover Township in chanting as third-grader J.T. Iavino dumped spoonfuls of sugar into a glass of water. The sugar solution turned cloudy, and Wang's colleagues from the Ernest Mario School of Pharmacy offered sips, to no takers.

The company's philanthropic focus has long been on children's issues, and "for us to be involved in the prevention as well as the treatment of obesity is important."

— Leslie Hare, spokeswoman for Sanofi-Synthelabo Inc., an event sponsor



"That's how much sugar is in a can of soda," Wang told the children. "Who likes to have their teeth drilled by the dentist?" Stick to water or milk, she added, "and then you can stay out of the dentist's chair."

West Dover was first stop yesterday on a tour of 28 schools in Ocean and Monmouth counties where the new "Shape It Up" program will visit to foster healthy eating habits and combat obesity among elementary school children. It's a statewide effort to 150 elementary schools, sponsored by Horizon Blue Cross Blue Shield of New Jersey and the Rutgers pharmacy school, where nearly half of the 150 pharmacy and post-graduate students have volunteered as teaching aides.

Horizon Vice President and Chief Medical Officer Richard Popiel said the initiative seeks to educate children about the risks that come with being overweight.

One advocacy group, the American Obesity Association, has estimated that 15.5 percent of teens ages 12 to 19 are obese, a three-fold increase since 1980, Popiel said. Similar percentages seen among the elementary-age population between ages 6 and 11 represent a doubling in the last 24 years, he said.

Taking that message to a younger audience is an important experience in their own training, the Rutgers pharmacy students said.

"We're health care professionals. As pharmacists, we're more accessible to the public. To see a doctor you usually make an appointment, but we're around the pharmacy all day talking to people and answering questions," Yang said.

"It's kind of hard for a kid to go back and tell their parents they want apples and bananas instead of a hamburger," said Dana Pikul of East Brunswick. "But hopefully we're giving them information they can use to make informed decisions about their own eating habits."

West Dover pupil Chase Greenberg said the best part of the program "was probably the exercises," an energetic spell of jumping jacks that won apples and bananas for kids who volunteered.

The pupils participated in other demonstrations too, like a graphic demonstration of what cholesterol does when its fatty molecules clog blood vessels. A length of clear 2-inch laboratory hose represented an artery, as the kids donned plastic gloves to gingerly pack vegetable shortening into one end.

J.T. Iavino (above), a third-grader at West Dover Elementary School, learns that a can of soda can have as much as 12 spoonfuls of sugar while Rutgers graduate pharmacy student Ryan Bucco sets out healthy snacks for the children.

(STAFF PHOTOS: TIM MC CARTHY)

"We're going to show what happens if you eat fast food every day," narrated Rutgers student Yoon Young Kim of East Brunswick. "Cheeseburger . . . Chicken nuggets, going in . . ."

The Shape It Up program is funded in part with an unrestricted $100,000 grant from Sanofi-Synthelabo Inc., part of the multinational pharmaceutical group Sanofi-Aventis, said Leslie Hare, a company spokeswoman.

The company's philanthropic focus has long been on children's issues, and "for us to be involved in the prevention as well as the treatment of obesity is important," Hare said.

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Visit our Web site,
www.app.com
and click on the Web Extras button for a link to:
Horizon Blue Cross Blue Shield

The Star-Ledger

October 10, 2004

The war against fat gains new ammunition

September 28, 2004

The importance of eating right

November 16, 2004

Principal discusses child obesity

The Philadelphia Inquirer

November 1, 2004

Schools trim the fat from their lunch menus

THE JERSEY JOURNAL

November 15, 2004

Healthy eating wins student attention with vivid display of junk food's risks

November 25, 2004

Students turned off by fast food demo

January 20, 2005

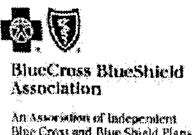
Shaping up in Florham Park

January 21, 2005

Heart-health lesson greased in Vernon Everyday items used to show pupils value of healthy eating

"Shape It Up" Award

Best of Blue
Sharing innovative and effective Blue Plan programs



BlueCross BlueShield Association
An Association of Independent Blue Cross and Blue Shield Plans

March 22, 2005

Mr. William J. Marino
President and CEO
Horizon Blue Cross and Blue Shield
of New Jersey, Inc.
3 Penn Plaza East
Newark, NJ 07105

Dear Mr. Marino:

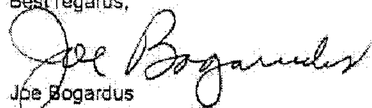
Congratulations! I'm pleased to inform you that Horizon Blue Cross and Blue Shield of New Jersey, Inc. will be presented with an award in the 9th annual Best of Blue Marketing and Communications competition. Your Plan has won an award for the entry titled ***Shape it Up*** in the ***Public/Media Relations*** Category.

The competition received 182 entries in 10 different categories from 35 Blue Plans. The entries were judged by an external panel of marketing and communications professionals.

A formal presentation will honor the winners at a Best of Blue Awards breakfast at BCBSA's Marketing, Communications and National Program Delivery Conference in San Francisco on Tuesday, May 3rd.

Once again, congratulations on your Plan's outstanding marketing communications achievement. I look forward to seeing you at the conference.

Best regards,



Joe Bogardus
Executive Director
Brand Marketing Communications
Strategic Services

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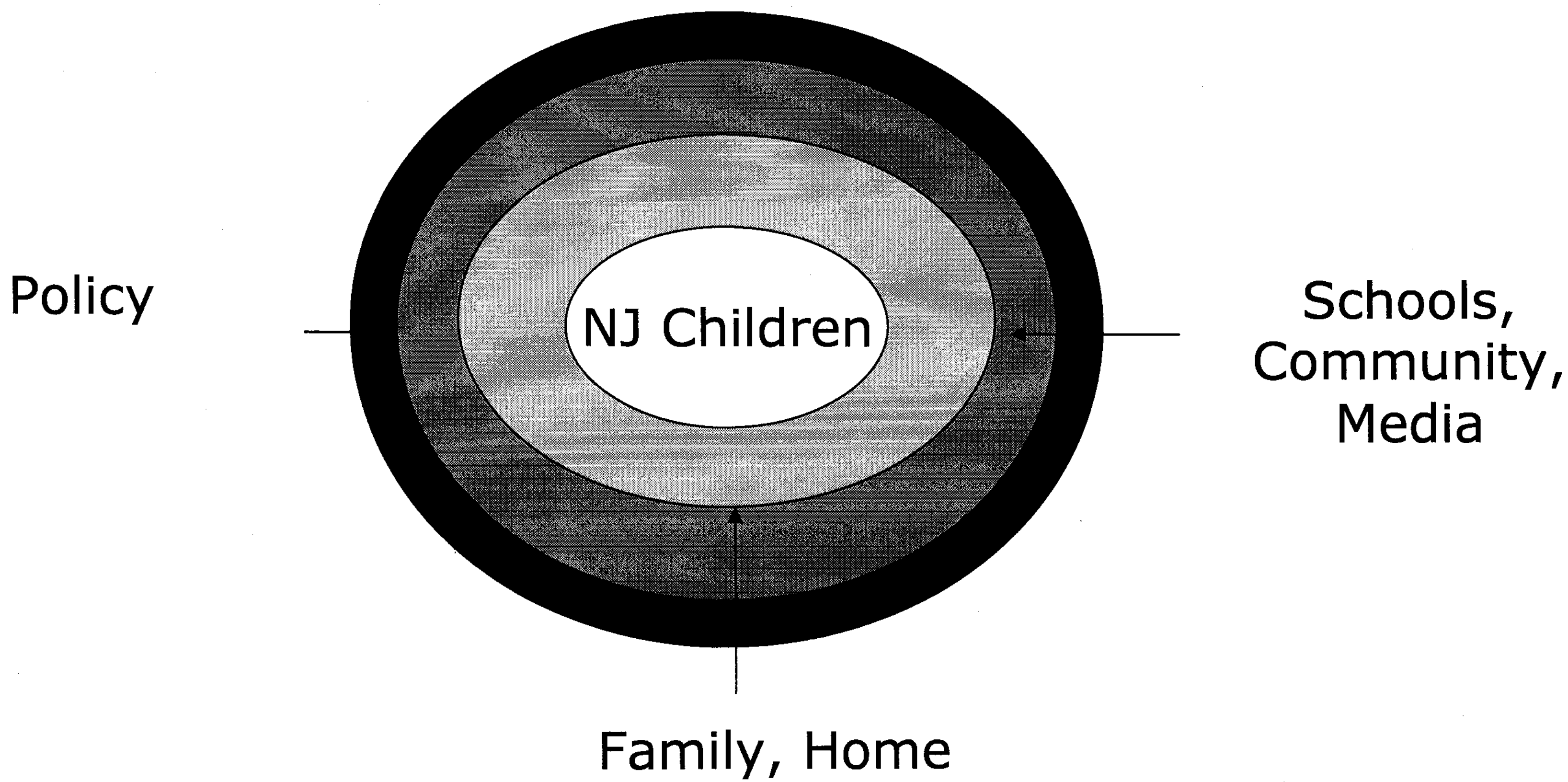
Ecological Perspective on Factors Influencing Childhood Overweight/Obesity



Questions?