Adolescent Health Symposium

Obesity in Adolescents

Nicole W. Bungum, MS, CHES
Office of Chronic Disease Prevention & Health Promotion
Southern Nevada Health District
“The function of protecting and developing health must rank even above that of restoring it when it is impaired.”

-Hippocrates
Overview

• What does the data show?
  – In Nevada
  – In the United States
• Social costs for long-term obesity
• What is contributing to the epidemic among adolescents?
• What prevention activities and initiatives are occurring?
• Opportunities for action and advocacy
• Resources
Terminology

• **Overweight** is defined as having excess body weight for a particular height from fat, muscle, bone, water, or a combination of these factors

• **Obesity** is defined as having excess body fat

• **Childhood Obesity** - For the purposes of this presentation, a general term to include youth up to and including the age of 19
Body Mass Index (BMI)

• BMI: A number calculated from a person’s weight and height

BMI/Weight Status Categories for Adults

<table>
<thead>
<tr>
<th>BMI</th>
<th>Weight Status</th>
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</thead>
<tbody>
<tr>
<td>Below 18.5</td>
<td>Underweight</td>
</tr>
<tr>
<td>18.5 - 24.9</td>
<td>Normal</td>
</tr>
<tr>
<td>25.0 - 29.9</td>
<td>Overweight</td>
</tr>
<tr>
<td>30.0 and Above</td>
<td>Obese</td>
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BMI for Children & Teens

- BMI calculated the same way
- BMI age- and sex-specific percentiles are used because the amount of body fat changes with age and differs between boys and girls

<table>
<thead>
<tr>
<th>Weight Status Category</th>
<th>Percentile Range</th>
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<tbody>
<tr>
<td>Underweight</td>
<td>Less than the 5(^{th}) percentile</td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>5(^{th}) percentile to less than 85(^{th}) percentile</td>
</tr>
<tr>
<td>Overweight</td>
<td>85(^{th}) to less than the 95(^{th}) percentile</td>
</tr>
<tr>
<td>Obese</td>
<td>Equal to or greater than the 95(^{th}) percentile</td>
</tr>
</tbody>
</table>
Setting the Context:

The Adult Obesity Epidemic in the United States

1985 - 2010
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, 1990
(*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, 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)

No Data          <10%           10%–14%  15%–19%  ≥20%

14
Obesity Trends* Among U.S. Adults

BRFSS, 2001

(*BMI ≥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)
Obesity Trends* Among U.S. Adults
BRFSS, 2006

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2007
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2008

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2009

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2010

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Adult Obesity Prevalence (%), US and Nevada (BRFSS, 2011-2013)
Setting the Context:
Obesity in Young Children
Figure 2. Prevalence of obesity among children and adolescents aged 2–19, by sex and age: United States, 2009–2010

Age in years: 2–19  2–5  6–11  12–19

<table>
<thead>
<tr>
<th></th>
<th>All 1</th>
<th>Boys</th>
<th>Girls 1</th>
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</thead>
<tbody>
<tr>
<td>Percent</td>
<td>16.9</td>
<td>18.6</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td>12.1</td>
<td>14.4</td>
<td>9.6</td>
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<tr>
<td></td>
<td>18.0</td>
<td>20.1</td>
<td>15.7</td>
</tr>
<tr>
<td></td>
<td>18.4</td>
<td>19.6</td>
<td>17.1</td>
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</tbody>
</table>

1Significant increasing linear trend by age (p < 0.005).

Weight Status of Children Entering Kindergarten in NV
Nevada Institute for Children’s Research & Policy

- Under Wt.
- Healthy Wt
- Unhealthy

<table>
<thead>
<tr>
<th>Year</th>
<th>Under Wt.</th>
<th>Healthy Wt</th>
<th>Unhealthy</th>
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<tbody>
<tr>
<td>2010-2011</td>
<td>12</td>
<td>50</td>
<td>38</td>
</tr>
<tr>
<td>2011-2012</td>
<td>13</td>
<td>52</td>
<td>35</td>
</tr>
<tr>
<td>2012-2013</td>
<td>14</td>
<td>53</td>
<td>34</td>
</tr>
<tr>
<td>2013-2014</td>
<td>14</td>
<td>54</td>
<td>33</td>
</tr>
</tbody>
</table>
Obesity among 2-4 year olds from low-income families in Nevada
In Summary:

• Childhood obesity has more than doubled in children in the past 30 years.

• The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 18% in 2012.
Adolescent Obesity
Adolescent Obesity

Figure 1. Trends in obesity among children and adolescents: United States, 1963–2008

NOTE: Obesity is defined as body mass index (BMI) greater than or equal to sex- and age-specific 95th percentile from the 2000 CDC Growth Charts.
Percentage of high school students who were obese in 2013 - YRBS
Youth Weight Status (%), US, Nevada, Clark, Washoe (YRBSS, 2013)
Youth Overweight (%), US, Nevada, Selected Demographics (YRBSS, 2013)
Youth Obese (%), US, Nevada, Selected Demographics (YRBSS, 2013)
BMI in a Sample of CCSD Students

• We do have data from measured height and weight versus self-reported height and weight for adolescents

A History of the Legislative Mandate:

• 2003: Senate Resolution created the interim study of the Medical and Societal Costs and Impacts of Obesity in Nevada
• 2007: Assembly Bill 354 required the collection of height and weight data in representative sample of 4th, 7th and 10th grades until June, 2010
• 2009 – Assembly Bill 191 extended the sunset to June 20, 2015
• 2013 – Senate Bill 442 limits height and weight data to school districts in a county whose population is 100K+ and ends requirement on June 30, 2015
• Reports for Clark and Washoe Counties
  – Washoe County: www.washoecounty.us
  – Southern Nevada Health District: www.southernnevadahealthdistrict.org
  – State of Nevada: www.health.nv.gov
Weight Status (%), Sampled CCSD Students (2010-2014)
Unhealthy Weight (%), Sampled CCSD Students, By Gender (2010-2014)
Unhealthy Weight (%), Sampled CCSD Students, By Race/Ethnicity (2010-2014)
Obesity-Related Disparities

- Some racial and ethnic groups have higher rates of obesity
- Lower income individuals have higher rates of obesity
- Individuals with lower rates of educational attainment have higher rates of obesity
- While childhood obesity rates have started to level off or even decline in some areas, the more significant declines have been among higher income, White children/adolescents
  - Case Study: NY implemented a comprehensive, community-wide approach to reducing childhood obesity
  - Childhood obesity among White K-8 students in NY dropped from 17.6% to 15.4% in 2 years
    - The drop among Hispanic and African-American students was far less, .4 percentage points
    - Higher income students saw a 1.4 percentage point decline compared to lower income students who saw a .7 percentage point decrease
Obesity in Adolescents Ages 12-19, by Gender and Race/Ethnicity

- **Hispanic**:
  - Boys: 25.5%
  - Girls: 17.5%

- **Mexican-American**:
  - Boys: 26.7%
  - Girls: 17.4%

- **White**:
  - Boys: 16.7%
  - Girls: 14.5%

- **Black**:
  - Boys: 19.8%
  - Girls: 29.2%

© National Center for Children in Poverty [www.nccp.org]
Adolescent Obesity in the United States
Obesity is a problem that impacts all population groups, but rates are disproportionately high among certain racial and ethnic groups and among individuals with lower socio-economic status and educational attainment. We must look at all interventions, policy, systems, and environmental changes from a health equity perspective to ensure that we are not inadvertently making the problem worse.
In Summary:

• In 2012, more than one third of children and adolescents were overweight or obese

• Obesity rates have quadrupled in adolescents in the past 30 years

• The percentage of adolescents aged 12–19 years who were obese increased from 5% to nearly 21% from 1980 to 2012

• Certain racial and ethnic populations have higher rates of obesity as populations with lower socio-economic status
Obesity Costs

Besides the physical health consequences, obesity also has negative social, psychological and economic impacts.
“Childhood” Obesity?

• If one parent is obese, there is a 50% chance that a child will also be obese. When both parents are obese, a child has an 80% chance of becoming obese.

• One study showed that children who became obese as early as age 2 were more likely to be obese as adults.

• A child who is obese between the ages of 10 and 13 has an 80 percent chance of becoming an obese adult.
Immediate health effects:

• Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease.

• Obese adolescents are more likely to have prediabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes.

• Children and adolescents who are obese are at greater risk for bone and joint problems, and sleep apnea.
Long-term health effects:

• Children and adolescents who are obese are likely to be obese as adults and are therefore more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.

• Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin’s lymphoma.
• The rise in obesity has contributed to a rise in diabetes – “Twin Epidemic”
• Type 2 diabetes, previously considered an ‘adult’ disease, has increased dramatically in overweight children and adolescents
• One in three American children born in the year 2000 will develop diabetes in their lifetime because of the increase in overweight and obesity. Among children of Hispanic origin children, that number is one in two.
Age-adjusted Percentage of U.S. Adults Who Were Obese or Who Had Diagnosed Diabetes

**Obesity (BMI ≥30 kg/m²)**

- **1994**
- **2000**
- **2009**

**Diabetes**

- **1994**
- **2000**
- **2009**

Emotional Issues Related to Obesity in Adolescents:

- Depression
- Anxiety
- Low self-esteem
- Feelings of worthlessness or inferiority
- Body dissatisfaction
- Disordered eating/unhealthy weight control behaviors
- Substance use
- Negative stereotyping, stigmatization, and teasing
- Behavior problems
- Poor academic performance
- School absenteeism
Case Study:

• In a study of children between ages 5 to 18 asking them to rate their quality of life based on things like their ability to walk more than one block, play sports, sleep well, get along with others and keep up in school

• The study found that obese children often rated their quality of life with scores as low as those of young cancer patients on chemotherapy

• The results indicated that teasing at school, difficulties playing sports, fatigue, sleep apnea and other obesity-linked problems severely affected the children's well-being
Financial Costs

The financial costs of obesity will continue to rise as today’s obese and overweight youth become tomorrow’s obese and overweight adults.
A Few Examples:

• The estimated annual health care costs of obesity-related illness are a staggering $190.2 billion or nearly 21% of annual medical spending in the United States.

• Childhood obesity alone is responsible for $14 billion in direct medical costs. If obesity rates were to remain at 2010 levels, the projected savings for medical expenditures would be $549.5 billion over the next two decades.

• Type 2 diabetes will cost each person who has it an average of $85,500 to treat the disease/complications over his or her life.

• In addition to growing health care costs attributed to obesity, the nation will incur higher costs for disability and unemployment benefits. Businesses are suffering due to obesity-related job absenteeism ($4.3 billion annually). These costs also will continue to rise.
HOW DID WE GET HERE?
What the Experts Say

- Despite obesity having strong genetic determinants, the genetic composition of the population does not change rapidly. Therefore, the large increase in obesity must reflect major changes in non-genetic factors.
- Although there are some genetic and hormonal causes of childhood obesity, most cases are caused by kids eating too much and exercising too little.
- Although certain medical disorders can cause obesity, less than 1 percent of all obesity is caused by physical problems.
- Overweight and obesity are the result of “caloric imbalance” – too few calories expended for the amount of calories consumed – and are affected by various genetic, behavioral, and environmental factors.
Our genetics haven’t changed, but our environment has!
Is it easier and cheaper to be physically inactive and eat unhealthy foods than it is to be physically active and eat healthy foods?
Behavioral and Environmental Contributors to Obesity Among Adolescents

• Physical Activity:
  – Guideline: Children (youth) should get 60+ minutes of physical activity each day.
  – Guideline: Adults should get 150 minutes of moderate activity or 75 minutes of vigorous activity per week

• In Nevada, 57% of high school students are MVA on 5 or more days per week and 22% are MVA 7 days a week
Some Contributing Factors to the Obesity Epidemic in Adolescents – Physical Inactivity

• Social norms are to use cars
• Fewer children using ‘active transport’ to/from school
• Engineering physical activity out of the day
• Increased screen time
• Less time for Physical Education classes
• Environments that are unsupportive of physical activity
Social norms are to use cars

- Each hour spent in a car contributes a 6% risk in obesity and chronic disease while each km walked contributes a 5% decrease in risk
Decrease in Active Transportation to School

Percent of Children 5 to 14 years of age who usually walked or biked to school. (National Safe Routes to School)
Decreases in Active Transport to School

• Children who walk or bike to school are much more likely to meet physical activity guidelines

• Reasons
  – Lack of time
  – Living farther from school
    • In 1969, 41 percent of children in grades K–8 lived within one mile of school;
    • 89 percent of these children usually walked or bicycled to school.
    • In 2009, 31 percent of children in grades K–8 lived within one mile of school;
      35 percent of these children usually walked or bicycled to school.
  – Safety concerns and perceptions about safety
  – Is it a pleasant and safe experience for kids to walk/bike to school? Or, does it look like this?
Engineering Physical Activity Out of the Day

- Decline in utilitarian daily activity and increase in technology-supported sedentary activity
- Utilitarian physical activity is important component
- Just 2 minutes of stair climbing a day burns enough calories to prevent average U.S. adult annual weight gain
Increased Screen Time Can Equal Increased BMI

• Each additional hour of television watching per day was associated with an almost 10% increase in BMI in children and adolescents aged 9-19

• Each additional hour of total screen time per day, including movies and games but not computers, was associated with a 7% increase in BMI for girls and a 5% increase for boys

• Associations were stronger among overweight girls than lean girls at normal weight
Less Physical Education & Physical Activity in Schools

Participation in PE Classes declines:

• In 2013, less than half (48%) of high school students attended physical education classes in an average week

• The percentage of high school students who attended physical education classes daily decreased from 42% in 1991 to 29% in 2013

• Exemptions and waivers for PE are often granted

Benefits of PE and PA in Schools:

• Builds and maintain healthy bones and reduces risk of obesity and chronic diseases

• Reduces feelings of depression and anxiety and promotes well-being

• May help improve students’ academic performance, including
  – Academic achievement and grades
  – Academic behavior, such as time on task
  – Factors that influence academic achievement, such as concentration and attentiveness in the classroom.
Environments that are unsupportive of physical activity

- Children living in neighborhoods with more green space were less likely to be overweight than those living in less-green neighborhoods.

- Creating or improving access to places for physical activity can result in a 25% increase in number of people who exercise at least 3 times per week.
Some Contributing Factors to the Obesity Epidemic in Adolescents – Unhealthy Eating/Drinking

- Eating more food prepared away from home
- Portion Sizes are increasing
- Increased Sugar Sweetened Beverage Consumption
- Food Marketing to Children
- Environments where healthy food is not accessible/affordable
• In Nevada, 30% of high school students ate fruit or drank 100% fruit juice two or more times per day

• 12% of Nevada high school students ate vegetables 3 or more times per day

• 16% of Nevada high school students drank soda or pop one or more times per day and 10% drank soda or pop two or more times per day
Less Eating in and More Eating Out

- Adolescents and their families eat more food prepared away from home than in the past.
- When people eat outside the home, they consume more total calories per eating occasion than they do at home, and a higher proportion of those calories comes from saturated fats.
- Empty calories from added sugars and solid fats contribute to 40% of daily calories for children and adolescents aged 2–18 years, affecting the overall quality of their diets.
- Approximately half of these empty calories come from six sources:
  - Soda
  - Fruit drinks
  - Dairy desserts
  - Grain desserts
  - Pizza, and
  - Whole milk.
Restaurant Meals

• Children get about 25% of calories from fast-food and other restaurants
• The majority of kids’ meals—97%—are unhealthy. Over three-quarters of top chains offer sugary drinks with kids’ meals
• Studies show little progress improving the nutritional quality of kids’ meals:
  • In 2012—only 3% of kids’ meals met expert nutrition standards—up from 1% in 2008
PORTION DISTORTION

• A portion is the amount of food you choose to eat for a meal or snack
• A serving is a measured amount of food or drink
• Growing portion sizes are changing what we think of as a ‘normal’ portion
• The average restaurant meal is more than four times larger than in the 1960s
• Larger portions are leading to larger waist sizes
• Adults consume approximately 300 more calories per day than they did in 1985
THE NEW (AB)NORMAL

Portion sizes have been growing. So have we. The average restaurant meal today is more than four times larger than in the 1950s. And adults are, on average, 26 pounds heavier. If we want to eat healthy, there are things we can do for ourselves and our community: Order the smaller meals on the menu, split a meal with a friend, or, eat half and take the rest home. We can also ask the managers at our favorite restaurants to offer smaller meals.

FOR MORE INFORMATION, VISIT MakingHealthEasier.org/TimeToScaleBack

SOURCES
Sugar Sweetened Beverage Consumption

• Sugary drinks (sugar sweetened beverages) are beverages that are sweetened with naturally-derived caloric sweeteners such as sucrose (table sugar) or high fructose corn syrup
• Major source of calories and very little if any nutrients
• Regular soda, fruit drinks and energy drinks continue to have the highest median sugar content at 24-29 grams per 8-oz serving
• Sugar sweetened beverages are the largest source of sugar in a child’s diet contributing an average of 300 calories/day; 109,500/year or the equivalent of 31 pounds per year
• In one study, sugar sweetened beverages made up nearly 11% of children’s total caloric consumption
Sources of added sugars of children/adolescents ages 2-18: 2009-2010

- Sugary drinks: 49%
- Grain desserts: 18%
- Sweet snacks, candies: 16%
- RTE cereals: 9%
- Dairy desserts: 8%
Food and Beverage Marketing
IT’S NOTHING NEW
It used to look like this
Now it looks more like this
Annual expenditures in millions spent marketing food/beverages to youth

- Fast-food/restaurant foods: $714.3
- Carbonated beverages: $395.1
- Cereal: $186.1
- Other: $161.3
- Snack Foods: $123.3
- Juice & Non-carbonated beverages: $121.2
- Candy/Frozen Desserts: $79.0
- Fruits & Vegetables: $7.2
Annual marketing expenditures to youth by source (millions)
• On television alone, the average US teen sees approximately 16 food commercials each day; 5,900 a year
• Preschoolers see over 1,000 fast food ads on television a year (almost 3 a day)
• Food products most advertised include high-sugar breakfast cereals, fast food, candy, and sugary drinks
• In comparison, kids see about one ad per week for healthy foods such as fruits and veggies and bottled water
• Food and beverage companies have explicitly identified multicultural youth as prime targets for their growth strategies and have focused on sponsorships of events and celebrities that attract multicultural audiences
• Sugary drink beverage advertising on Spanish-language TV increased by 44% since 2012
Case Study: Children’s Food and Beverage Advertising Initiative (CFBAI)

• The Children's Food and Beverage Advertising Initiative established in 2006 by 10 leading US Food Companies
• Agreed to self-regulate child-directed advertising
• Shift advertising to children towards healthier foods and beverages
• Restrict use of licensed characters, celebrities, movie tie-ins and games
• Prohibits product placement in food advertising to children and marketing in elementary schools
CFBAI Case Study (continued)

- Voluntary
- Applies to children aged 12 years or under
- Applies to media with an audience share of 35% or more children.
- Allows for circumventing though advertising strategies that integrate promotions across multiple channels such as mobile apps, advergames, and Facebook
- Excludes premium offers (free toy or gift with fast food meal)
- Excludes product packaging and labeling, in-store promotions, product displays and forms of promotion in and around fast food restaurants
- Nutrition standards are considered weak allowing companies to advertise products such as Coco-Pops, Chocolate Lucky Charms and Hershey’s Cookies and Cream cereals
- Companies can circumvent nutrition standards through brand promotion (promoting their brand versus a specific food)
From CFBAI to the Interagency Working Group on Marketing to Children

• In 2009 following concerns about the CFBAI, the US Congress directed the government to convene an Interagency Working Group on Marketing to Children

• Representatives from 4 government agencies

• Goal was to develop uniform standards for the nutritional quality of food advertised to children that the food industry would voluntarily adopt for use in the CFBAI

• Worked for many months to come up with evidence based standards
The result...

- During congressional hearings, some members of congress and the food industry argued the standards were quasi-regulatory and infringed on first amendment rights.
- Food industry spent $6.6 million lobbying against the standards during the first quarter of 2011 and announced it would adopt its own (weaker) nutrition criteria which would do away with the need for the Working Group’s tougher standards.
- Working group did revise its standards but then Congress required the standards to undergo a cost-benefit analysis (a measure usually applied only to mandatory regulation).
- This month, a national panel of experts convened by RWJF will release ‘Expert Recommendations for Responsible Food Marketing to Children’ a comprehensive set of model definitions for food marketing practices directed at children.
- Self regulation has resulted in some declines in unhealthy food marketing to children, but there needs to be consistency in terms and definitions.
- Time will tell.....
Environments where healthy food is unavailable and/or unaffordable

• Prices for low-nutrient energy-dense foods/beverages have declined sharply. At the same time, prices for more nutritious foods have increased
  • Limited access to supermarkets and healthy foods
    • In one study, the presence of each additional supermarket was linked to a 32% increase in fruit and vegetable consumption and this number was higher for Latinos
    • In the same study, presence of a convenience store in the neighborhood was associated with fewer daily fruit and vegetable servings among Latinos than African Americans
  • In many neighborhoods the only food retail outlets are fast food and convenience stores
What are we doing about it?
“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”

- Institute of Medicine
Guiding Principles

• Assessing environments and making changes to ensure that the healthy choice is the easy, default, and affordable choice.

• Everyone should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of where they live, their income, education, or racial or ethnic background.

• The opportunity for health begins in our families, neighborhoods, schools, worksites, places of faith, and community
Strategies to Address Obesity Among Adolescents

• Federal Initiatives
  – Healthy Hunger Free Kids Act
  – School Wellness Policies (Federal, State and Local)
  – Affordable Care Act (Menu Labeling)
  – Updating CACFP nutrition standards (proposed rule just released*)

• State Initiatives
  – Nevada 2015 Legislative Session
  – Nevada State Health Division

• Local Initiatives and Resources
Healthy, Hunger-Free Kids Act (2010):

- Included several provisions aimed at improving the quality of school lunch and breakfast
  - Updated nutrition standards for school meals for the first time in more than a decade
  - Updated nutrition standards for school snacks and drinks for the first time in more than 30 years (competitive foods) – Smart Snack Guidelines
  - Phased in implementation starting with the beginning of the 2012-2013 school year
  - Increased the amount of fruits and vegetables served, emphasizes whole grain-rich foods, requires only lower fat and nonfat milk, sets calorie ranges, and reduces saturated fat and sodium
  - “Offer vs. Serve” as recommended by IOM
  - Improved cultural food options, such as allowing tofu to qualify as a meat/meat alternate
Why are school foods/meals important?

- Lots of kids eat school meals/foods
- Kids consume 50% of their daily calories at school
- Kids eat less lunch, consume more fat and take in fewer nutrients when schools sell unhealthy snacks and drinks outside of meals
- More than 90% of LEAs report meeting the new requirements
- Kids are eating more fruits and vegetables as a result of the updated standards
• School Wellness Policies
  – All LEAs that participate in the National School Lunch Program or other federal Child Nutrition program is required to establish a local school wellness policy for all schools under its jurisdiction
  – As of the 2006-2007 school year, all districts were required to establish a policy
  – For school year 2013-2014, HHFK Act encouraged LEAs to review, assess, and update their policies to include new requirements. Intent was to strengthen school wellness policies
Nevada School Wellness Policy

• Broad group of stakeholders convened to revise the NV School Wellness Policy in 2014 to reflect USDA’s Smart Snacks Nutrition Standards (HHFKA)
• Implementation manual to assist districts with implementation
• Standards apply during school day (midnight to 30 minutes past school dismissal bell)
  – Schools are encouraged not to use food/beverages as incentives. If they are used, they must meet Smart Snacks Nutrition Standards
  – Opportunities must be provided for 30 minutes of MVPA daily in at least 10 minute increments
  – Food/beverage marketing is limited only to products that meet Smart Snack standards
  – Local districts are required to identify a School Wellness Coordinator to ensure communication with schools, parents, teachers and administrators and complete required reports
  – Local districts are required to establish a wellness committee and develop 3 specific annual goals for schools in the district
Smart Snacks Nutrition Standards

Any food sold in school must:
- Be a ‘whole grain-rich’ grain product; or
- Have as the first ingredient a fruit, vegetable, dairy product or protein; or
- Be a combination food that contains at least ¼ c. fruit and/or vegetable
- Contain 10% of the DV of one of the nutrients of public health concern in the 2010 Dietary Guidelines (calcium, potassium, vitamin D, or dietary fiber)

- Beverage serving size limitations
- Calorie recommendations now included for entrée and snack/side items
- Sodium, Fat and Sugar limits that reflect USDA guidelines
- Schools can sell plain water, unflavored low fat milk, unflavored or flavored fat free milk (or milk alternative approved by NSLP)
- 100% fruit or vegetable juice or 100% fruit or vegetable juice diluted with water (no carbonation or added sweeteners)
- Additional ‘no calorie’ and ‘lower calorie’ beverage options for high school
- No carbonation (Nevada standard)
Affordable Care Act: Menu Labeling

• Final rule issued in 2014
• Require certain chain restaurants and similar food retail outlets to list calorie content information for certain/standard menu items and a succinct statement concerning suggested daily caloric intake on menus and menu boards
  - Chain of 20 or more locations doing business under the same name, selling the same products
    • Sit down and drive-through restaurants
    • Take out food (pizza)
    • Grocery store deli
    • Self-serve foods from hot/cold food bar
    • Bakery/coffee shops
    • Movie theaters
    • Vending machines (operators who own/operate 20+ machines)
• Restaurants must be in compliance by 12/15; 12/16 for vending
• Some evidence that menu labeling can impact choices
State Issues

State Projects:
Promoting use of best practices for obesity prevention in Early Care and Education (ECE), Schools, and Worksites:

• Providing training and technical assistance to ECE staff and providers on nutrition standards, physical activity, breastfeeding support and decreased screen/media time

• Providing professional development opportunities for K-12 school staff and administrators on nutrition and physical education/physical activity

• Developing and implementing worksite wellness policies relating to nutrition, physical activity and health promotion opportunities

• For more information contact: Jessica Lamb at jalamb@health.nv.gov

2015 Legislative Session

• Potential Issues (BMI Screening, PA/Nutrition Standards for Child Care Settings, Encourage PA in Schools)

• Children’s Health Week at the Legislature: March 9-12, 2015
  - Will have a focus on obesity on March 10th
  - For more info visit: www.nic.unlv.edu or www.caanv.org
Local Initiatives (Southern Nevada)

• **Partnerships to increase physical activity/healthy eating in after-school programs**
  - Implemented evidence-based PA/nutrition curriculum in Safe Key & after school programs in Henderson, North Las Vegas, Boulder City, Las Vegas and YMCA

• **Partnerships to increase physical activity/healthy eating in early child care**
  - Implemented evidence-based PA/nutrition curriculum in child care settings; assisted with development of voluntary site-based policies. Children’s Advocacy Alliance, state stakeholder group now leading efforts to improve PA/Nut standards

• **Partnerships to increase access to and usability of local trails and park paths**
  - Supported implementation distance and way-finding signage on 88 miles of local trails
  - Neon to Nature website and mobile app (www.gethealthyclarkcounty.org)

• **Partnerships to improve community design to support active transport**
  - Supported development of RTC’s Complete Streets Policy and will be working with City of North Las Vegas on development of a Complete Streets Policy
  - Supported instillation of over 25 miles of bike lanes

• **Partnerships to support healthy vending**
  - Working with local partners to implement healthy vending policies and practices
  - Sugar Savvy Beverage mobile app (www.gethealthyclarkcounty.org)

• **Farmers’ Markets**
  - Helping promote farmers’ markets and ensure that they accept SNAP/EBT benefits
Local Initiatives: Northern Nevada (WCHD)

- Partnering to promote voluntary wellness policies with childcare providers
- Promotion of voluntary wellness policies with out-of-school time providers (before and after school). Providing TA and incentives for play equipment
- Work with WCSD to analyze the height and weight data (BMI). Data made available to the community
- Voluntary menu labeling program
- Chronic Disease Report Card, including data on physical activity, nutrition, overweight and obesity (last report card was released July 2014)
- Partnership on statewide efforts to promote breastfeeding (Breastfeeding Welcomed Here campaign)
- Participation with the WCSD on implementation of their student wellness policy
- GetHealthyWashoe.com website (resources and additional information)

- For more information contact, Kelli Goatley-Seals at Kseals@washoecounty.us or 775-328-6160
Southern Nevada Local Initiatives and Resources

• Partners for a Healthy Nevada (PHN) coalition
  - Access to a diverse group of partners that address obesity-related issues
  - Quarterly face to face meetings, obesity and advocacy updates
  - Contact me (bungum@snhdmail.org) to be added to e-mail distribution list

• CCSD Safe Routes to School Program: Sherie Moore at: skmoore@interact.ccsd.net
• CCSD Wellness Coordinator: Shannon LaNeve: slaneve@interact.ccsd.net (PD trainings for activity breaks, etc.)

• Get Healthy Website (www.gethealthyclarkcounty.org or www.vivasaludable.org)
  - Resources, lesson plans, programs and activities for teachers, parents, health care providers
  - Healthy Meeting Guides
  - Healthy Vending Toolkit
  - Worksite Wellness Toolkits
  - Free mobile apps (Neon to Nature, SSB, more soon!)
  - Community Calendar
  - Free physical activity and nutrition on-line programs (Walk Around Nevada, Nutrition Challenge, 10 in 10 Program)

• Washoe County: GetHealthyWashoe.com
• State: nevadawellness.org
Advocacy and Engagement Opportunities:

• School Lunch Standards
  - Appropriations for FY 15 “Cromnibus”
  - Was language that would have waived all school meal standards, but advocates worked to minimize changes to modest exemptions for whole grains/sodium
  - Appetite to roll back school food lunch standards. Child Nutrition Programs set for reauthorization in 2015 so school nutrition standards will be a target again.

• Nevada Legislative Session
  - PHN Advocacy Updates
School Wellness Policy

- Public Comment Website
  www.nutrition.nv.gov/Programs/Wellness/Comments
  - Public/Parents can access their school’s compliance with the policy and submit comments
  - Smart Snack Approved List:
    http://nutrition.nv.gov/Programs/Wellness
  - Alliance for Healthier Generation Smart Snack Calculator: https://www.healthiergeneration.org

- CCSD Wellness Regulation
  - Drafted and going through review process
  - Tentatively scheduled for public comment in spring 2015
  - Opportunities for advocates to voice support for strong school wellness policies in our schools
Advocacy Resources

- PHN Advocacy Training (Feb. 20th) – Contact me for more information
- Advocacy resources on PHN webpage (data, white paper, legislative session information): www.gethealthyclarkcounty.org/phn
- Children’s Advocacy Alliance & Nevada Institute for Children’s Research and Policy (www.caanv.org or www.nic.unlv.edu
  - 2015 Legislative Briefing Book
  - 2014 Nevada Children’s Report Card
- We’re all advocates! Speak up and support issues and causes that are important to you.
“We think that today’s younger generation will have shorter and less healthy lives than their parents for the first time in modern history unless we intervene.”

- Dr. S. Jay Olshansky
References
(Separate Handout)
Thank You!

Contact Information

Nicole W. Bungum
Office of Chronic Disease Prevention & Health Promotion
Southern Nevada Health District
bungum@snhdmail.org
759-1270
www.gethealthyclarkcounty.org
www.vivasaludable.org