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Details:

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10

(session year)

Senate

(Assembly, Senate or Joint)

Committee on ... Education (SC-Ed)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

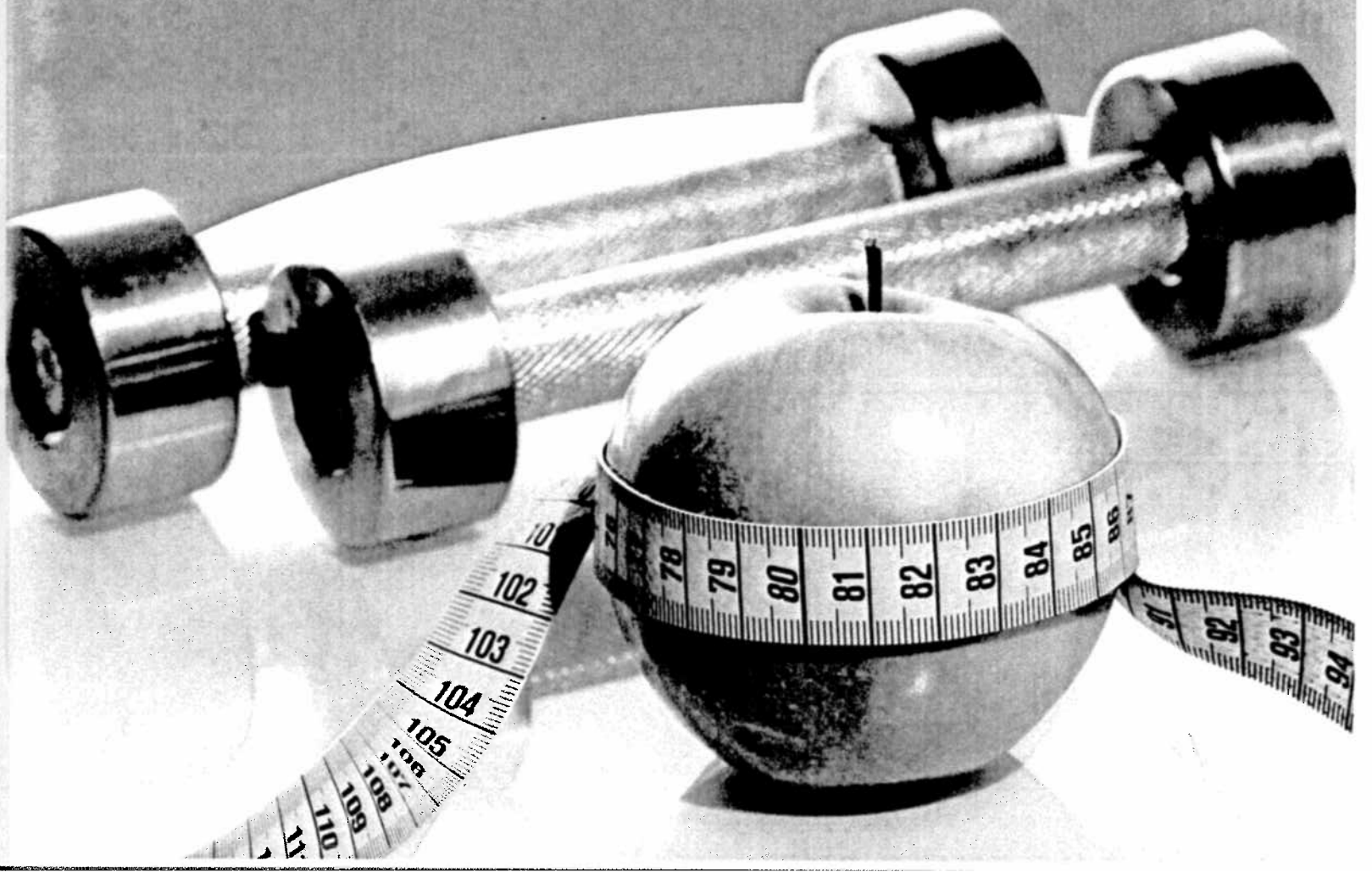
- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Gigi Godwin (LRB) (August/2011)

Obesity, Nutrition, and Physical Activity in Wisconsin

Wisconsin Department of Health Services | Division of Public Health | Nutrition, Physical Activity, and Obesity Program
and Wisconsin Partnership for Activity and Nutrition 2008

Executive Summary



The Problem of Overweight and Obesity in Wisconsin

Overweight and Obesity Pose a Significant Health Threat to Wisconsin Residents

Did you know that...

Wisconsin's obesity rate ranked 16th highest in the country in 2006.

- Since 1990, the obesity rate for adults has more than doubled.
- Nearly 27% of adults are obese and about 65% are overweight or obese.
- 46% of women participating in the Wisconsin Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are either overweight or obese prior to pregnancy.

Obesity in adults is associated with many chronic diseases and poor health outcomes.

- Obesity is a risk factor for type 2 diabetes, cardiovascular disease, certain cancers, asthma, arthritis, high blood pressure, high cholesterol levels, and depression.
- Obesity is related to poor reproductive outcomes, including infertility, hypertension or diabetes during pregnancy, cesarean birth, birth trauma, and stillbirth.

Obesity is placing an economic strain on the healthcare system.

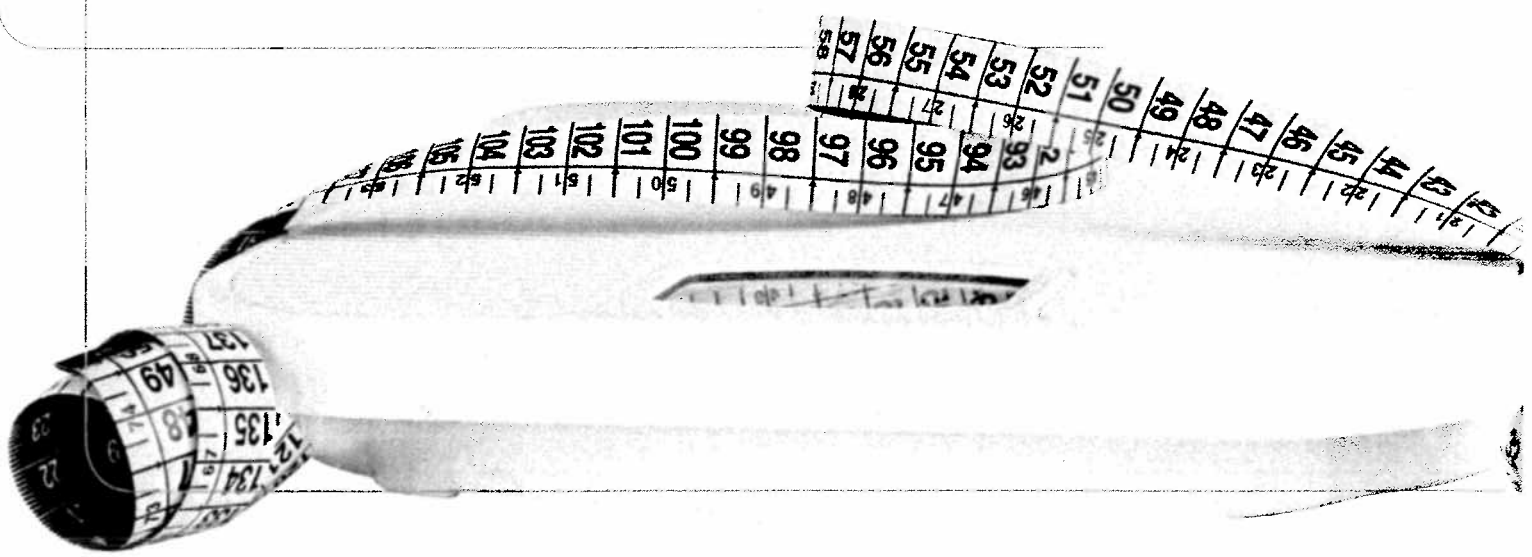
- The annual economic cost of obesity-related medical expenses for Wisconsin is estimated at more than $1.5 billion annually.

Many Wisconsin children and adolescents are also affected by overweight or obesity.

- One in four Wisconsin high school students are overweight or obese.
- 29% of the two- through four-year-old children participating in the WIC Program are overweight or obese.

Children and adolescents are increasingly being diagnosed with adult illnesses.

- Obese youth are more likely to have sleep apnea, asthma and orthopedic problems.
- More than half of obese children in elementary school have at least one risk factor for cardiovascular disease, and a quarter have at least two risk factors.
- Of the children who are obese at ages 3-4 years, 20-40% are destined to be obese as adults.
- About 60% of obese adolescents will be obese as adults.
- Unless the obesity epidemic can be curbed, today's children are likely to have a shorter life expectancy than their parents do.



Remedying the Obesity Problem in Wisconsin Will Require Effort and Commitment by Communities, Organizations, and Individuals Across the State

There is a crucial need for strategic action at both the state and local levels to counter the obesity problem in Wisconsin and thus greatly improve the health and well-being of its residents.

Become part of the solution

Successfully reversing obesity rates in Wisconsin will require the active involvement of numerous partners across the state: individuals, schools, early childhood education and care organizations, workplaces, restaurants and grocery stores, food producers and vendors, healthcare systems and providers, media, community-based and faith-based organizations, policymakers, state and local governments, and other groups.

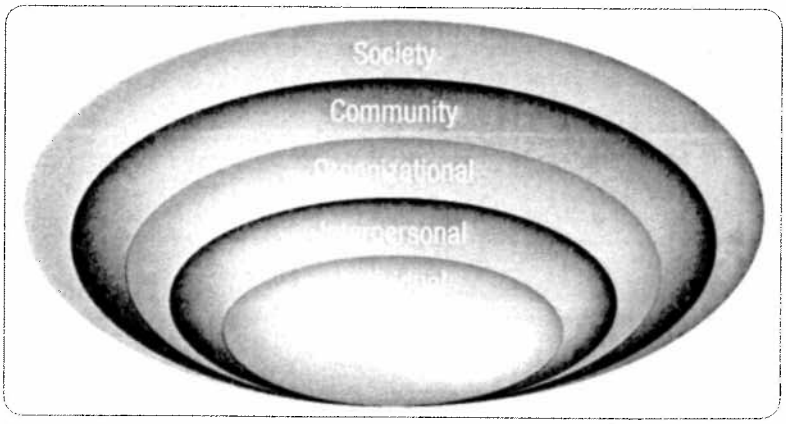
- Join local efforts to fight obesity by contacting your local public health department and asking whether or not a local coalition is already working on this issue in your area. If not, think about starting one.
- Participate in ongoing coordinated statewide activities to address the obesity issue by joining the Wisconsin Partnership for Activity and Nutrition.
- Take advantage of the resources and technical assistance provided by the Nutrition, Physical Activity, and Obesity Program of the Wisconsin Department of Health Services (available at: http://dhs.wisconsin.gov/health/physicalactivity/).

Implement the Wisconsin Nutrition and Physical Activity State Plan

The Wisconsin Nutrition and Physical Activity State Plan is a framework to improve nutrition, increase physical activity, and decrease obesity in Wisconsin (available at the above website).

Work to create environments that support healthy behaviors and prevent obesity

Healthful eating, being physically active, and achieving and maintaining a healthy weight are not solely an individual responsibility. It is also the responsibility of families, organizations, communities, and society to help change the environments in which people live, work, and play in ways that encourage good health. (The many layers of influence on health-related behaviors are shown on the right.) Environmental and policy changes are those most likely to reach the largest number of people and have the greatest impact on individual behavior. Key behaviors that ultimately need to change to reduce the burden of obesity in Wisconsin include: being physically active, eating fruits and vegetables, breastfeeding, limiting the consumption of sweetened beverages and high energy dense foods, and restricting television viewing time.



Learn more...

- To participate in obesity prevention and control efforts in keeping with the Wisconsin Nutrition and Physical Activity State Plan and to obtain resources for doing so, please visit our website at http://dhs.wisconsin.gov/health/physicalactivity/.
- For additional information about the obesity problem in Wisconsin, please read this important new report, Obesity, Nutrition, and Physical Activity in Wisconsin, also available on our website.

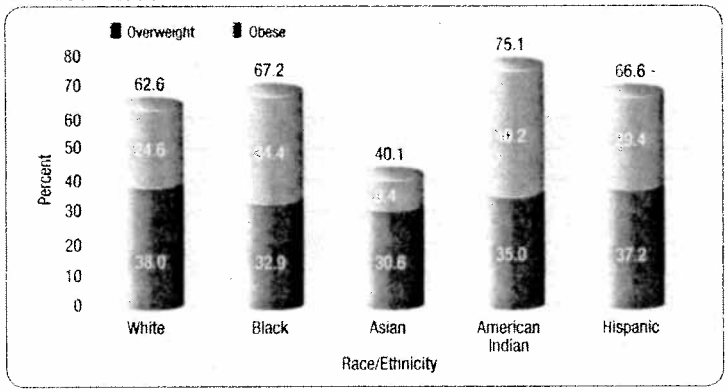
The Burden of Overweight and Obesity in Wisconsin is Not Shared Equally Among Its Residents or Communities

Notable differences in the rates of overweight and obesity are apparent by age, sex, racial or ethnic group, socioeconomic status, and location.

Adults:

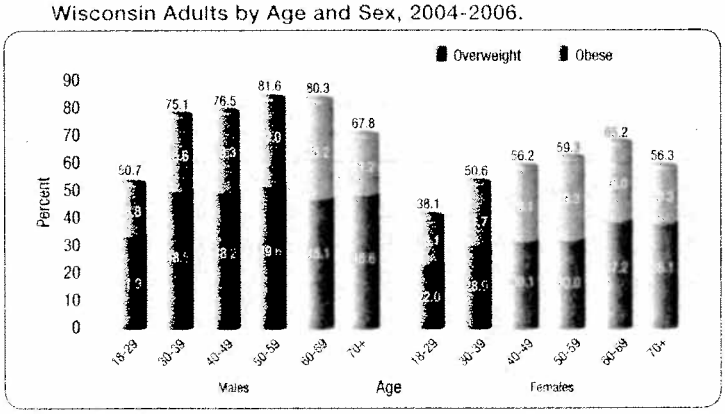
- Asians have a low obesity rate, relative to rates for all other racial or ethnic groups.
- Compared with females, males are about a third more likely to be either overweight or obese.
- For males, American Indians have a high obesity rate, relative to the rates for Whites, Blacks, and Hispanics.
- For females, American Indians, Blacks, and Hispanics have higher obesity rates, relative to the rate for Whites.
- About 45% of adults under the age of 30 are already either overweight or obese.
- For adults in their fifties and sixties, about 13 in 20 females and 16 in 20 males are either overweight or obese.
- Adults with a household income of less than $15,000/year have an obesity rate of 34%, while those earning at least $50,000 have a rate of 24%.
- Between half and three-quarters of adults in each county are either overweight or obese.

Prevalence of Overweight, Obesity, and Total Overweight (Overweight or Obesity) for Wisconsin Adults by Race/Ethnicity, 2004-2006.



Data source: 2004-2006 Behavioral Risk Factor Surveillance System, Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health Services.

Prevalence of Overweight, Obesity, and Total Overweight for Wisconsin Adults by Age and Sex, 2004-2006.

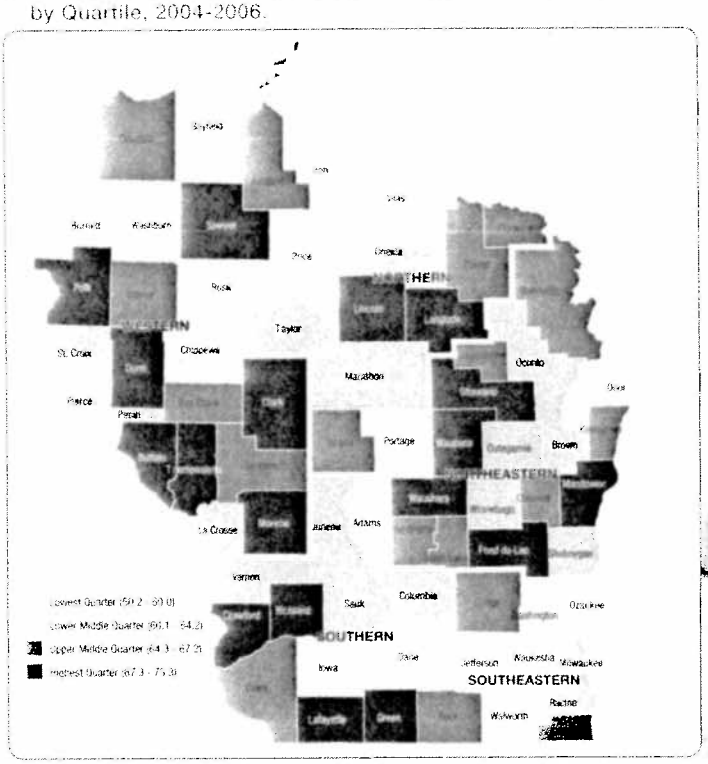


Data source: 2004-2006 Behavioral Risk Factor Surveillance System, Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health Services.

Children and Adolescents:

- The percentage of overweight or obese high schools students is 25% for Wisconsin and 37% for the Milwaukee Public School District.
- Male high school students have an obesity rate that is more than twice that of their female counterparts.
- For high school students, 24% of Black females are overweight or obese, compared with 18% of White females.
- 43% of the two- through four-year-old American Indian children participating in the WIC Program are overweight or obese. This value compares with a rate of 37% for Hispanics, 31% for Asians, 27% for Whites, and 24% for Blacks.
- The percentage of two- through four-year-old children participating in the WIC Program who are either overweight or obese varies three-fold by county, from 15% to 46%.

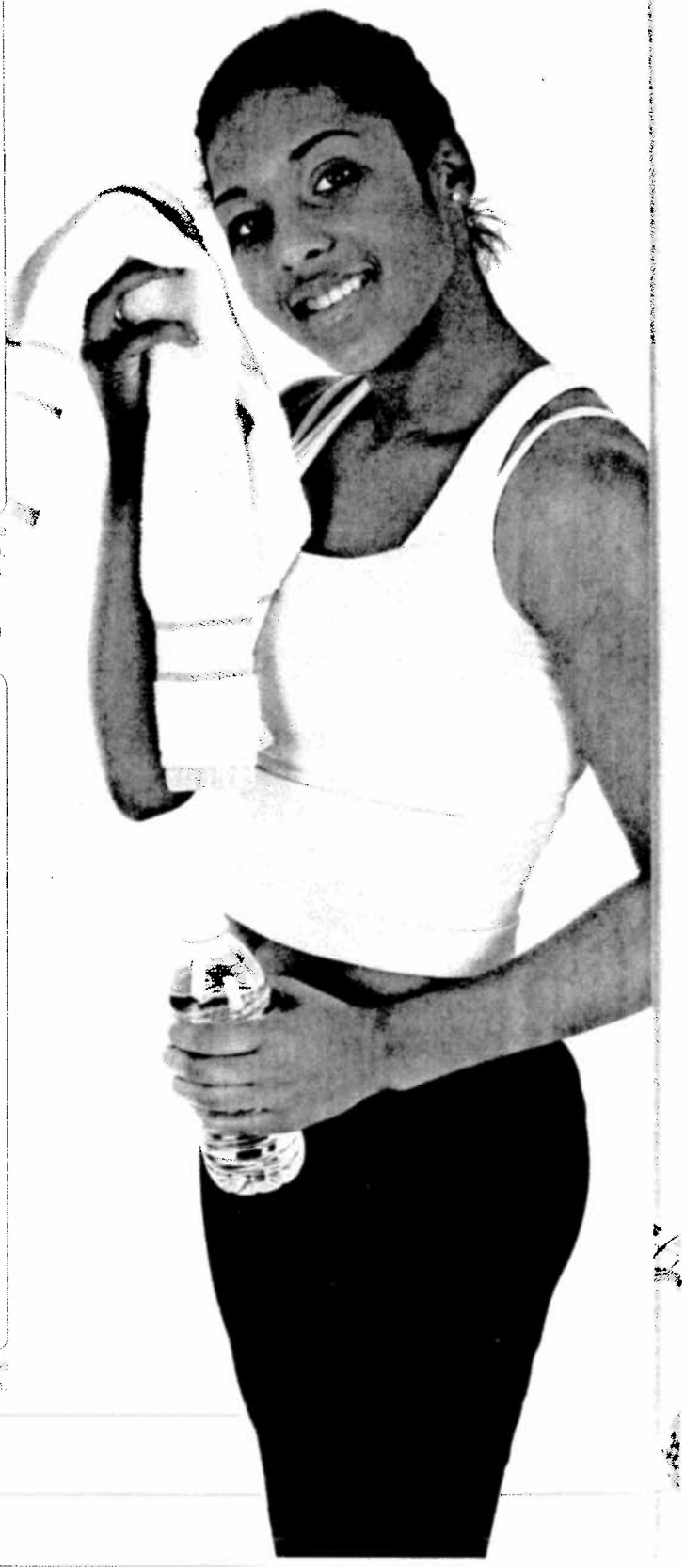
Adult Total Overweight Prevalence for Wisconsin Counties by Quartile, 2004-2006.



Data source: 2004-2006 Behavioral Risk Factor Surveillance System. Values were provided by the Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health Services.

Total Overweight Prevalence in Wisconsin Counties by Quartile for Children, Aged Two Through Four, Participating in the Wisconsin WIC Program, 2004-2006.

Data source: 2004-2006 Pediatric Nutrition Surveillance System, Centers for Disease Control and Prevention.



Wisconsin Nutrition, Physical Activity, and Obesity Program

The Wisconsin Nutrition, Physical Activity, and Obesity Program (NPAO) is one of 23 state programs awarded a five-year (2008-2013) cooperative agreement from the Centers for Disease Control and Prevention (CDC). The purpose of the cooperative agreement is to improve healthful eating and physical activity to prevent and control obesity and other chronic diseases. This is to be done by building and sustaining statewide capacity to address the issue in the population and by implementing relevant strategies and interventions. A few of the resources developed by the NPAO Program and its partners for these purposes (available at: http://dhs.wisconsin.gov/health/physicalactivity) include:

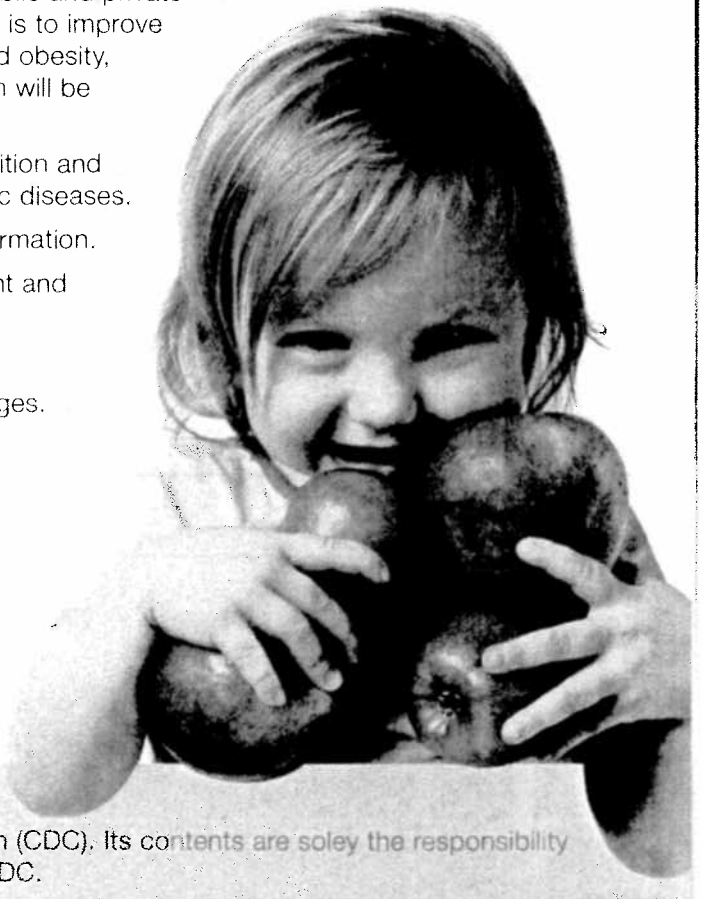
- Summary sheets containing evidence-based strategies within specific settings: What Works in Schools, Worksites, or Healthcare
- Wisconsin Worksite Wellness Resource Kit
- Got Dirt? Gardening Initiative Toolkit
- Active Community Environments Resource Kit
- Ten Steps to Breastfeeding Friendly Child Care Centers Resource Kit
- Improving Access to Fruits and Vegetables Resource Kit
- Governor's School Health Award and Worksite Wellness Award

Wisconsin Partnership for Activity and Nutrition

The Wisconsin Partnership for Activity and Nutrition (WI PAN) developed and is implementing the Wisconsin Nutrition and Physical Activity State Plan. WIPAN is comprised of over 200 members representing a variety of public and private organizations, programs, and coalitions. The mission of WIPAN is to improve the health of Wisconsin residents by decreasing overweight and obesity, improving nutrition and increasing physical activity. This mission will be accomplished by:

- Planning, implementing and evaluating a state plan for nutrition and physical activity to prevent and manage obesity and chronic diseases.
- Serving as a resource for nutrition and physical activity information.
- Coordinating nutrition and physical activity efforts to prevent and manage obesity and chronic diseases.
- Advocating for public health policy change at all levels.
- Encouraging individual and population based lifestyle changes.

For more information:
Department of Health Services
Division of Public Health
Nutrition, Physical Activity, and Obesity Program
PO Box 2659
Madison, WI 53701-2659
Phone: 608-267-3694 E-mail: Mary.Pesik@wisconsin.gov
http://dhs.wisconsin.gov/health/physicalactivity



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P-00009 (12/08)

Physical Fitness Assessments in Schools

Wisconsin Kids Aren't Physically Active

- Only half of Wisconsin high school students met the minimum physical activity requirement of 60 minutes per day. [1]
- Physical inactivity is a major cause of obesity and obese children are much more likely to become obese adults.
- 23% of WI high school students are already overweight or obese. [1]

Inaction is Costly

- Obesity is a leading cause of many chronic diseases.
- The estimated health care cost attributable to obesity in WI adults is $1.5 billion. [2]
- If the obesity rate in WI continues to climb at its current rate, costs are projected to quadruple within the next decade. [3]

Wisconsin Needs a Physical Fitness Assessment

- To provide high quality, cost effective physical education.
- To improve academic performance. Fit students do better academically.
- To strengthen parent/school partnership in promoting children's health.
- To collect statewide data to inform policies and programs to improve children's health.

It Can Be Done in Wisconsin

- A good fitness test already exists (Fitnessgram).
- Many Wisconsin schools (39%) are already doing fitness testing using Fitnessgram . [4]
- Fitness testing is already being done in over 25% of other states.

Now is the Time

"Because of the increasing rates of obesity, unhealthy eating habits, and physical inactivity, we may see the first generation that will be less healthy and have a shorter life expectancy than their parents." [5]

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[1] 2009 Youth Risk Behavior Surveillance Survey (YRBSS)

[2] Finkelstein, EA, Fiebelkorn, IC, Wang, G. National medical spending attributable to overweight and obesity: How much, and who's paying? *Health Affairs* 2003;W3;219–226.

[3] United Health Foundation, American Public Health Association, & Partnership for Prevention (2009). The future costs of obesity: National and state estimates of the impact of obesity on direct health care expenses. Available at: http://www.americashealthrankings.org/2009/report/Cost%20Obesity%20Report-final.pdf.

[4] WI PE Survey results 2007

[5] Surgeon General Richard H. Carmona, MD: Testimony to US Senate, March 2, 2004

Physical Fitness Assessments in Schools
Talking Points and Background Information

Wisconsin Kids Aren't Physically Active

- **Only half of Wisconsin high school students met the minimum physical activity recommendation of 60 minutes per day.** [1] (moderately active for a total of at least 60 minutes per day on five the last 7 days).
- **Physical inactivity is a major cause of obesity and obese children are much more likely to become obese adults.** Since obese children are more likely to become obese adults, intervening early will help with long term costs.
- **23% of WI high school students are already overweight or obese.** [1] (overweight (14%) , obese (9%)

Inaction is Costly

- **Obesity is a leading cause of many chronic diseases.**
- **The estimated health care cost attributable to obesity in WI adults is $1.5 billion.** [2] Since obese children are more likely to become obese adults, intervening early will help with long term costs.
- **If the obesity rate in WI continues to climb at its current rate, costs are projected to quadruple within the next decade.** [3]

Wisconsin Needs a Physical Fitness Assessment

- **To provide high quality, cost effective physical education.**
  Schools can use the results to tailor their physical education programs. Schools will have access to regular assessment of their pupils' physical fitness and can use this data to best plan curriculum and structure physical activity for their student populations. Schools may also be able to use the results to seek funding for health related programming or resources.
- **To improve academic performance. Fit students do better academically.**

  Results from two major 2009 studies of more than 2.4 million public school students in Texas and 1.1 million students within the New York City Department of Education show an association between higher physical fitness scores and higher academic test scores among students.
- **To strengthen parent/school partnership in promoting children's health.**

  Individual pupil data will be shared with parents, facilitating better school-parent communication and allowing parents to react as appropriate in addressing any concerns regarding child's fitness capacity/ability and provides an opportunity for early intervention in obesity prevention. Only aggregate data will be sent to DPI.

  School-based BMI assessment programs used for individual health screening purposes are not recommended unless there is careful consideration of privacy issues, adequate training, measurement techniques, parental notification, adequate evaluation, and the importance of linking families/caregivers with resources in the community.
  To reduce the risk of harming students, BMI measurement programs should adhere to the following safeguards:

  (1) Introduce the program to school staff and community members and obtain parental consent,
  (2) Train staff in administering the program (ideally, implementation will be led by a highly qualified staff member, such as the school nurse),

(3) Establish safeguards to protect student privacy,
(4) Obtain and use accurate equipment,
(5) Accurately calculate and interpret the data,
(6) Develop efficient data collection procedures,
(7) Avoid using BMI results to evaluate student or teacher performance, and
(8) Regularly evaluate the program and its intended outcomes and unintended consequences.
http://www.cdc.gov/HealthyYouth/obesity/BMI/pdf/BMI_execsumm.pdf

- **To collect statewide data to inform policies and programs to improve children's health.**

The availability of this comprehensive, statewide data will fill a gap in current demographic and health data for school-aged children, therefore contributing to the public health evidence base and allowing public health practitioners and school administrators and staff to better design and implement prevention interventions. The existence of school- and district-specific data will allow for targeting of prevention programs and the best use of limited financial and personnel resources.

It Can Be Done in Wisconsin

- **A good fitness test already exists (Fitnessgram).**

Through DPI's three-year pilot project, the FitnessGram physical fitness test that was administered in volunteering middle schools was determined by the University of Wisconsin to be a good measure of fitness and a good indicator of diabetes risk. The cost of the software and materials is only about $300 per school. The cost for the "server version", which could be used in all the schools in a district is 1,500.

- **Many Wisconsin schools (39%) are already doing fitness testing using Fitnessgram .** [4]

A survey of Wisconsin schools done in 2006 and 2007 showed that 90% (2006) to 93% (2007) of schools were already doing fitness testing and many (47% 2006, 39% 2007) were already using FitnessGram.

- **Fitness testing is already being done in over 25% of other states.**

In 2000, 26 percent of states required schools to screen students for height and weight or body mass; of these, 61 percent required them to notify parents of the results. Among school districts, 38 percent required such screening, of which 81 percent required parental notification. Taking these measures annually and converting them to an age and gender-specific BMI percentile for each child makes it possible to monitor individual children over time. It also provides an opportunity for early intervention in obesity prevention.

A 2008 study by Morrow et al indicates that the prevalence of fitness test use is 65% across all school levels. Other information from state initiatives is summarized below:

In 2008, at least 8 states considered legislation related to student body mass index or fitness screening including Florida, Georgia (fitness screening), Maryland, Minnesota, New Jersey, New York, Oklahoma and Vermont. Of those states, New York made an appropriation of $1,980,000 for expenses related to reporting body mass index on school physical forms, and two states, Oklahoma and Vermont, passed legislation in 2008 that will require the development of student body mass index (BMI) screening tools. Oklahoma's requirement is part of a more comprehensive student fitness assessment. In addition, in 2008, Maryland legislators established a multi-disciplinary committee on childhood obesity to provide recommendations to the governor and the General Assembly on topics including methods to increase the rate of obesity screening for children.

As of December 2008, states that have required some type of student BMI reporting are Arkansas, California (pilot program for diabetes risk assessment that included BMI measurement was replaced by statewide distribution of diabetes risk information in 2008), Delaware (piloting BMI as part of student

fitness testing), Florida, Illinois, Iowa (pilot program to track student height and weight), Missouri (required aggregate screening results), New York (requires school entry health certificates to include information about the student's body mass index), Pennsylvania, South Carolina (phasing in student fitness testing), Tennessee, Texas (screening as part of a student risk assessment program for Type 2 diabetes in selected regions of the state) and West Virginia. Some of these state requirements are aggregate BMI data reporting requirements, rather than requirements for individual BMI reports to parents. The Arkansas, California, Delaware, Missouri, South Carolina, Tennessee and West Virginia requirements were enacted legislatively. In Pennsylvania and Florida, state health departments require measuring BMI as part of annual student growth screenings. In Arkansas, the first state to enact BMI legislation in Act 1220 of 2003, legislation was enacted in 2007 to change the frequency of BMI screening from annual to every other year and to allow parents to submit a written refusal for their child to participate in BMI screening to the child's school. California enacted legislation in 2003 (AB 766, Cal. Ed. Code §49452.6) that required non-invasive screening of 7th grade (female) and 8th grade (male) students for type 2 diabetes risk including measurement of body mass index as one of four diabetes risk factors and the pilot program was renewed to 2008 when it was replaced by statewide distribution of diabetes risk information.
http://www.ncsl.org/Default.aspx?TabId=13883#BMI

In **Arkansas**, HB 1173, enacted in 2007, changed student BMI screenings to every other year, beginning in kindergarten and then in even numbered grades. It permits any parent to refuse to have their child's body mass index percentile for age assessed and reported, by providing a written refusal to the school. This bill exempts students in grades 11 and 12 from BMI requirements. (The Arkansas Act 1220 of 2003 required annual body mass index (BMI) screenings for all public school students, with the results reported to parents confidentially by letter via U.S. mail, as part of a more comprehensive approach that halted the increase of childhood obesity in the state.) Community health nurses are all assigned under its supervision to work with schools to assure that body mass index for age assessment protocols are followed by school employees or their designees who conduct body mass index for age assessments and other student health screenings.

In 2007, a study showed that the percentage of Arkansas children who were overweight or at risk of becoming overweight was 37.5 percent, down from 38.1 percent in 2004. University figures from a later study showed that 68 percent of parents and 85 percent of students said they were comfortable with the reports. That survey also found that the percentage of students reporting being teased because of their weight was 6 percent, half what it was two years earlier. One physician said that 13 percent of the children who come to her fitness clinic do so after getting the obesity report cards from school.

In **California**, state law requires school districts to administer a physical fitness test, designated by the State Board of Education, to all fifth, seventh, and ninth graders annually. The physical fitness test designated for California public school students is the FITNESSGRAM®. Commencing July 1, 2010, statewide distribution of diabetes risk information to school children (California Education Code § 49452.7) will replace individual student BMI reports to parents via confidential letter as part of a non-invasive diabetes screening pilot program for 7th and 8th graders.

Delaware is piloting a new law that requires physical fitness testing for students and includes measuring BMI as part of the testing in some local school districts. The law, HB 372, enacted in 2006, requires the Department of Education to develop a regulation requiring each local school district and charter school to assess the physical fitness of each student at least once at the elementary, middle and high school level and outlining the grades at which the assessment will be given. The assessment results are to be provided to the parent, guardian, or relative caregiver. The intent is to provide baseline and periodic updates for each student and his or her parent, guardian or relative caregiver sharing in the knowledge of obesity and other chronic illnesses.

Florida Statute § 381.0056(5) requires school health services programs administered jointly by the Department of Health and the Department of Education to administer growth and development screening for students. BMI is encouraged as part of these screenings for all students in 1st, 3rd, 6th and, optionally, 9th grades.

Illinois Administrative Code, Title 77, Subchapter i, Part 665, §665.710 and §665.720 requires that the results of a diabetes screening, including body mass index as one indicator of whether a child is overweight, be documented on the certificate of child health examination form for the required school health examination.

Iowa's SB 2124, enacted in 2006, established a nutrition and physical activity community obesity prevention grant program, contingent upon the receipt of public health funding. Funding was allocated as of July 2006. Pilot program activities in six locations were selected to receive grants and must include measurement, reporting, and tracking of the height and weight of students in elementary schools.

Maryland passed Senate Bill 329 in 2006 which established a process for schools to measure the body mass index for age (BMI for age) of public school students in the first, third, fifth, and eighth grades and to notify parents of the results. Aggregate results are to be sent to the Maryland State Department of Education (MSDE), where they are to be compiled for an annual report.

Missouri's legislatively established Model School Wellness Program, funded by Child Nutrition and WIC Reauthorization federal grant money, created pilot programs in school districts encouraging students to avoid tobacco use, balance their diets, get regular exercise, and become familiar with chronic conditions resulting from being overweight. A required evaluation after the 2005-2006 school year was to include aggregate data on changes in body mass index and measurement of changing behaviors related to nutrition, physical activity and tobacco use. (HB 568T, enacted 2005)

New York's AB 4308 (same as SB 2108 C), enacted in 2007, requires school entry health certificates to include the student's body mass index and weight status category as defined by the commissioner of health. Also, New York's SB 6804 which was enacted in 2008 made an appropriation of $1,980,000 to pay for expenses related to reporting body mass index on school entry physical forms.

In **Oklahoma**, House Bill 1699 created the RIGHTTRACK Act authorizing school districts to implement programs identifying children at risk for poor nutrition. This act requires school districts to have teachers available to provide nutrition instruction, to have school staff and volunteers trained in measuring body mass index (BMI), and to complete a BMI for age annually for students enrolled in kindergarten through grade nine. The school districts must then provide a confidential health report to the parent or guardian and transmit test results to RIGHTTRACK Oversight Committee. Senate Bill 519, which was enacted in 2008, directs the state's departments of education and health to facilitate development of a physical fitness assessment software program customized for public schools with the capability to track the five components of student health-related physical fitness, including: 1. aerobic capacity; 2. muscular strength; 3. muscular endurance; 4. flexibility; and 5. a weight status assessment that includes measurement of height and weight, calculation of body mass index (BMI) for age, and plotting of these measures on standard growth charts. This requires the software program to have the capability of creating a confidential individual student report for parents that includes an explanation of the data. In addition, requires the software program to be developed and made accessible to school districts at no cost.

The **Pennsylvania** state health department requires school nurses to compute body mass index for students in grades one through eight during annual growth screenings. BMI measurements were required for students in all grades as of the 2007-2008 school year. Parents receive letters about the BMI results that encourage them to share the information with their family physician.

South Carolina's legislature passed the Student Health and Fitness Act (HB 3499) in the spring of 2005. Among other provisions related to student health, nutrition, physical education and fitness, the law requires all K-12 schools in the state to participate in the South Carolina Physical Education Assessment and requires that fitness reports be sent home to parents in the 5th and 8th grades and high school. Body mass index screening is not specifically mentioned in the legislation.

Tennessee legislation, HB 445, enacted 2005, now Public Chapter 194, requires reporting student BMI to parents as part of a confidential health report card. These reports provide parents with basic information about what BMI means and also explain what they can do with the information. This encourages schools where BMI data suggest high rates of overweight to expand or implement school-based nutrition and physical activity programs.

Texas's SB 415 (Chapter 95, HB1363-identical companion bill) was enacted in 2007 and established a student risk assessment program for type 2 diabetes in certain regions of the state that includes screening of body mass index for students identified by a noninvasive screening as at risk for type 2 diabetes.

In **Vermont**, HB 887, enacted in 2008, requires the commissioner of health, among other items, to develop a plan for promoting measurement and tracking of body mass index (BMI) percentile for children and adolescents, such as through the collection of data relating to BMI, lack of physical exercise, and inappropriate diet and eating habits using the ICD-9-DM V-codes in the ninth edition of International Classification of Disease Codes.

In **West Virginia**, the legislation establishes physical activity requirements in public schools using BMI as an indicator of progress and includes BMI measurement in kindergarten screening procedures. Students in grades four through eight and those in high school physical education undergo BMI measurement in required fitness testing procedures. The legislation protects student confidentiality and requires that all BMI data be reported in aggregate to the governor, the State Board of Education, the Healthy Lifestyles Coalition, and the Legislative Oversight Commission on Health and Human Resource Accountability. Senate Bill 785, which was enacted in 2006, amends the state's current BMI measurement policy by requiring that only a scientifically valid sample of students be assessed.

Pros:

- Through DPI's three-year pilot project, the FitnessGram physical fitness test that was administered in volunteering middle schools was determined by the University of Wisconsin to be a good measure of fitness and a good indicator of diabetes risk.
- Schools will have access to regular assessment of their pupils' physical fitness and can use this data to best plan curriculum and structure physical activity for their student populations.
- The availability of this comprehensive, statewide data will fill a gap in current demographic and health data for school-aged children, therefore contributing to the public health evidence base and allowing public health practitioners and school administrators and staff to better design and implement prevention interventions. The existence of school- and district-specific data will allow for targeting of prevention programs and the best use of limited financial and personnel resources.
- The cost of software is relatively low for schools ($300: 1 site only) or school districts ($1,500-multiple sites) and many already have the software (approximately 40%).
- Data collected may be used by individual schools or districts to seek funding for health related programming or resources.
- Individual pupil data will be shared with parents, facilitating better school-parent communication and allowing parents to react as appropriate in addressing any concerns regarding child's fitness capacity/ability.
- 9.2 million children and youth lack health insurance and, thus, likely do not get adequate medical care, making free, school-based prevention a critical option (Story p121).

- Story: "In 2000, 26 percent of states required schools to screen students for height and weight or body mass; of these, 61 percent required them to notify parents of the results. Among school districts, 38 percent required such screening, of which 81 percent required parental notification. Taking these measures annually and converting them to an age and gender-specific BMI percentile for each child makes it possible to monitor individual children over time. It also provides an opportunity for **early intervention in obesity prevention.**" (p111)
- The Robert Wood Johnson Foundation supported an independent evaluation of efforts to implement Arkansas Act 1220, which mandated a comprehensive approach to addressing childhood obesity in public schools. The Foundation also funded a separate initiative to analyze body mass index (BMI) data for all Arkansas public school students. Already, the BMI analysis has indicated that, in just three years, Arkansas has **halted the progression of the epidemic** in the state. Reports indicate that parents and adolescents are generally comfortable with the BMI assessment and reporting process. The evaluation also noted that no negative outcomes were found to be associated with the BMI assessment and reporting process.

Cons:

- Staff time is required on an annual basis to complete these assessments. Time and financial resources will be required for training. Although the software is only $300 per school site, there is a personnel cost for doing the administrative work of collecting the data and creating reports. Again, in many school districts, this is already being done.
- There will be financial and personnel costs at the Department of Public Instruction to collect and analyze the data at a central repository. That cost would be dependent on how automated the reporting process would be and amount and types of analysis that would be done with the data.
- A number of concerns have been expressed about school-based BMI screening programs, including that they might stigmatize students and lead to harmful behaviors. Other concerns are that these programs might be ineffective, waste scarce health promotion resources, and distract attention from other school-based obesity prevention activities. More research is needed to assess the validity of these concerns. http://www.cdc.gov/HealthyYouth/obesity/BMI/pdf/BMI_execsumm.pdf.

Summary & Preliminary Recommendation

Amend the bill to allow for sharing of data with the Department of Health Services to use for developing public policy and statewide interventions with the purpose of improving the health outcomes of children. The data from these tests should be de-identified and recorded as individual data for more accurate analysis by DPI and DHS.

In lines 14-17, an amendment should be added to include that the administrative rule also includes data collection and reporting. Administration and DPI should also collaborate with DHS on data collection.

The bill should specify use of all of the FitnessGram Software beyond aerobic capacity. Collection of height and weight, a quasi-situp abdominal strength test, a flexibility test, and an aerobic capacity test is ideal; however, *at minimum* the height, weight, and aerobic capacity results should be recorded. Page 3, Line 1 should specify that the assessment instrument include at a minimum the collection of height, weight and aerobic capacity.

SB 313: Effect on Existing State Law

This amendment will require public schools, charter schools, and private schools to ensure that physical fitness of pupils enrolled in grades 3 to 12 is assessed annually beginning 2010-11 school year. The assessment must include an evaluation of pupils' aerobic capacity based upon criterion – referenced standards that are specific to a pupil's age and gender and based on the physical fitness level required for good health.

Administrative Significance

The Department of Health Services recommends that data-sharing be extended to DHS, thus requiring an additional administrative procedure. This will require DPI to share data files with DHS after annual collection. As a partnership between DPI and DHS already exists for many programs and initiatives, this is not anticipated to

require significant changes in communication or relationship. DPI will be required to collect data from schools, organize, and submit to DHS.

Summary & Preliminary Recommendation

Amend the bill to allow for sharing of data with the Department of Health Services to use for developing public policy and statewide interventions with the purpose of improving the health outcomes of children.

Now is the Time

"Because of the increasing rates of obesity, unhealthy eating habits, and physical inactivity, we may see the first generation that will be less healthy and have a shorter life expectancy than their parents." [5]

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[1] 2009 Youth Risk Behavior Surveillance Survey (YRBSS)

[2] Finkelstein, EA, Fiebelkorn, IC, Wang, G. National medical spending attributable to overweight and obesity: How much, and who's paying? *Health Affairs* 2003;W3;219–226.

[3] United Health Foundation, American Public Health Association, & Partnership for Prevention (2009). The future costs of obesity: National and state estimates of the impact of obesity on direct health care expenses. Available at: http://www.americashealthrankings.org/2009/report/Cost%20Obesity%20Report-final.pdf.

[4] WI PE Survey results 2007

[5] Surgeon General Richard H. Carmona, MD: Testimony to US Senate, March 2, 2004

Nutrition Standards for Unhealthy Foods in Schools

Unhealthy Food Access Harms Wisconsin Kids

- If unhealthy foods and beverages are accessible in vending machines, school stores, and as a la carte items, kids will choose them over healthy options. [1]
- **60%** of Wisconsin middle and high schools sell unhealthy foods like soda, candy, chips, cookies, or snack cakes.[2]
- Unhealthy eating is a major cause of obesity and obese children are much more likely to be obese adults.
- 23% of WI high school students are already overweight or obese.[3]

Inaction Is Costly

- Obesity is a leading cause of many chronic diseases.
- The estimated health care cost attributable to obesity in WI adults is $1.5 billion.[4]
- If the obesity rate in WI continues to climb at its current rate, costs are projected to quadruple within the next decade. [5]

Wisconsin Needs Standards for School Vending, A la Carte Lines, & School Stores (i.e., Items Sold Outside of the National School Lunch Program)

- Students consume between 1/3 and 2/3 of their daily meals and snacks at school.
- Nutrition standards will replace junk food access with healthy options.
- Good nutrition is essential for obesity prevention and healthy growth and development.
- Good nutrition boosts academic achievement.[6]

It Can Be Done in Wisconsin

- Twenty-seven other states and several school districts have adopted similar policies.[7]
- Schools can maintain or increase revenue from the sale of healthful foods and beverages.[8]

Now is the Time

Limiting junk food in schools is a feasible and effective way to improve student health without harming schools.

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1. Robert Wood Johnson Foundation. Healthy Eating Research: Building Evidence to Prevent Childhood Obesity: School Food Sold Outside of Meals (Competetive Foods). May 2007:5.
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3. Centers for Disease Control and Prevention. 2007 Youth Risk Behavior Surveillance System. www.cdc.gov.
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7. Institute of Medicine. Nutrition Standards for Foods in Schools: Leading the Way Towards Healthier Youth. 2007:109-110.
8. Centers for Disease Control and Prevention. Healthy Youth: School Nutrition Success Stories. http://www.cdc.gov/healthyyouth/nutrition/making-it-happen/FAQ.htm

Nutrition Standards for Unhealthy Foods in Schools
Talking Points and Background Information

Unhealthy Food Access Harms Wisconsin Kids

- **If unhealthy foods and beverages are accessible in vending machines, school stores, and as a la carte items, kids will choose them over healthy options.** [1] Nearly all schools with a la carte programs (94 percent) sell drinks and snacks during the schools lunch period.

- **60% of Wisconsin middle and high schools sell unhealthy foods like soda, candy, chips, cookies, or snack cakes.** Twice as many of these schools sell sports drinks (71%) than fruits (39%) or non-fried vegetables (27%) in vending machines, or at the school store, canteen or snack bar. Only 14% of middle and high schools price nutritious foods and beverages at a lower cost than less nutritious foods.[2]

- **Unhealthy eating is a major cause of obesity and obese children are much more likely to be obese adults.** After age 6, obese children have a greater than 50% chance of becoming obese adults.

- **23% of WI high school students are already overweight or obese.**[3]

Inaction Is Costly

- **Obesity is a leading cause of many chronic diseases.** These chronic diseases including diabetes, cardiovascular disease, and some cancers.

- **The estimated health care cost attributable to obesity in WI adults is $1.5 billion.**[4] .

- **If the obesity rate in WI continues to climb at its current rate, costs are projected to quadruple within the next decade.** [5]

Wisconsin Needs Standards for School Vending, A la Carte Lines, & School Stores
(i.e., Items Sold Outside of the National School Lunch Program)

- **Students consume between 1/3 and 2/3 of their daily meals and snacks at school.**

- **Nutrition standards will replace junk food access with healthy options.** Schools participating in the National School Lunch Program were required to establish a school wellness policy by the 2006-2007 school year. These wellness policies were to address foods of minimal nutritional value (e.g. candy, cookies, chips), but Wisconsin currently has no means of enforcing these local school wellness policies.
- **Good nutrition is essential for obesity prevention and healthy growth and development.** Purchasing of competitive food items is associated with higher energy (calorie) intakes and higher consumption of fat. [8] Ludwig, et al. found that for every can of regular soda, a child's chance of becoming obese increased by 60%.[11] Briefel, et al. found that attending a school without stores or snack bars was estimated to reduce sugar-sweetened beverage consumption by 22 calories per school day in middle school school children and 28 calories per day in high school children.[12]
- **Good nutrition boosts academic achievement.**[6] Research shows that healthy, well-nourished children are more prepared to learn, more likely to attend school and class, and able to take advantage of educational opportunities.[7]

Nutrition Standards for Unhealthy Foods in Schools
Talking Points and Background Information

It Can Be Done in Wisconsin

- **Twenty-seven other states and several school districts have adopted similar policies.**[8] In addition to legislation, the Institute of Medicine and the American Dietetic Association also recommend that competitive foods be limited in schools.[8,9] Organizations such as the Alliance for a Healthier Generation (William Clinton Foundation) are also striving to put healthy foods and beverages in vending machines and cafeteria snack bars.
- **Schools can maintain or increase revenue from the sale of healthful foods and beverages.**[10] CDC's *Making It Happen!* program altered the food environment in schools through activities including regulating and limiting access to competitive foods. The program has demonstrated positive results: students *will* buy and consume healthy foods and schools *can* gain revenue from selling healthier foods. Of the 17 schools and school districts in *Making It Happen!* that reported sales data, 12 increased their revenue as a result of the changes, and four reported no change.

Now is the Time

- **Limiting junk food in schools is a feasible and effective way to improve student health without harming schools.** The Robert Wood Johnson Foundation states that the majority of intervention research related to sales of school snacks and drinks have focused on environmental changes to improve the quality of students' food choices. Results from these studies have indicated that interventions to improve the school environment are feasible and effective and may be implemented without reducing school revenue.[1]

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1. Robert Wood Johnson Foundation. Healthy Eating Research: Building Evidence to Prevent Childhood Obesity: School Food Sold Outside of Meals (Competetive Foods). May 2007:5.
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Establishing nutrition standards for "competitive foods" in schools

Nearly one in four of Wisconsin high school students are overweight or obese; these students have a 75% chance of becoming obese adults. Obesity can lead to serious chronic diseases, such as heart disease and type 2 diabetes. In order to stem the obesity epidemic, it is imperative to utilize a public health approach, such as school-based programs to promote healthful eating in our children and adolescents.

Targeting schools as a venue to promote healthful eating in our youth is logical. Our children spend nine months out of the year in school, five days a week and seven hours per day. Students consume between 1/3 and 2/3 of their daily meals and snacks at school.

One proposal to promote healthful eating in students is to establish nutrition standards for food and beverages sold outside of the school meal program called "competitive foods". These are food and beverages sold in a la carte lines, snack bars, vending machines, and school fundraisers. Nationally, 97% of high schools and 82% of middle schools had vending machines in 2005. In that same year, almost all high schools and middle schools sold food and beverages a la carte. In Wisconsin, 60% of middle and high schools sell foods like soda, candy, chips, cookies, and snack cakes as a la carte and vending machine items. When available and accessible, kids will choose these items over healthier items. Having nutrition standards for competitive foods in schools will provide objective criteria that can be applied consistently and determine the foods and beverages that can and cannot be offered on a school campus. It changes the food environment such that the student now has to choose between a piece of fresh fruit or a healthy snack instead of having to choose between a bag of chips and a piece of fruit. When available and accessible, children and adolescents will eat more fresh fruits and vegetables. Students who eat more fruits and vegetables and limit higher calorie, low nutrition foods and beverages are less likely to be overweight or obese. Creating an environment in schools where it is easier to make a healthy food choice has the potential to decrease obesity in our students.

Twenty-seven other states and several school districts have adopted similar policies. It has been found that schools can maintain or increase revenue from the sale of healthful foods and beverages.

As a parent of three school-aged children, to me, a school district that takes the time to establish nutrition guidelines for the food served, whether in the cafeteria or in a la carte, says they understand the importance of nutrition and its well known association with academic achievement. As a family physician that works directly with children, adolescents, and adults with obesity and its health consequences, a school that offers healthful food choices says they want their food environment to be consistent with what is being taught in their classrooms and with what I and other primary care physicians are teaching in a clinic setting. As a public health professional and researcher on obesity and American Indian adolescents, this is an effort to raise the public's awareness that child and adolescent obesity is the most serious public health issue facing us today. It is

common, very costly, and disproportionately affects communities of color and low income families.

Getting our children to consume more fruits and vegetables and less unhealthy snacks and sugar sweetened beverages is a formidable task. Establishing nutrition guidelines for a la carte and vending machine items in middle and high schools is a small step toward helping our students make healthier food choices on a consistent basis without harming the school's revenue. Supporting this legislation reflects a Wisconsin that is committed to investing in our students' academic performance, preventing and/or reducing adolescent obesity, and lowering health care costs. We cannot afford to pass up this opportunity.

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WISCONSIN LEGISLATIVE COUNCIL
REPORT TO THE LEGISLATURE

SPECIAL COMMITTEE ON PERFORMANCE-BASED DISEASE MANAGEMENT PROGRAMS FOR LARGE POPULATIONS

[2009 SENATE BILLS 312, 313, AND 314]

October 5, 2009

RL 2009-07

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Special Committee on Performance-Based Disease Management Programs for Large Populations

Prepared by:
Mary Matthias and Rachel Letzing, Senior Staff Attorneys
October 5, 2009

CONTENTS

PART I

KEY PROVISIONS OF COMMITTEE RECOMMENDATIONS

The Joint Legislative Council recommends the following for introduction in the 2009-10 Session of the Legislature.[1]

Health Care Delivery System

2009 Senate Bill 312, relating to the electronic medical records tax credit

Senate Bill 312 makes the following changes to the electronic medical records (EMR) tax credit that goes into effect in 2010:

- Allows credits to be claimed for costs of EMR services provided by a third party if a health care provider does not own its own EMR system.

- Specifies that priority must be given to claims for costs related to the establishment of new EMR systems and to upgrading EMR systems to enable them to meet interoperability standards.

- Specifies that priority must be given to claimants that provide health care to underserved or low-income populations and to claimants that have the greatest need for financial assistance.

Youth Fitness, School Nutrition, and Quality Rating System

2009 Senate Bill 313[2], relating to physical fitness assessments, school nutrition, a quality rating system for day care centers, and granting rule-making authority

2009 Senate Bill 313 does all of the following:

- Directs public schools, charter schools, and private schools to annually assess the physical fitness and aerobic capacity of pupils in grades 3 through 12. Exceptions are made for pupils who have a disability or other condition. The results must be shared with the parent or guardian and the Department of Public Instruction (DPI) but otherwise must be kept confidential.

- Specifies that, generally beginning in the 2012-13 school year, the following requirements apply to foods sold on school grounds outside of federally reimbursed U.S. Department of Agriculture (USDA) meal programs:

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[1] The Joint Legislative Council recommended introduction of WLC: 0389/2, relating to health care homes. However, the provisions in WLC: 0389/2 were subsequently enacted in the 2009-11 Biennial Budget Act, 2009 Wisconsin Act 28; therefore, WLC: 0389/2 is not being introduced by the Joint Legislative Council as a separate bill.

[2] 2009 Senate Bill 313 combines the provisions of WLC: 0385/2, WLC: 0388/2, and WLC: 0387/2.

- No more than 30% of its total calories shall be from fat (except for the sale of nuts or seeds);
- No more than 10% of its total calories shall be from saturated fat; and
- The consumption of whole grains, fresh fruits, and fresh vegetables must be encouraged.

- Prohibits the sale of soft drinks and candy on school grounds during the school day.
- Prohibits the sale of soft drinks and candy from vending machines on school grounds at all times.
- Allows soft drinks and candy to be sold on school grounds (but not from vending machines) starting one-half hour after the end of the school day.
- Prohibits the sale of any beverages other than milk, water, and 100% fruit juice or 100% vegetable juice on school grounds, during the school day.

The bill encourages school fundraising that involves the sale of food to follow these requirements.

- Requires the child care quality rating system created by the Department of Children and Families (DCF) to rate the quality of the child care provided by all licensed day care centers, and provides that the quality rating system must include indicators relating to the food and beverages provided, nutrition policies and education, and physical activity.

Walkable and Bikeable Communities

2009 Senate Bill 314, relating to traditional neighborhood development ordinances, mixed-use zoning, and the state housing plan

Senate Bill 314 does all of the following:

- Requires certain communities to report whether they have enacted a traditional neighborhood development ordinance and encourages smaller communities to enact such ordinances.
- Clarifies that municipalities with zoning authority may establish mixed-use zoning districts.
- Requires the state housing plan to promote bicycle and pedestrian-oriented design in residential and mixed-use developments.

PART II

COMMITTEE ACTIVITY

Assignment

The Joint Legislative Council established the Special Committee on Performance-Based Disease Management Programs for Large Populations and appointed the chairperson by an April 9, 2008 mail ballot. (A subsequent mail ballot dated January 8, 2009, appointed Senator Lassa as chairperson, and former Representative Wieckert as a public member.) The committee was directed to: (1) examine the role of disease management programs in assisting to address the state's health care needs; (2) review best practice disease management programs from around the nation; (3) review current practices of the State of Wisconsin's programs; (4) review state-of-the-art procedures for measuring performance of disease management programs; (5) make recommendations on ways to more effectively measure disease management results; and (6) focus on group settings for children, primarily schools, preschool, and day care settings and the laws, rules, and policies related to nutrition and physical activities in those settings especially in regard to childhood obesity.

Membership of the Special Committee, appointed by a June 9, 2008 mail ballot, consisted of one Senator, three Representatives, and nine public members. A list of committee members is included as ***Appendix 3*** to this report.

Summary of Meetings

The Special Committee held five meetings on the following dates:

July 24, 2008
September 12, 2008
October 17, 2008
November 21, 2008
February 11, 2009

At the July 24, 2008 meeting, Amy Winterfeld, Program Principal, Health Program, National Conference of State Legislatures (NCSL), provided an overview of the obesity epidemic in the United States and described state legislative approaches to combating childhood obesity, including state farm-to-school policies and increasing physical education requirements. Jennifer Kammerud, Legislative Liaison, DPI, provided an overview of the state laws, rules, and policies related to nutrition, health, and physical activities in schools that target childhood obesity. Milda Aksamitauskas, MPP, Policy Analyst, Division of Health Care Access and Accountability, DHS, provided an overview of BadgerCare Plus initiatives to reduce childhood obesity. Mary Pesik, Nutrition and Physical Activity Coordinator, Division of Public Health, DHS, described the Wisconsin Nutrition and Physical Activity State Plan, designed to prevent obesity and reduce chronic disease. Denise Runde, MSPH, Policy Initiatives Advisor, Division of Access and Accountability, DHS, discussed disease management and its role in the health care system. Public Member Marilyn Follen, Administrator, Quality Improvement and Care Management, Marshfield Clinic, discussed Marshfield Clinic's participation in the Centers for Medicare and Medicaid Services Physician Group Practice Demonstration. Dr. David B. Allen, M.D./Professor Pediatrics-Endocrinology, University of Wisconsin (UW) American Family Children's Hospital, described policies and laws to combat childhood obesity, including tracking and reporting of body mass index (BMI) and fitness, school nutrition requirements, school daily physical activity requirements, safe walking routes to schools, and requiring parents to obtain treatment for children with chronic obesity. Dr. Brian Fidlin, PsyD Program Director, NEW Kids Program, Children's Hospital of Wisconsin, provided an overview of the NEW (Nutrition, Exercise and Weight management) Kids Program at Children's Hospital. His suggestions included medical reimbursement of preventive services for

obesity, treatment for obesity, universal coverage of health and behavior codes, and increased Medicare coverage of dietitians for preventive services.

At the September 12, 2008 meeting, Ken Thorpe, Executive Director, Partnership to Fight Chronic Disease, Atlanta, highlighted the causes of rising health care costs and laid out a state roadmap for health care reform. Laura Tobler, Program Director, Health Program, NCSL, described the economic impact of chronic health conditions and unhealthy lifestyles. She described state legislation, such as the Vermont Blueprint for Health, enacted to improve the delivery and quality of health care for those with chronic conditions. Monica Pomasl, Food Services Director, Appleton School District, described her district's successful food service program policy change to include healthier food options and integrative nutrition education. Dr. John Barkmeier described ThedaCare's disease management initiative, which has improved patient outcomes. Verna Van Nuland, a graduate of ThedaCare's Coronary Health Improvement Project (CHIP) program, now a program facilitator, described how the CHIP program dramatically improved her health and quality of life. Carolyn Fisher, Senior Advisor, Coordinated School Health Programs Office of the Director, Division of Adolescent and School Health CDC/NCCDPHP, Atlanta, made a presentation entitled "How Schools Can Help Prevent Obesity and How States Can Help Them Do It." She stressed the importance of using data, such as the CDC's Youth Risk Behavior Survey results, to guide policy development. Wisconsin Olympians Casey Fitzrandolph and Suzy Favor Hamilton described their involvement in the Movin' and Munchin' Schools Program.

At the October 17, 2008 meeting, James Galloway, Assistant Surgeon General, Region V, Chicago, described "Building a Healthier Chicago," which promotes healthy lifestyles. Elaine Mischler, CEO, Mischler Consultants, Waukesha, explained the population health services program impact model and discussed the ways in which disease management programs measure their impact and calculate cost savings. Denise Webb, Program Manager, eHealth Care Quality and Patient Safety Board, DHS, provided an overview of the Wisconsin eHealth Initiative and explained the state efforts regarding health information technology (HIT). Dr. Tim Bartholow, Wisconsin Health Information Organization, described the benefits and challenges to EMR adoption and discussed Prairie Clinic's experience with EMRs. Strategies to encourage physicians to use HIT include tax credits and technical assistance to smaller practice groups.

Following the testimony by invited speakers, the committee began to discuss options for committee recommendations and chose to pursue legislative options including K-12, preschool, and early childhood-based interventions; workplace wellness initiatives; community-based interventions; strengthening the nutrition education components of programs, such as WIC and FoodShare; and setting standards for HIT.

At the November 21, 2008 meeting, Dr. Lowell Keppell, President, Wisconsin Academy of Family Physicians, discussed the patient-centered medical home (PCMH) model for health care delivery. Dr. Keppell also described a legislative proposal developed by the Wisconsin Academy of Family Physicians under which a physician practice that is a PCMH would receive increased reimbursement for services provided to Medicaid patients.

Rachel Letzing and Mary Matthias, Legislative Council Staff, led the committee in a discussion of the alternatives set forth in Memo No. 5, *Options for Legislation,* based upon the discussion from the October 17 meeting. These options included drafting bills related to child care provider nutrition requirements, K-12 nutrition programs and reimbursements, funding for the Governor's Health Award, requiring schools to administer a physical fitness test, K-6 Physical Education requirements, the creation of a beverage tax, requiring nutritional information to be posted on restaurant menus, promoting walkable communities, and health information technology. The committee requested draft letters of support regarding a wellness component for a child care rating system, K-12 nutrition standards. The committee requested further information on state efforts to support Health Professional Shortage Areas.

Information relevant to many of the options was also provided by staff of DPI, Jennifer Kammerud and John Hisgen, as well as staff of DHS, Amy Meinen and Jon Morgan, much of which is

set forth in a table provided to the committee by DHS and DPI, entitled *DHS and DPI Input to Wisconsin Legislative Council Memorandum #5*.

At the February 11, 2009 meeting, Ms. Matthias and Ms. Letzing presented draft legislation requested by the committee. The committee approved WLC: 0382/1, WLC: 0390/2, WLC: 0391/1, WLC: 0392/1, relating to the promotion of walkable and bikeable communities, and asked that they be combined into one draft (subsequently drafted as WLC: 0399/1). Committee members approved WLC: 0387/2, relating to school physical fitness assessment. The committee amended and approved WLC: 0389/1, establishing a health care home pilot project (subsequently redrafted as WLC: 0389/2 to include the committee's amendments). After amendments were agreed upon, mail ballots were requested for the revised versions of the following bill drafts: WLC: 0384/1, related to electronic medical records; WLC: 0385/1, related to a quality rating system for child care; and WLC: 0388/1, related to school nutrition. The committee also agreed on the elements of a new draft relating to physical education teachers (subsequently drafted as WLC: 0397/1) and asked that it be included in the mail ballot.

Committee members approved a draft letter addressed to Governor Doyle regarding the child care quality rating system; a draft letter addressed to the Wisconsin Congressional Delegation regarding restaurant menu labeling; draft letters addressed to Governor Doyle and the Joint Finance Committee regarding school meal reimbursement and incentives; and draft letters addressed to Governor Doyle and the Joint Finance Committee regarding the AmeriCorps Farm-to-School program funding.

Bridget Holcomb, Associate Policy Director, Michael Fields Agricultural Institute, addressed the committee to discuss a letter to the committee from herself and Luke Rollins, Chair of Advocacy, WIPAN, Director of State Advocacy, American Heart Association. Based on this presentation, the committee requested that the letters addressed to Governor Doyle and the Joint Finance Committee in support of the Buy Local Buy Wisconsin program be amended to include a request for a Farm-to-School Economic Development Consultant. These revised letters were included in the mail ballot subsequently sent to the committee.

PART III

RECOMMENDATIONS INTRODUCED BY THE JOINT LEGISLATIVE COUNCIL

This part of the report provides background information on, and a description of, the bills as recommended by the Special Committee on Performance-Based Disease Management Programs for Large Populations and introduced by the Joint Legislative Council.

2009 Senate Bill 312, Relating to the Electronic Medical Records Tax Credit

Background

A state tax credit for EMRs will go into effect in 2012. The amount of tax credit available will be equal to 50% of the amount paid by a health care provider in a tax year for information technology hardware or software that is used to maintain medical records in an electronic form.

The Department of Commerce (Commerce) must implement a program to certify health care providers as eligible for the credit. If Commerce certifies a health care provider, Commerce must determine the amount of credits to allocate to that provider. No more than $10 million in credits may be allocated each year.

There are currently no standards in state law pertaining to the interoperability of health care information technology. The American Recovery and Reinvestment Act of 2009 (the ARRA) provides funding to assist health care providers in adopting and using EMR systems. The ARRA contains a framework for the development of standards for certifying EMR systems as eligible for funding. One goal of implementing national standards is to facilitate interoperability of EMR systems, to enable the electronic exchange and use of health information among providers.

Description

Senate Bill 314 makes the following changes to the EMR tax credit program:

1. Specifies that tax credits may be provided only for costs related to EMR systems that are certified or are being upgraded to become certified as specified in the ARRA.

2. Specifies that when allocating credits, Commerce must grant priority to claimants that provide health care to underserved or low-income populations and to claimants have the greatest need for financial assistance.

3. Specifies that the credit may be claimed for amounts paid by a health care provider to a 3rd party to provide EMR services to the health care provider.

4. Requires Commerce to establish penalties that apply to a credit recipient that commits a breach of privacy as defined in the ARRA.

The American Recovery and Reinvestment Act of 2009 define "breach" as follows:

> (1) BREACH.--(A) IN GENERAL.--The term "breach" means the unauthorized acquisition, access, use, or disclosure of protected health

information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

(B) EXCEPTIONS.--The term "breach" does not include:

(i) any unintentional acquisition, access, or use of protected health information by an employee or individual acting under the authority of a covered entity or business associate if:

(I) such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and

(II) such information is not further acquired, accessed, used, or disclosed by any person; or

(ii) any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at same facility; and

(iii) any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person.".Description

2009 Senate Bill 313, Relating to Physical Fitness Assessments, School Nutrition, Day Care Centers, and Granting Rule-Making Authority

Background

Quality Rating System

Current law requires anyone caring for four or more children, under age seven, unrelated to the provider, to be licensed by DCF. The two types of licensed child care providers are family child care (up to eight children in care at any given time) and group child care (nine or more children at any given time).

Current licensing requirements specify that meals and snacks provided at a licensed child care center must comply with the USDA Child and Adult Care Food program minimum meal requirements.

Licensed child care centers must provide children with experiences which promote large and small muscle development and children must go outside daily unless the weather prohibits doing so.

Current licensing requirements do not specifically direct child care centers to provide nutrition education to children.

Licensed child care providers are not rated as to the quality of services they provide in relation to each other.

Current law, as created by the 2009-11 Biennial Budget Act, 2009 Wisconsin Act 28, requires DCF to provide a child care quality rating system that rates the quality of the child care provided by a

licensed day care center that receives reimbursement under the Wisconsin Works program or that volunteers for rating under the system and to make the rating information provided under that system available to the parents, guardians, and legal custodians of children who are recipients, or prospective recipients, of care and supervision from a day care center that is rated under the system.

Description

Senate Bill 313 requires the child care rating system created by DCF to rate the quality of the care provided by *all* licensed day care centers. The bill requires the quality rating system to include indicators relating to the food and beverages provided, nutrition policies and education, and physical activity. In addition, the bill requires DCF to consult with the Department of Health Services in establishing the indicators used to evaluate the quality of care provided at a licensed day care center.

DCF must make the rating information available to the parents, guardians, and legal custodians of children who are recipients or prospective recipients of care from a rated provider. The bill also requires DCF to seek funding to provide financial assistance to licensed day care centers to improve their rating under the quality rating system.

Background

School Nutrition

The National School Lunch and School Breakfast programs provide federal funding to schools to serve free and reduced-priced meals and snacks. In exchange for receiving federal funds, schools must serve meals and snacks that adhere to federal nutritional requirements set by the UDSA. USDA requires school lunches to meet the applicable recommendations of the 1995 Dietary Guidelines for Americans, which recommend that no more than 30% of an individual's calories come from fat and less than 10% from saturated fat.

Federal guidelines do not apply to or limit the sale of *à la carte* or vending machine foods sold in addition to federally funded meals and snacks.

Description

Senate Bill 313 establishes nutritional standards for all foods sold on school grounds outside of federally reimbursed USDA meal programs (school lunch, school breakfast, school milk, and nutritional improvement for the elderly).

The requirements apply to all public, charter, and private schools. These requirements apply beginning in the 2012-13 school year. The bill specified that, beginning on July 1, 2011, all public schools, charter schools, and private schools may not enter into, modify, or renew a contract with a vending machine operator or vendor unless the terms of the contract that will be in effect on July 1, 2012, comply with the restrictions in the bill:

- No more than 30% of its total calories shall be from fat (except for the sale of nuts or seeds);
- No more than 10% of its total calories shall be from saturated fat; and
- The consumption of whole grains, fresh fruits, and fresh vegetables must be encouraged.

The bill also does all of the following:

- Prohibits the sale of soft drinks and candy on school grounds during the school day.

- Prohibits the sale of soft drinks and candy from vending machines on school grounds at all times.

- Allows soft drinks and candy to be sold on school grounds (but not from vending machines) starting one-half hour after the end of the school day.

- Prohibits the sale of any beverages other than milk, water, and 100% fruit juice or 100% vegetable juice on school grounds, during the school day.

The bill encourages school fundraising that involves the sale of food to follow these requirements.

Background

Physical Fitness Assessments

DPI and the UW received a three-year grant, which ends in 2010, to administer the FitnessGram physical fitness test in middle schools that volunteer to participate. For all elements of the FitnessGram, age and gender norms have been developed and individual scores are measured against these norms.

The FitnessGram is a software program which is comprised of four tests: BMI measurement, a quasi-situps abdominal strength test, a flexibility test, and the Progressive Aerobic Cardiovascular Endurance Run (PACER).

The PACER is a 20-meter shuttle run (back and forth) which is conducted in a class-based setting in which 20-50 children can run at a time. The PACER is designed to measure aerobic capacity. The UW has found that the PACER test is a good measure of fitness and a good indicator of diabetes risk.

Description

Senate Bill 313 directs public schools, charter schools, and private schools to ensure that the physical fitness of pupils in grades 3 through 12 is assessed annually. The assessment must include an evaluation of pupils' aerobic capacity. Schools are not required to assess pupils who have a disability or other condition as specified by DPI administrative rule. DPI must also promulgate an administrative rule which specifies the assessment instrument schools must use for the required physical fitness assessment.

The results of the physical fitness assessments must be kept confidential but schools are required to send results to DPI and to provide an individual child's results to their parent or guardian.

2009 Senate Bill 314, Relating to Traditional Neighborhood Development Ordinances, Mixed-Use Zoning, and the State Housing Plan

Background

Traditional Neighborhood Development Ordinances

A traditional neighborhood development is a compact, mixed-use neighborhood where residential, commercial, and civic buildings are within close proximity to each other.

A conservation subdivision is a housing development in a rural setting that is characterized by compact lots and common open space, and where the natural features of land are maintained to the greatest extent possible.

Current law (s. 66.1027, Stats.) requires UW-Extension to develop a model ordinance for a traditional neighborhood development and an ordinance for a conservation subdivision. The model ordinance was completed on January 1, 2001.

Current law also requires every city and village with a population of at least 12,500 to enact an ordinance that is similar to the model traditional neighborhood development ordinance by January 1, 2002. A city or village whose population reaches at least 12,500, after January 1, 2002, must enact an ordinance that is similar to the model traditional neighborhood development within one year.

Description

This draft requires all communities with a population of 12,500 or more to report to the Department of Administration (DOA), by January 1, 2011, whether they are in compliance with the statutory requirement to enact a traditional neighborhood development ordinance.

The draft also requires a city or village whose population reaches 12,500 after January 1, 2011, to report to DOA, within 18 months after reaching that population size, whether it has adopted a traditional neighborhood development ordinance.

The draft also encourages communities with populations smaller than 12,500 to enact traditional neighborhood development ordinances.

Mixed-Use Zoning

Background

Current law authorizes cities, villages, and counties to enact zoning ordinances. A town may also enact a zoning ordinance if a town meeting authorizes a town board to exercise powers relating to villages and conferred on village boards by statute.

Description

This draft clarifies that a municipality that is authorized to enact a zoning ordinance may establish mixed-use districts that contain any combination of uses, such as industrial, commercial, public, or residential uses, in a compact urban form.

State Housing Strategy Plan

Background

Current law requires Commerce to prepare a comprehensive five-year state housing strategy plan and to update it every year. Commerce must submit the plan to the federal Department of Housing and Urban Development.

The state housing strategy plan must include all of the following:

- A statement of housing policies and recommendations.

- An evaluation and summary of housing conditions and trends in the state, including housing stock and housing cost analyses, general population and household composition demographic analyses, and housing and demographic forecasts.

- An evaluation of housing assistance needs.

- A discussion of major housing issues, including housing production, housing and neighborhood conservation, housing for persons with special needs, fair housing and accessibility, and housing affordability.

- Housing policies that set the general framework for the state's housing efforts.

- Strategies for utilizing federal funding and for coordinating federal and state housing efforts.

- Specific recommendations for public and private action that contribute to the attainment of housing policies under the plan.

Under current law, the Wisconsin Housing and Economic Development Authority must exercise its powers and perform its duties related to housing consistent with the state housing strategy plan created by Commerce.

Under current law, Commerce must prepare a report on every proposed administrative rule that directly or substantially affects the development, construction, cost, or availability of housing in Wisconsin before the Legislature acts on it. Among other things, the report must discuss the proposed rule's effect on the policies, strategies, and recommendations of the state housing strategy plan.

Description

The draft adds another element to the state housing strategy plan. It requires Commerce to include in the plan strategies and specific recommendations for public and private action that will facilitate the inclusion of bicycle and pedestrian-oriented design in residential and mixed-use developments that include residential elements.

PART IV

OTHER ACTION OF THE COMMITTEE

At its February 11, 2009 meeting, the Special Committee directed Senator Lassa, Chair of the Special Committee, to send the following letters expressing the committee's support of and recommendations pertaining to several programs and proposals related to its charge.

- Letters to Governor Jim Doyle and Representative Mark Pocan and Senator Mark Miller, Co-Chairs, Joint Committee on Finance, relating to the Buy Local Buy Wisconsin (BLBW) Initiative. (A copy of the letter to the Governor is included as ***Appendix 2***.)

These letters urge the Governor and the Co-Chairs of the Joint Finance Committee to continue to fund the BLBW program. The letters also request additional funding for the BLBW program for the creation of a Farm-to-School Economic Development Consultant.

These letters were approved by the committee by mail ballot on a vote of Ayes, 9 (Sen. Lassa; Rep. Benedict; and Public Members, Adams, Christensen, Duran, Follen, Musser, Nitzke, and Schellhase); and Not Voting, 2 (Public Members Wubben and Wieckert).

- A letter to Governor Jim Doyle, with a copy sent to DHS Secretary Timberlake and DCF Secretary Bicha, relating to establishment of a child care quality rating system. (A copy of the letter is included as ***Appendix 3***.)

This letter asks the Governor to direct the Advisory Council on Early Childhood Education and Care to create a quality rating system for child care, and to include within the quality rating system indicators regarding: (1) the developmentally appropriate nutrition education provided by the day care center; and (2) the developmentally appropriate physical activity provided to children attending the day care center.

The letter states that if the Advisory Council is not the appropriate vehicle to create the quality rating system, the committee requests that the Governor direct DCF to create the system.

This letter was approved by the committee by unanimous consent at its February 11, 2009 meting.

- Letters to Governor Jim Doyle and Senator Mark Miller and Representative Mark Pocan, Co-Chairs, Joint Finance Committee, relating to school lunch reimbursement and incentives. (A copy of the letter to the Governor is included as ***Appendix 4***.)

These letters express the committee's support for the DPI's 2009-11 budget requests of: (1) $2,500,000 annually above annual base funding to increase payments to school districts under the state school lunch reimbursement program; and (2) $1,263,100 in 2009-10 and $2,176,900 in 2010-11 over annual base funding to increase payments to school districts under the state school breakfast reimbursement program.

These letters also express support for creation of a mechanism within the National School Lunch program to serve more fruits, vegetables, and whole grains to school children, in addition to any other increase in reimbursement rates the state is able to provide to schools.

These letters were approved by the committee by unanimous consent at its February 11, 2009 meting.

- Letters to Governor Jim Doyle and Senator Mark Miller and Representative Mark Pocan, Co-Chairs, Joint Finance Committee, relating to the farm-to-school program. (A copy of the letter to the Governor is included as ***Appendix 5***.)

These letters discuss the important role of the AmeriCorps Farm-To-School Pilot Program in fighting obesity and chronic disease. It also asks the Governor and the Joint Committee on Finance to continue to support funding from Serve Wisconsin for the efforts of the Department of Agriculture, Trade and Consumer Protection, DPI, and DHS in piloting the 10 farm-to-school projects throughout Wisconsin.

These letters were approved by the committee by unanimous consent at its February 11, 2009 meting.

- Letter to Wisconsin Congressional Delegation relating to menu labeling. (A copy of the letter is included as ***Appendix 6***.)

This letter expresses the committee's support of federal legislation such as the proposed LEAN Act of 2008, which would amend the federal Food, Drug and Cosmetic Act to require restaurants to provide calorie counts and other nutritional information to consumers at the point-of-purchase. The letter requests that the Delegation actively support legislation similar to the LEAN Act of 2008 in the 111th Congress of the United States.

This letter was approved by the committee by unanimous consent at its February 11, 2009 meting.

Appendix 1

Committee and Joint Legislative Council Votes

The following drafts were recommended by the Special Committee on Performance-Based Disease Management Programs for Large Populations to the Joint Legislative Council for introduction in the 2009-10 Session of the Legislature.

Special Committee Votes

The Special Committee voted to recommend the following bill drafts to the Joint Legislative Council for introduction in the 2009-10 Session of the Legislature. The vote on the drafts were as follows:

- *WLC: 0384/2, relating to electronic medical records tax credit, passed by a vote of Ayes, 10 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Follen, Musser, Nitzke, Schellhase, and Wubben); Noes, 0; and Not Voting, 1 (Public Member Wieckert).*

- *WLC: 0385/2, relating to a quality rating system for child care, passed by a vote of Ayes, 10 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Follen, Musser, Nitzke, Schellhase, and Wubben); Noes, 0; and Not Voting, 1 (Public Member Wieckert).*

- *WLC: 0387/2, relating to physical fitness assessments, passed by a vote of Ayes, 9 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Musser, Nitzke, Schellhase and Wubben); Noes, 0; and Absent, 2 (Public Members Follen and Wieckert).*

- *WLC: 0388/2, relating to school nutrition, passed by a vote of Ayes, 10 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Follen, Musser, Nitzke, Schellhase, and Wubben); Noes, 0; and Not Voting, 1 (Public Member Wieckert).*

- *WLC: 0389/2, relating to health care homes, passed by a vote of Ayes, 9 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Musser, Nitzke, Schellhase, and Wubben); Noes, 0; and Absent, 2 (Public Members Follen and Wieckert).*

- *WLC: 0397/1, relating to physical education teachers, passed by a vote of Ayes, 8 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Musser, Nitzke, and Schellhase); Noes, 2 (Public Member Follen and Wubben); and Not Voting, 1 (Public Member Wieckert).*

- *WLC: 0399/1, relating to traditional neighborhood development ordinances, mixed-use zoning, department of transportation planning for bicycle and pedestrian ways, and the state housing strategy plan, passed by a vote of Ayes, 9 (Sen. Lassa; Rep. Benedict; and Public Members Adams, Christensen, Duran, Musser, Nitzke, Schellhase, and Wubben); Noes, 0; and Absent, 2 (Public Members Follen and Wieckert).*

Joint Legislative Council Vote

At its March 26, 2009 meeting, the Joint Legislative Council voted as follows on the recommendations of the Special Committee:

> *Rep. Black moved, seconded by Sen. Robson, that the following four drafts recommended by the Special Committee on Performance-Based*

Disease Management Programs for Large Populations, be introduced by the Joint Legislative Council:

1. *WLC: 0389/2, relating to health care homes.*

2. *WLC: 0388/2, relating to school nutrition.*

3. *WLC: 0387/2, relating to physical fitness assessments.*

4. *WLC: 0399/1, relating to traditional neighborhood development ordinances, mixed-use zoning, Department of Transportation planning for bicycle and pedestrian ways, and the state housing strategy plan.*

The motion passed on a roll call vote as follows: Ayes, 20 (Sens. Risser, Coggs, Darling, Decker, Fitzgerald, Harsdorf, Kreitlow, Miller, Robson, and Schultz; and Reps. Schneider, Ballweg, Black, Berceau, Fitzgerald, Kaufert, Nelson, Pocan, Sheridan, and Staskunas); Noes, 1 (Sen. Wirch); and Absent, 1 (Rep. Vos).

Co-Chair Schneider moved, seconded by Co-Chair Risser, that WLC: 0384/2, be amended as follows:

1. *Page 3, line 8: delete the material beginning with "In" and ending with "care" on line 14 and substitute:*

   "Credits may be provided under the program only for costs related to electronic medical records systems that are certified or are being upgraded to become certified as specified under section 3301(C)(5)(A) of the American Recovery and Reinvestment Act of 2009.".

2. *Page 3, line 14: delete "further".*

3. *Page 3, line 18: after that line insert:*

   *"**SECTION 5.** 560.204 (4) of the statutes is amended to read:*

   560.204 (4) The department, in consultation with the department of revenue, shall promulgate rules to administer this section. The rules shall establish penalties that apply to a credit recipient that commits a breach as defined in s. 13400 (1) (A) of the American Recovery and Reinvestment Act of 2009.".

   ***NOTE:** The American Recovery and Reinvestment Act of 2009 defines "breach" as follows:*

   "(1) BREACH.--

   (A) IN GENERAL.--The term "breach" means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

   (B) EXCEPTIONS.--The term "breach" does not include--

(i) any unintentional acquisition, access, or use of protected health information by an employee or individual acting under the authority of a covered entity or business associate if--

(I) such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and

(II) such information is not further acquired, accessed, used, or disclosed by any person; or

(ii) any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at same facility; and

(iii) any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person.".

Co-Chair Risser called for a voice vote on the question and the amendment was adopted.

Co-Chair Schneider moved, seconded by Co-Chair Risser, that WLC: 0384/2, relating to the electronic medical records tax credit, be introduced by the Joint Legislative Council, as amended. The motion passed on a roll call vote as follows: Ayes 21 (Sens. Risser, Coggs, Darling, Decker, Fitzgerald, Harsdorf, Kreitlow, Miller, Robson, Schultz, and Wirch; and Reps. Schneider, Ballweg, Black, Berceau, Fitzgerald, Kaufert, Nelson, Pocan, Sheridan, and Staskunas); Noes, 0; and Absent, 1 (Rep. Vos).

Co-Chair Schneider moved, seconded by Sen. Robson, that WLC: 0385/2, relating to a quality rating system for child care, be introduced by the Joint Legislative Council. The motion passed on a roll call vote as follows: Ayes 13 (Sens. Risser, Coggs, Darling, Miller, Robson, and Wirch; and Reps. Schneider, Black, Berceau, Nelson, Pocan, Sheridan, and Staskunas); Noes, 7 (Sens. Decker, Fitzgerald, Harsdorf, and Schultz; and Reps. Ballweg, Fitzgerald, and Kaufert); and Absent, 2 (Sen. Kreitlow; and Rep. Vos).

Appendix 2

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Co-Chairs
FRED A. RISSER
President, State Senate

MARLIN D. SCHNEIDER
Representative, State Assembly

LEGISLATIVE COUNCIL STAFF
Terry C. Anderson
Director
Laura D. Rose
Deputy Director

March 11, 2009

The Honorable Jim Doyle
Room 115 East
State Capitol
Madison, WI 53702

Dear Governor Doyle:

I am writing in my capacity as Chair of the Joint Legislative Council's Special Committee on Performance-Based Disease Management Programs for Large Populations. Based upon the research and testimony undertaken during its tenure, the Special Committee members would like to recognize the important role of the Buy Local Buy Wisconsin Initiative (BLBW) in providing public access to fresh, local produce. This letter sets forth a committee recommendation regarding this issue.

Over its course of study, this committee heard testimony regarding the high public and private costs of chronic disease. State and national leaders in health policy emphasized the importance of increasing access to fresh fruits and vegetables to prevent chronic disease. The committee believes the Buy Local Buy Wisconsin program is particularly well-designed to advance efforts to promote healthy lifestyles in this state.

In 2008, the grant program was successful at enhancing the appeal of locally-sourced produce to consumers and expanding the regional markets for local farmers. During its first grants cycle in April 2008, the program received 94 applications requesting over $3 million. This overwhelming interest points to a ready supply of local foods available for consumption.

The Special Committee requests that the Governor and the Joint Committee on Finance will continue to fund the BLBW program in recognition of its key role in increasing public access to fresh, healthy foods and supporting the livelihoods of Wisconsin farms, businesses, and nonprofits. The Committee also requests additional funding for BLBW for the creation of a Farm-to-School Economic Development Consultant. The Consultant would fill a special need within BLBW to work directly with school districts to provide local food to public schools. We believe expanded support for this already successful program will place Wisconsin at the forefront of the local food movement, while leading to long-term cost-savings in health care and improvements in public health for Wisconsin residents.

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Thank you for your consideration of this request. If you have questions, please contact Rachel Letzing or Mary Matthias at the Legislative Council.

Sincerely,

Senator Julie Lassa
Chair, Special Committee on
Performance-Based Disease Management
Programs for Large Populations

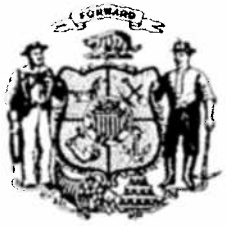
JL:ksm

Appendix 3

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Co-Chairs
FRED A. RISSER
President, State Senate

MARLIN D. SCHNEIDER
Representative, State Assembly



LEGISLATIVE COUNCIL STAFF
Terry C. Anderson
Director
Laura D. Rose
Deputy Director

March 11, 2009

The Honorable Jim Doyle
Room 115 East
State Capitol
Madison, WI 53702

Dear Governor Doyle:

I am writing in my capacity as chair of the Joint Legislative Council's Special Committee on Performance-Based Disease Management for Large Populations. Among other items in its charge, the Special Committee is directed to focus on group settings for children, primarily schools, preschools, and day care settings and the laws, rules, and policies related to nutrition and physical activities in those settings, especially in regard to childhood obesity.

The Special Committee has received extensive testimony and research regarding methods to combat childhood obesity, including educating young children about good nutrition and providing them with daily physical activity. Much of the information regarding childhood obesity indicates that school-based approaches can be very effective in combating childhood obesity. To that end, the Special Committee members believe that nutrition education and physical activity must be included and encouraged at the earliest possible time in a child's life and incorporated into child care settings.

By executive order, you recently created the Advisory Council on Early Childhood Education and Care. On behalf of the Special Committee, I ask you to consider including in the council's charge a directive to create a quality rating system for child care, and to include within the quality rating system indicators regarding: (1) the developmentally appropriate nutrition education provided by the day care center; and (2) the developmentally appropriate physical activity provided to children attending the day care center. If the advisory council is not the appropriate vehicle to create the quality rating system, I ask that you direct the Department of Children and Families to create a quality rating system for child care and to include within a quality rating system indicators regarding the developmentally appropriate nutrition education and physical activity provided at the child care center. The Special Committee believes that giving parents and caregivers information about these important indicators will help them to better understand and identify quality care for their children.

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Thank you for your consideration of this request. If you have questions, please contact Rachel Letzing or Mary Matthias at the Legislative Council.

Sincerely,

Senator Julie Lassa
Chair, Special Committee on
Performance-Based Disease Management
Programs for Large Populations

JL:ksm

cc: Karen Timberlake, Secretary, Department of Health Services
Reggie Bicha, Secretary, Department of Children and Families

Appendix 4

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Co Chairs
FRED A. RISSER
President, State Senate

MARLIN D. SCHNEIDER
Representative, State Assembly

LEGISLATIVE COUNCIL STAFF
Terry C. Anderson
Director
Laura D. Rose
Deputy Director

March 11, 2009

The Honorable Jim Doyle
Room 115 East
State Capitol
Madison, WI 53701

Dear Governor Doyle:

I am writing in my capacity as chair of the Joint Legislative Council's Special Committee on Performance-Based Disease Management for Large Populations. Among other items in its charge, the Special Committee is directed to focus on group settings for children, primarily schools, preschool, and day care settings and the laws, rules, and policies related to nutrition and physical activities in those settings especially in regard to childhood obesity.

The Special Committee would like to express its support for the Department of Public Instruction's 2009-11 budget requests of: (1) $2,500,000 annually above annual base funding to increase payments to school districts under the state school lunch reimbursement program; and (2) $1,263,100 in 2009-10 and $2,176,900 in 2010-11 over annual base funding to increase payments to school districts under the state school breakfast reimbursement program.

As you know, the national school lunch and school breakfast programs provide nutritionally balanced, low-cost or free meals and snacks to children every school day. The state is then required to provide a set matching payment under the federal programs, based in part on the state's per capita income in a given year. According to the Legislative Fiscal Bureau, this amount has equaled approximately .43 per meal for lunches served and .1351 per breakfast served. The department's requested funding would provide an increase of approximately .025 per lunch served and provide sufficient funding for the full statutory reimbursement of .15 per breakfast served. The Special Committee members believe that these reimbursement increases would decrease the amount school districts are transferring from educational funds to school nutrition funds by approximately 50%.

The Special Committee also supports creating a mechanism within the national school lunch program to serve more fruits, vegetables and whole grains to school children, in addition to any other increase in reimbursement rates the state is able to provide to schools. The Special Committee believes that encouraging children to develop healthy eating habits complements existing statewide efforts to improve public health in Wisconsin. Preparing children to value health and nutrition will ensure that Wisconsin continues to be a national leader in public health.

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Thank you for your consideration of this request. If you have questions, please contact Rachel Letzing or Mary Matthias at the Legislative Council.

Sincerely,

Senator Julie Lassa
Chair, Special Committee on
Performance-Based Disease Management
Programs for Large Populations

JL:ksm

Appendix 5

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Co-Chairs
FRED A. RISSER
President, State Senate

MARLIN D. SCHNEIDER
Representative, State Assembly

LEGISLATIVE COUNCIL STAFF
Terry C. Anderson
Director
Laura D. Rose
Deputy Director

March 11, 2009

The Honorable Jim Doyle
Room 115 East
State Capitol
Madison, WI 53702

Dear Governor Doyle:

I am writing in my capacity as Chair of the Joint Legislative Council's Special Committee on Performance-Based Disease Management Programs for Large Populations. Based upon the research and testimony undertaken during its tenure, the Special Committee members would like to recognize the important role of the AmeriCorps farm-to-school pilot program in fighting obesity and chronic disease by encouraging children to eat fresh, local foods. This letter sets forth a committee recommendation regarding this program.

In 2008, an AmeriCorps farm-to-school pilot program began to work with school lunch service staff and teachers in 10 Wisconsin schools to help with the procurement, education, and promotion of locally grown foods. AmeriCorps members have the unique role of working directly with school food service staff to identify local farmers and processors interested in selling produce to schools. They also work with school wellness programs to help teachers educate children about nutrition and healthy eating habits. Students benefit directly from the farm-to-school program. They learn the components of a healthy diet by eating fresher and more diverse food and by learning the origins of their food through classroom nutrition lessons and field trips to local farms. Educating children about healthy eating habits is an important way to address the increasing prevalence of obesity and chronic disease among children.

The Special Committee requests that the Governor and the Joint Committee on Finance will continue your support of funding from Serve Wisconsin for the efforts of DATCP, DPI, and DHS in piloting the ten farm-to-school projects throughout Wisconsin. Utilizing AmeriCorps members to help schools with the procurement, education, and promotion of locally grown foods is an effective and efficient way to improve the overall health of Wisconsin's children.

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http://www.legis.state.wi.us/lc

Thank you for your consideration of this request. If you have questions, please contact Rachel Letzing or Mary Matthias at the Legislative Council.

Sincerely,

Senator Julie Lassa
Chair, Special Committee on
Performance-Based Disease Management
Programs for Large Populations

JL:ksm

Appendix 6

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

March 11, 2009

Senator Herb Kohl
330 Hart Senate Office Building
Washington, D.C. 20515

Senator Russell Feingold
506 Hart Senate Office Building
Washington, D.C. 20510

Representative Tammy Baldwin
2446 Rayburn Building
Washington, D.C. 20515

Representative Ron Kind
1406 Longworth House Office Building
Washington, D.C. 20515

Representative Gwen Moore
1239 Longworth House Office Building
Washington, D.C. 20515-4905

Representative Paul Ryan
1113 Longworth House Office Building
Washington, D.C. 20515

Representative Thomas Petri
2462 Rayburn House Office Building
Washington, D.C. 20515

Representative David Obey
2314 Rayburn House Office Building
Washington, D.C. 20515

Representative Steve Kagen
1232 Longworth House Office Building
Washington, D.C. 20515

Representative James Sensenbrenner
2449 Rayburn House Office Building
Washington, D.C. 20515

Dear Members of the Wisconsin Congressional Delegation:

I am writing to you as the Chair of the Joint Legislative Council's Special Committee on Performance-Based Disease Management Programs for Large Populations. This study committee was established by the leadership of the Wisconsin Legislature to, among other things, formulate legislative responses to the profound obesity epidemic that has emerged in Wisconsin. The study participants were a diverse and knowledgeable group of Wisconsin citizens who are medical and policy experts in children's health and health policy. A list of the committee membership is enclosed with this letter.

Over its course of our study, we heard disturbing testimony regarding the escalating public and private costs of obesity. According to a report published by the National Conference of State Legislatures, being overweight or obese increases the risk for heart disease, stroke, high blood pressure, diabetes, and cancer. These chronic diseases are the leading causes of death,

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illness and disability in the United States. The Centers for Disease Control and Prevention (CDC) estimated the total medical costs related to obesity in Wisconsin in 2003 at nearly $1.5 billion. Taxpayers foot the bill for almost half of that amount through Medicare and Medicaid.

The CDC reports that during the past 20 years there has been a dramatic increase in obesity in the United States. The CDC statistics for Wisconsin show that in 1990, the obesity rate was in the 10-14% range. Since then it increased steadily until 2006, when the rate was reported at 25-29%.

The committee received many suggestions for legislation to help address this epidemic, and we have recommended a package of legislation for introduction in the 2009-10 Wisconsin Legislative Session.

In addition to our package of state legislation, the committee strongly supports the enactment of federal legislation such as the proposed LEAN Act of 2008, which would amend the federal Food, Drug and Cosmetic Act to require restaurants to provide calorie counts and other nutritional information to consumers at the point of purchase. Disclosure of this information is of crucial importance for consumers of so-called "fast food," which is a major contributor to the obesity epidemic. Providing this information at the point of sale will help consumers make healthier choices. An additional benefit of this type of legislation was revealed when New York City passed an ordinance that required posting of nutritional information on menu boards resulted in many fast food chains. When faced with the prospect of consumers seeing the nutritional information at the moment they placed an order, many fast food chains reformulated their products to significantly decrease the fat and calorie content. This kind of change is urgently needed to address the health emergency in this country.

The Special Committee respectfully and urgently requests that you actively support legislation similar to the LEAN Act of 2008 in the 111th Congress of the United States.

Thank you for your consideration of this request. If you have questions, please contact Rachel Letzing or Mary Matthias at the Legislative Council.

Sincerely,

Senator Julie Lassa, Chair
Special Committee on Performance-Based Disease Management Programs for Large Populations

JL:ksm

Enclosure

Appendix 7

Joint Legislative Council

[Joint Legislative Council Members Who Selected and Appointed Committee and Its Membership]

Co-Chair
FRED RISSER
Senate President
5008 Risser Road
Madison, WI 53705

Co-Chair
STEVE WIECKERT
Representative
1 Weatherstone Drive
Appleton, WI 54914

SENATORS

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Eland, WI 54427

TIM CARPENTER
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2957 South 38th Street
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SPENCER COGGS
3732 North 40th Street
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ALBERTA DARLING
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River Hills, WI 53217

RUSSELL DECKER
Majority Leader
6803 Lora Lee Lane
Weston, WI 54476

SCOTT FITZGERALD
Minority Leader
N4692 Maple Road
Juneau, WI 53039

SHEILA HARSDORF
N6627 County Road E
River Falls, WI 54022

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De Pere, WI 54115

MARK MILLER
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Monona, WI 53716

JUDY ROBSON
2411 E. Ridge Road
Beloit, WI 53511

REPRESENTATIVES

JOAN BALLWEG
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Markesan, WI 53946

JEFF FITZGERALD
Majority Leader
910 Sunset
Horicon, WI 53032

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Speaker Pro Tempore
1205 Noridge Trail
Port Washington, WI 53074

MICHAEL HUEBSCH
Speaker
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West Salem, WI 54669

DEAN KAUFERT
1360 Alpine Lane
Neenah, WI 54956

JIM KREUSER
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3505 14th Place
Kenosha, WI 53144

THOMAS NELSON
1510 Orchard Dr.
Kaukauna, WI 54130

MARK POCAN
309 N. Baldwin Street
Madison, WI 53703

KITTY RHOADES
708 4th Street
Hudson, WI 54016

MARLIN SCHNEIDER
3820 Southbrook Lane
Wisconsin Rapids, WI 54494

This 22-member committee consists of the majority and minority party leadership of both houses of the Legislature, the co-chairs and ranking minority members of the Joint Committee on Finance, and 5 Senators and 5 Representatives appointed as are members of standing committees.

Joint Legislative Council

[Current Joint Legislative Council Members Who Received Committee Report]

Co-Chair
FRED A. RISSER
Senate President
100 Wisconsin Avenue, Unit 501
Madison, WI 53703

Co-Chair
MARLIN D. SCHNEIDER
Representative
3820 Southbrook Lane
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SENATORS

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DALE SCHULTZ
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Richland Center, WI 53581

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TONY STASKUNAS
Speaker Pro Tempore
2010 South 103rd Court
West Allis, WI 53227

ROBIN VOS
4710 Eastwood Ridge
Racine, WI 53406

This 22-member committee consists of the majority and minority party leadership of both houses of the Legislature, the co-chairs and ranking minority members of the Joint Committee on Finance, and 5 Senators and 5 Representatives appointed as are members of standing committees.

PERFORMANCE-BASED DISEASE MANAGEMENT PROGRAMS FOR LARGE POPULATIONS

Steve Wieckert, Chair (4/08 – 1/09)
1 Weatherstone Drive
Appleton, WI 54914

Representative Chuck Benedict
3639 Bee Lane
Beloit, WI 53511

Cinthia S. Christensen
Children's Hospital of WI
9000 W. Wisconsin Ave.
Milwaukee, WI 53201

Marilyn Follen
Marshfield Clinic
7749 Lanae Avenue
Hewitt, WI 54441

Professor Susan A. Nitzke
UW-Madison
1415 Linden Drive
Madison, WI 53706

Dr. Deborah Wubben
Physicians Plus Insurance
P.O. Box 2078
Madison, WI 53701-2078

Senator Julie Lassa, Chair (1/09 to completion)
4901 Beaver Dam Road
Stevens Point, WI 54481

Dr. Alexandra Adams
University of Wisconsin-Madison
777 South Mills Street
Madison, WI 53715

Mikki Duran
Appleton Area School District
2725 E. Forest St.
Appleton, WI 54915

Jo Musser
WPS Insurance
1717 W. Broadway
Madison, WI 53708-8190

Dr. Kenneth Schellhase
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226

STUDY ASSIGNMENT: The committee is directed to: (1) examine the role of disease management programs in assisting to address the state's health care needs; (2) review best practice disease management programs from around the nation; (3) review current practices of the State of Wisconsin's programs; (4) review state-of-the-art procedures for measuring performance of disease management programs; (5) make recommendations on ways to more effectively measure disease management results; and (6) focus on group settings for children, primarily schools, preschool, and day care settings and the laws, rules, and policies related to nutrition and physical activities in those settings especially in regard to childhood obesity.

12 MEMBERS: 1 Senator, 1 Representative, and 9 Public Members.

LEGISLATIVE COUNCIL STAFF: Mary Matthias and Rachel Letzing, Senior Staff Attorneys, and Kelly Mautz, Support Staff.

Appendix 9

Committee Materials List

(Copies of documents are available at www.legis.state.wi.us/lc)

Recommendations to the Joint Legislative Council (March 26, 2009)

- Results of the March 26 meeting.
- Proposed Report to the Legislature 2009-07, *Special Committee on Performance-Based Disease Management Programs for Large Populations* (March 18, 2009).
- WLC: 0384/2, relating to the electronic medical records tax credit.
- WLC: 0389/2, relating to health care homes.
- WLC: 0385/2, relating to a quality rating system for child care.
- WLC: 0388/2, relating to school nutrition.
- WLC: 0387/2, relating to physical fitness assessments.
- WLC: 0397/1, relating to physical education teachers.
- WLC: 0399/1, relating to traditional neighborhood development ordinances, mixed-use zoning, department of transportation planning for bicycle and pedestrian ways, and the state housing strategy plan.

March 2, 2009 Mail Ballot

- WLC: 0384/2, relating to the electronic medical records tax credit.
- WLC: 0385/2, relating to a quality rating system for child care.
- WLC: 0388/2, relating to school nutrition.
- WLC: 0397/1, relating to physical education teachers.
- Draft letter to Governor Jim Doyle, relating to the Buy Local Buy Wisconsin Initiative (March 2, 2009).
- Draft letter to Representative Mark Pocan and Senator Mark Miller, Co-Chairs, Joint Committee on Finance, relating to the Buy Local Buy Wisconsin Initiative (March 9, 2009).

February 11, 2009 Meeting

- WLC: 0382/1, relating to traditional neighborhood development ordinances.
- WLC: 0384/1, relating to the electronic medical records tax credit.
- WLC: 0385/1, relating to a quality rating system for child care.
- WLC: 0386/1, relating to physical education.
- WLC: 0387/2, relating to physical fitness assessments.
- WLC: 0388/1, relating to school nutrition.
- WLC: 0389/1, relating to health care homes.
- WLC: 0390/2, relating to department of transportation planning for bicycle and pedestrian ways.
- WLC: 0391/1, relating to mixed-use zoning.
- WLC: 0392/1, relating to the state housing plan.
- Draft letter to Governor Jim Doyle, relating to a quality rating system.
- Draft letters to Governor Jim Doyle and Senator Mark Miller and Representative Mark Pocan, Co-Chairs, Joint Finance Committee, relating to school lunch reimbursement and incentives.
- Draft letters to Governor Jim Doyle and Senator Mark Miller and Representative Mark Pocan, Co-Chairs, Joint Finance Committee, relating to the farm-to-school program.
- Draft letters to Governor Jim Doyle and Senator Mark Miller and Representative Mark Pocan, Co-Chairs, Joint Finance Committee, relating to Buy Local Buy Wisconsin.
- Draft letter to Wisconsin Congressional Delegation relating to menu labeling.
- Appleton School District student nutrition guidelines, distributed at the request of Public Member Mikki Duran (June 9, 2003).
- Letter from Karent Ordinans and Paul Costanzo, Co-Chairs, Governor's Council on Physical Fitness and Health (January 21, 2008).
- Letter from Andrea Gavin, MD - President, Wisconsin Academy of Family Physicians (February 11, 2008).
- Memorandum, *Farm-to-School Policy Options for Improving School Nutrition*, from Bridget Holcomb,

Associate Policy Director, Michael Fields Agricultural Institute, and Luke Rollins, Chair of Advocacy, WIPAN, Director of State Advocacy, American Heart Association (February 11, 2009).

November 21, 2008 Meeting

- Memo No. 5, *Options for Legislation* (November 17, 2008).
- Memo No. 6, *Documents Relating to Options for Legislation Described in Memo No. 5* (November 17, 2008).
  - Summaries of selected healthy lifestyle initiatives of other states, from the Association of State and Territorial Health Officials Compendium of State Healthy Lifestyles Initiatives (2006).
  - The Wisconsin Nutrition and Physical Activity State Plan 2007 Progress Report.
  - 2007 Assembly Bill 1168 and fiscal estimates.
  - New York City ordinance, s. 81.50, and California law, Chapter 600, Laws of 2007, requiring posting of calorie information on restaurant menus.
  - National Committee on Quality Assurance (NCQA) Physician Practice Connections – Patient-Centered Medical Home Content and Scoring Summary.
  - 2007 Assembly Bill 90.
  - 2005 Assembly Bill 235 and fiscal estimates.
- Policy Assessments from the Wisconsin Partnership for Activity and Nutrition (WIPAN) Advocacy Committee, distributed at the request of Luke Rollins, Director of State Advocacy, American Heart Association, Midwest Affiliate.
  - Physical education instruction in Wisconsin schools.
  - Complete streets; physical activity built environment.
  - Increasing access to fruits and vegetables in Wisconsin communities.
  - Menu labeling of foods and beverages in Wisconsin restaurants.
  - Nutrition education standards in Wisconsin schools.
  - Nutrition standards for foods and beverages sold in Wisconsin schools.
- National Governor's Association Expert Policy Panel Proceedings Proposed Addendum.
- *Healthier Wisconsin Schools Project*, Expert Policy Panel Proceedings, National Governors Association Center for Best Practices Health Kids, Healthy America Grant (October 2008).
- DHS and DPI Input to Wisconsin Legislative Council Staff Memorandum #5 (November 21, 2008).
- Testimony from Dr. Lowell Keppel, President, Wisconsin Academy of Family Physicians (November 21, 2008).
- Letter from Dr. Lowell Keppel, President, Wisconsin Academy of Family Physicians (November 21, 2008).
- Chart, *TransforMed, The TransforMED Medical Home.*
- WAFP Patient-Centered Medical Home Medicaid Payment Proposal.
- Joint Principles of the Patient-Centered Medical Home (March 2007).

October 17, 2008 Meeting

- Memo No. 1, *Summary of Recommendations Made to the Special Committee at its July 24 and September 12, 2008 Meetings* (October 8, 2008).
- Memo No. 2, *Selected State Legislation Regarding Childhood Obesity* (October 9, 2008).
- Memo No. 3, *2008 Minnesota Legislation on Health Care Homes* (October 9, 2008).
  - Enclosure, *Joint Principles of the Patient-Centered Medical Home* (March 2007), American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association.
- Memo No. 4, *Selected Provisions of 2005 Vermont Act 191, Relating to Health Care Affordability and the Blueprint for Health* (October 9, 2008).
- Article, *Weight Management and Fruit and Vegetable Intake Among US High School Students*, Journal of School Health, August 2008, Vol. 78, No. 8, distributed by Carolyn Fisher, EdD, CHES, Senior Advisor, Division of Adolescent and School Health, NCCDPHP, CDC.
- Legislative Fiscal Bureau Paper #372, *Health Care Quality and Patient Safety Council and Grant Program (DHFS - Health Care Quality Fund)* (June 8, 2007).
- Presentation by Elaine Mischler, CEO, Mischler Consultants, Waukesha.
- Presentation by Denise Webb, Program Manager, eHealth Care Quality and Patient Safety Board, Department of Health Services, and Dr. Tim Bartholow, Wisconsin Health Information Organization.
  - Handout, *Persons Enrolled in Diabetes Program at Prairie Clinic, Sauk City, WI By Year,*

submitted by Dr. Bartholow, Wisconsin Health Information Orgranization.

- Presentation by James Galloway, Assistant Surgeon General, Region V, Chicago, IL.

September 12, 2008 Meeting

- Presentation, *ThedaCare Disease Management: Process and Outcomes, by* Dr. John Barkmeier, ThedaCare (September 12, 2008).
  - Testimony by Dr. John Barkmeier, Medical Director, Information Technology, ThedaCare Physicians-Menasha, ThedaCare, Inc. (September 12, 2008).
  - Testimony by Verna Van Nuland.
- Presentation by Ken Thorpe, Executive Director, Partnership to Fight Chronic Disease, Atlanta.
- Presentation by Laura Tobler, Program Director, Health Program, National Conference of State Legislatures (NCSL) (September 12, 2008).
  - Handout, *Medicaid Disease Management, States Turn to Private Sector Solutions to Improve Medicaid Programs*, distributed by Laura Tobler, Program Director, Health Program, NCSL (August 2008).
- Presentation by Carolyn Fisher, EdD, CHES, Senior Advisor, Division of Adolescent and School Health, NCCDPHP, CDC (September 12, 2008).
  - Handout, *Physical Activity and the Health of Young People*, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (October 2007).
  - Handout, *Nutrition and the Health of Young People*, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (October 2007).
  - Handout, *Division of Adolescent and School Health, School Health Programs 2008*, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (March 2008).
  - Handout, *Body Mass Index Measurement in Schools, Executive Summary*, Centers for Disease Control and Prevention.

July 24, 2008 Meeting

- Presentation by Amy Winterfeld, Program Principal, Health Program, NCSL (July 24, 2008).
  - Postcard, *Percentage of Children Who Are Obsese*, NCSL.
  - Report, *Childhood Obesity, Update of Policy Options and Research*, by Amy P. Winterfeld, NCSL (June 2007).
  - Report, *Childhood Obesity, Legislative Policy Approaches and the Evidence Base to Date*, by Amy Winterfeld, NCSL (July 2006).
  - Brief, *State Farm-to-School Policies*, NCSL Legisbrief (August/September 2008).
  - Article, *Nutrition Rules*, by Amy Winterfeld, NCSL (May 2006).
  - Article, *PE Makes a Comeback*, by Amy Winterfeld, NCSL (December 2007).
  - Article, *The High Costs of Obesity*, NCSL (April 2004).
- Presentation by Milda Aksamitauskas, MPP, Policy Analyst, Division of Health Care Access and Accountability, Department of Health Services (DHS).
- Presentation by Mary Pesik, Nutrition and Physical Activity Coordinator, Division of Public Health, DHS.
- Presentation by Denise Runde, MSPH, Policy Initiatives Advisor, Division of Access and Accountability, DHS.
- Presentation by Marilyn Follen, Administrator, Quality Improvement and Care Management, Marshfield Clinic.
- Presentation by Dr. Brian Fidlin, PsyD, Program Director, NEW Kids Program, Children's Hospital of Wisconsin.