LINC Commission Meeting

July 18, 2011

A student at the LINC Summer Program at Wayne Miner Caring Communities reads an educational booklet Food for Thought: Eating Well on a Budget. The bilingual multi-media program – developed by Sesame Workshop – helps support families who are coping with uncertain or limited access to affordable and nutritious food. Over 1,000 of the educational packets were distributed by LINC.

LINC
Local Investment Commission

3100 Broadway, Ste 1100- Kansas City, MO 64111 (816) 889-5050 - www.kclinc.org

Local Investment Commission (LINC) Vision

Our Shared Vision

A caring community that builds on its strengths to provide meaningful opportunities for children, families and individuals to achieve self-sufficiency, attain their highest potential, and contribute to the public good.

Our Mission

To provide leadership and influence to engage the Kansas City Community in creating the best service delivery system to support and strengthen children, families and individuals, holding that system accountable, and changing public attitudes towards the system.

Our Guiding Principles

1. COMPREHENSIVENESS: Provide ready access to a full array of effective services.
2. PREVENTION: Emphasize "front-end" services that enhance development and prevent problems, rather than "back-end" crisis intervention.
3. OUTCOMES: Measure system performance by improved outcomes for children and families, not simply by the number and kind of services delivered.
4. INTENSITY: Offering services to the needed degree and in the appropriate time.
5. PARTICIPANT INVOLVEMENT: Use the needs, concerns, and opinions of individuals who use the service delivery system to drive improvements in the operation of the system.
6. NEIGHBORHOODS: Decentralize services to the places where people live, wherever appropriate, and utilize services to strengthen neighborhood capacity.
7. FLEXIBILITY AND RESPONSIVENESS: Create a delivery system, including programs and reimbursement mechanisms, that are sufficiently flexible and adaptable to respond to the full spectrum of child, family and individual needs.
8. COLLABORATION: Connect public, private and community resources to create an integrated service delivery system.
9. STRONG FAMILIES: Work to strengthen families, especially the capacity of parents to support and nurture the development of their children.
10. RESPECT AND DIGNITY: Treat families, and the staff who work with them, in a respectful and dignified manner.
11. INTERDEPENDENCE/MUTUAL RESPONSIBILITY: Balance the need for individuals to be accountable and responsible with the obligation of community to enhance the welfare of all citizens.
12. CULTURAL COMPETENCY: Demonstrate the belief that diversity in the historical, cultural, religious and spiritual values of different groups is a source of great strength.
13. CREATIVITY: Encourage and allow participants and staff to think and act innovatively, to take risks, and to learn from their experiences and mistakes.
14. COMPASSION: Display an unconditional regard and a caring, non-judgmental attitude toward, participants that recognizes their strengths and empowers them to meet their own needs.
15. HONESTY: Encourage and allow honesty among all people in the system.

Monday, July 18th, 2011 | 4 – 6 pm
Kauffman Foundation
4801 Rockhill Rd.
Kansas City, Mo. 64110

Agenda

I. Welcome and Announcements

II. Approvals

a. May minutes (motion)

III. Superintendent's Reports

IV. LINC President's Report

V. LINC Health Initiatives

a. Kansas City Quality Improvement Consortium
b. Swope South Clinic
c. Eat, Live, Be Healthy

VI. Other

VII. Adjournment

THE LOCAL INVESTMENT COMMISSION – MAY 16, 2011

The Local Investment Commission met at the Kauffman Foundation, 4801 Rockhill Rd., Kansas City, Mo. Chairman **Landon Rowland** presided. Commissioners attending were:

Sharon Cheers
Steve Dunn
Herb Freeman
SuEllen Fried
Kiva Gates
Jim Giles (for Sly James)
Rob Givens
Anita Gorman
Dick Hibschman
Judy Hunt
Mary Kay McPhee
Richard Morris
Marge Peltier
David Ross

Rowland introduced **Jim Giles** of the Kansas City, Mo. Mayor's Office. Giles will attend LINC Commission meetings on behalf of ex-officio Commissioner Sly James.

A motion to approve the April 18, 2011, LINC Commission meeting minutes was passed unanimously.

Superintendents' Report

- **Bob Bartman** (Superintendent, Center School District) reported on a decrease in district revenues due to reductions in assessed property valuations. The district is preparing for an August bond issue vote.
- **Todd White** (Superintendent, North Kansas City School District) reported the district expects to serve 10,000 students for summer school. The district is going through a two-phase building improvement process.
- **Mark Enderle** (Superintendent, Fort Osage School District) reported families will have the opportunity to have their kids cared for this summer thanks to the LINC summer program.
- **Marti Dowd** (District Coordinator, Grandview School District) reported the district will operate a summer school program with the support of LINC summer programs.

President's Report

- **LINC summer programs.** LINC will offer summer programs in all seven school district it serves. To manage costs, the LINC programs will use full-time, year-round staff (site coordinators and supervisors).
- **Summer EBT food program.** LINC site coordinators are locating families who have been selected for surveys but whose notification letters have been returned to LINC because of incorrect or outdated addresses. Staff are implementing outreach efforts related to healthy eating activities and opportunities in addition to the Summer EBT program.
- **21st Century Community Learning Centers.** LINC staff are finalizing proposals for 21st Century grants for the Hickman Mills and Kansas City, Mo. school districts. The grants would provide funding to develop community schools while promoting academic achievement, family engagement and youth development.

LINC site coordinator **Norma Miller**, who will retire at the end of the school year, was recognized for her service to and love for children.

LINC Treasurer **David Ross** gave the third-quarter financial report. Financial statements reflect that LINC is on budget for this point in the fiscal year.

A motion to approve the 2009 IRS form 990 passed unanimously.

LINC Van Horn site coordinator **Lindsay Browne** introduced a presentation on the Missouri College Advising Corps (MCAC), a University of Missouri-Columbia college-access advisory initiative. A video was shown. Van Horn assistant principal **Patrick Layton** reported MCAC has helped transform Van Horn into a "college-going" culture. MCAC advisor **Meaghan Brougher** reported on her work advising students on the opportunities for higher education. Graduating Van Horn senior **Rosa Tarantola** reported on working with Brougher to seek scholarships and working with Browne as a volunteer with the Caring Communities site council. MCAC executive director **Beth Tankersley-Bankhead** gave an overview of MCAC, which is one of 10 founding advising corps nation-wide. She reported Van Horn has the highest increase in the rate of college attendees among MCAC schools. Discussion followed.

NorthWest CDC director **Bill Rogers** reported on the recent ribbon-cutting ceremony at the Norledge Place redevelopment project in Independence, which won an award for the U.S. Department of Housing and Urban Development. A video was shown. Discussion followed.

The meeting was adjourned.

LINC Health and Aging Committee co-chair and Kansas City Quality Improvement Consortium (KCQIC) executive director **Cathy Davis** reported KCQIC and LINC were recently awarded a $1.3 million grant from the Robert Wood Johnson Foundation. The grant will fund the third phase of the Aligning Forces for Quality (AF4Q) initiative, which works to improve health care by engaging patients in their care, publicly reporting the performance of physicians and hospitals, and improving the quality of care delivered in each community.

Kiva Gates introduced **Shantell Garrett**, president of R.U.B.I.E.S., Inc. (Realizing your Best in Every Situation), a nonprofit focusing on cultivating the minds of young women through community partnership, community outreach and curriculum-based mentoring. R.U.B.I.E.S. is offered at two LINC Caring Communities sites.

The meeting was adjourned.

QUALITY HEALTH TOGETHER

Who is KCQIC?

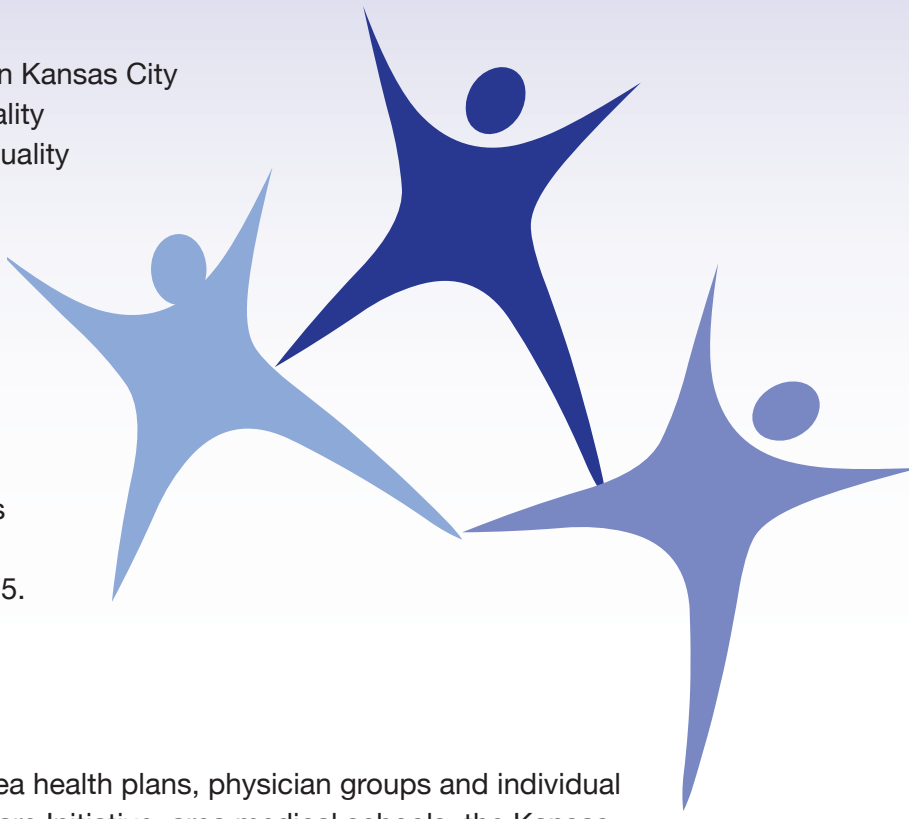
The Kansas City Quality Improvement Consortium (KCQIC) is a non-profit community coalition that promotes quality health care through collaboration, strategic leadership, education, information, and tools.

What Do We Do?

KCQIC seeks to lift the quality and value of health care in Kansas City. We do this through parallel strategies: engaging and improving health care systems, and engaging and improving community health.

Our Initiatives:

- Measure the quality and value of health care in Kansas City
- Support doctors and hospitals to improve quality
- Engage consumers and patients to improve quality
- Address disparities in health care



Our History

KCQIC was formed by the UAW-Ford Community Health Care Initiative and community stakeholders in November 2000 to create a forum for collaboration that encourages best practices in health care in Kansas City. KCQIC received 501(c)3 non-profit status in 2005.

Our Partners

KCQIC is an open collaborative that includes area health plans, physician groups and individual physicians, the UAW-Ford Community Health Care Initiative, area medical schools, the Kansas and Missouri Quality Improvement Organizations, and consumer networks like LINC.

Find Out More

Visit KCQIC's website at www.kcqic.org. To learn more about the quality of health care in Kansas City, visit www.qualityhealthtogether.org.

KCQIC
Kansas City Quality Improvement Consortium

www.kcqic.org | 816-453-4424 | 6000 N Oak Trfy, Ste. 300, Kansas City, MO 64118

QUALITY CARE REQUIRES A 50/50

Before buying a car, most people do their homework: they start by asking their friends, family and co-workers for recommendations. They check out expert reviews, examine warranties, ask questions of the dealer, and then search for the best value.

Now compare that to the way people typically research their health care. They may ask people they trust for recommendations, but most people rarely study doctors or their practices to see how they compare, much less prepare adequately for an appointment.

Shouldn't we devote as much time and attention to our health care as we do to our vehicles? After all, cars have to last us five or 10 years — maybe a little more — while our health has to last a lifetime. Even in Kansas City, there is good and bad quality health care, but the problem is most people don't understand those differences exist or know what quality of care they are receiving.

What is quality care?

So what is quality care? Simply put — it is getting the care you need when you need it — no less and no more. Quality care helps people stay well, get better when they are sick, or manage ongoing illnesses. It is the kind of care you want for yourself and your family.

Most people judge the quality of their care based on their relationship with their doctor. Can they get appointments when they need them? How long do they spend in the waiting room? Does the doctor talk to them and take time to explain what is going on, or does she just give a diagnosis, write a prescription and walk away?

While all of these are important factors, quality care only begins with the relationship between patients and their doctors. Melody O'Grady of Liberty succinctly expressed her opinion: "a doctor who doesn't lie to his patients." She went on to explain her statement: "A family member was sent by a doctor to an office in south

PARTNERSHIP

By Catherine Davis, Ph.D., President and CEO, Kansas City Quality Improvement Consortium

Kansas City — an hour's drive away — for a treatment he could have received a mile away from home in Liberty, because he (the doctor) had personally invested in the equipment being used at the South Kansas City office; he never told this family member that the same machine existed nearby."

Simply put — [quality care] is getting the care you need when you need it — no less and no more.

Quality care is care that works, care that is safe and care that's recommended for your condition. It's tailored for you. It means getting all of the care you need — for example, people with diabetes should receive certain blood tests and exams regularly; get help managing their blood pressure and cholesterol. But it also means not getting care that you don't need — for example, unnecessary antibiotics or exposure to dangerous radiation from an imaging scan.

Mutual respect is at the core. Quality care is delivered by professionals who respect you, communicate clearly with you, and involve you in decisions about your care.

Do your part to get quality care

To get quality care, you need to make informed choices about your health care and become a better partner with your doctor. What you can do:

Learn the quality of care that doctors and hospitals provide. This means look into the provider's skill and knowledge, his experience, how he treats patients (is there mutual respect), and do you get along with him.

Seek care as soon as you need it. Delays in getting care can make health problems more serious, more costly and harder to treat.

Ask questions. It's your body — you need to understand the information you are given. Prepare for an appointment by making a list of questions you want to ask, such as: "How is this treatment going to help me? Is there a downside? What could happen if I don't do this?" Use a checklist like the one found at www.rwjf.org/goto/checklist

Make sure you understand. If doctors use medical terms you don't understand, ask them to explain it in plain language and don't hesitate to ask for written instructions. It can actually be dangerous if you and your doctor don't understand each other.

Be involved in making decisions that affect your health. If your doctor recommends tests or treatment, ask for the information you need to make an informed decision. For example, you might want to know why a test is needed and how the results will be used.

Do your part to stay healthy. Stay active, maintain a healthy weight, and do your best to eat healthy foods.

Everyone who gets care, gives care and pays for care has a role to play in achieving high-quality health care. "It's your health, after all," says Dr. William Pankey, Chief Medical Officer Swope Health Services, "It is a joint responsibility, a 50-50 partnership between you and your provider."

The quality of your health care will improve only if you take the first step. Talk to your doctor. Do your research. Become an advocate

Continued on page 12

Improving the Quality of Your Care Checklist

Getting good medical care is a partnership between you and your doctor. You can get the most from every visit by using these simple tips:

✓ ***Give complete and accurate information.*** If you have a medical problem, your doctor will want to know about all your symptoms, including when they started, what they feel like and how long they last.

✓ ***Ask all your questions and make sure you understand the answers.*** Before your appointment, make a list of all the questions you want to ask. During the appointment, take notes of what the doctor says. Let your doctor know if you are confused or do not understand something.

✓ ***Talk with your doctor about lifestyle choices that affect your health.*** This includes foods you eat, how much exercise you get and whether you smoke, drink or use drugs. It is important to talk with your doctor about these choices even if it is awkward or embarrassing to do so.

✓ ***Let your doctor know about other doctors or health providers you see.*** Talk with your doctor about why you see these providers, what happened during the visit and any treatments or medications that were prescribed.

✓ ***Discuss benefits and risks before you make a treatment choice.*** Many times, there is more than one way to treat an illness or health problem. Talk with your doctor and learn as much as you want to know about the benefits and risks of each treatment choice.

✓ ***Find out when you will hear about test results.*** Call your doctor's office if you do not get test results when expected. Don't assume that "no news is good news."

✓ ***Make and keep all appointments, even when you are feeling well.*** One of the best ways to stay healthy is to follow your doctor's advice for follow-up care and prevention.

For more ideas on how you can work with your doctor to improve your care experience and for additional resources and information about health care quality, please visit QualityHealthTogether.org.

Continued from page 11

for your health. With those things in place, you will maximize your doctor's visit and increase your odds of maintaining your health. That is something you and your doctor can do together.

Kansas City is one of 17 communities across the country participating in Aligning Forces for Quality, a national initiative of the Robert Wood Johnson Foundation to improve the quality of health care. The Kansas City Quality Improvement Consortium (KCQIC) is helping Kansas City patients and doctors work together towards better quality care.

OHM

I Understand...I Think

Improving health literacy has become a national priority. What is health literacy? It is the ability to understand health information and to use that information to make good decisions about your health and medical care. ***Low health literacy is dangerous and also costly. Research shows that it costs Missouri taxpayers between $3.3 billion and $7.5 billion each year.***

Learn more about health literacy www.HealthLiteracyMissouri.org.

Knowledge is Power

catheterization — to insert a thin flexible tube into a part of the body to inject or drain away fluid or to keep a passage open

degeneration — in medicine, a disease that causes a weakening or worsening in a body part and a loss of function

invasive — inserting something into a body or operating on a body

mantra— an expression or idea that is repeated, often without thinking about it, and closely associated with something

metabolism — the series of processes by which food is converted into the energy and products needed to sustain life

nonsteroidal — A drug or other substance not containing a steroid

The New York Times
July 7, 2011

First Study of Its Kind Shows Benefits of Providing Medical Insurance to Poor

By GINA KOLATA

When poor people are given medical insurance, they not only find regular doctors and see doctors more often but they also feel better, are less depressed and are better able to maintain financial stability, according to a new, large-scale study that provides the first rigorously controlled assessment of the impact of Medicaid.

While the findings may seem obvious, health economists and policy makers have long questioned whether it would make any difference to provide health insurance to poor people.

It has become part of the debate on Medicaid, at a time when states are cutting back on this insurance program for the poor. In fact, the only reason the study could be done was that Oregon was running out of money and had to choose some people to get insurance and exclude others, providing groups for comparison.

Some said that of course it would help to insure the uninsured. Others said maybe not. There was already a safety net: emergency rooms, charity care, free clinics and the option to go to a doctor and simply not pay the bill. And in any case, the argument goes, if Medicaid coverage is expanded, people will still have trouble seeing a doctor because so few accept that insurance.

Until now, the arguments were pretty much irresolvable. Researchers compared people who happened to have insurance with those who did not have it. But those who do not have insurance tend to be different in many ways from people who have it. They tend to be less educated and to have worse health habits and lower incomes, said Dr. Alan M. Garber, an internist and health economist at Stanford. No matter how carefully researchers try to correct for the differences “they cannot be completely successful,” Dr. Garber said. “There is always some doubt.”

The new study, published Thursday by the National Bureau of Economic Research, avoided that problem. Its design is like that used to test new drugs. People were randomly selected to have Medicaid or not, and researchers then asked if the insurance made any difference.

Health economists and other researchers said the study was historic and would be cited for years to come, shaping health care debates.

“It’s obviously a really important paper,” said James Smith, an economist at the RAND Corporation. “It is going to be a classic.”

Richard M. Suzman, director of the behavioral and social research program at the National Institute on Aging, a major source of financing for the research, said it was “one of the most important studies that our division has funded since I’ve been at the N.I.A.,” a period of more than a quarter-century.

In its first year of data collection, the study found a long list of differences between the insured and uninsured, adding up to an extra 25 percent in medical expenditures for the insured.

Those with Medicaid were 35 percent more likely to go to a clinic or see a doctor, 15 percent more likely to use prescription drugs and 30 percent more likely to be admitted to a hospital. Researchers were unable to detect a change in emergency room use.

Women with insurance were 60 percent more likely to have mammograms, and those with insurance were 20 percent more likely to have their cholesterol checked. They were 70 percent more likely to have a particular clinic or office for medical care and 55 percent more likely to have a doctor whom they usually saw.

The insured also felt better: the likelihood that they said their health was good or excellent increased by 25 percent, and they were 40 percent less likely to say that their health had worsened in the past year than those without insurance.

The study is now in its next phase, an assessment of the health effects of having insurance. The researchers interviewed 12,000 people — 6,000 who received Medicaid and 6,000 who did not — and measured things like blood pressure, cholesterol and weight.

The study became possible because of an unusual situation in Oregon. In 2008, the state wanted to expand its Medicaid program to include more uninsured people but could afford to add only 10,000 to its rolls. Yet nearly 90,000 applied. Oregon decided to select the 10,000 by lottery.

Economists were electrified. Here was their chance to compare those who got insurance with those who were randomly assigned to go without it. No one had ever done anything like that before, in part because it would be considered unethical to devise a study that would explicitly deny some people coverage while giving it to others.

But this situation was perfect for assessing the impact of Medicaid, said Katherine Baicker, professor of health economics at the Harvard School of Public Health. Dr. Baicker and Amy Finkelstein, professor of economics at M.I.T., are the principal investigators for the study.

“Amy and I stumbled across the lottery in Oregon and thought, ‘This is an unbelievable opportunity to actually find out once and for all what expanding public health insurance does,’ ” Dr. Baicker said.

They had just a short window of time. Within two years, Oregon found the money to offer Medicaid to the nearly 80,000 who had been turned down in the lottery.

As an economist, Dr. Finkelstein was interested, among other things, in whether Medicaid did what all insurance — homeowner’s, auto, health — is supposed to do: shield people from financial catastrophe. Almost no one had even tried to investigate that question, she said.

“It is shocking that it is not even in the discourse,” Dr. Finkelstein said.

The study found that those with insurance were 25 percent less likely to have an unpaid bill sent to a collection agency and were 40 percent less likely to borrow money or fail to pay other bills because they had to pay medical bills.

Dr. Finkelstein said she had thought that the people were so poor to begin with that they just did not spend very much out of pocket on medical care when they did not have insurance. “Yet look at the results,” she said.

Dr. Baicker interviewed people for Part 2 of the study and was impressed by what she heard.

“Being uninsured is incredibly stressful from a financial perspective, a psychological perspective, a physical perspective,” she said. “It is a huge relief to people not to have to worry about it day in and day out.”

KansasCity.com
THE KANSAS CITY STAR.
July 02, 2011

The Star's editorial | An alarming trend on women's life expectancy

Life expectancy rates for women declined or were stagnant in more than one-fourth of Missouri's counties over a recent 20-year period.

That startling revelation should prompt soul-searching in Jefferson City and in local communities. Until recently, every generation born in the United States has lived longer than the one before. While that remains true in most of the nation, a new study shows that in many locations, a baby girl born today can expect to live a shorter life than her mother.

The decreases are concentrated in Missouri and six other states: Alabama, Kentucky, Mississippi, Oklahoma, Tennessee and West Virginia.

In Missouri, 26 of the state's 114 counties recorded decreasing life expectancies for women from 1987 to 2007, while rates remained stagnant in three counties.

And the crisis seems to be accelerating. In the second half of the study — from 1997 to 2007 — life expectancy for women decreased in 35 Missouri counties and was stagnant in 13 counties.

By contrast, only two Kansas counties showed decreased life expectancy for women over the study's 20-year span. In both states, life expectancy for men stayed constant or increased in all counties, although women generally still live longer than men.

For Missouri, the study's revelations are inexcusable, but not really surprising.

Missouri is shamefully stingy about investing in the health of its citizens. It encourages smoking by refusing to raise its lowest-in-the-nation cigarette tax. It has failed to enact a statewide smoking ban. And access to health care is a problem for many citizens.

"Missouri is one of the few states in the country where a massive percentage of the counties have been at a standstill or lost life expectancy for women in the past decade," said Ali Mokdad, a professor of global health at the University of Washington's Institute for Health Metrics and Evaluation, which did the study. "People should be alarmed and ask their local leaders what can be done."

The study, which is receiving considerable attention, reveals gaping life expectancy disparities inside the United States. It also shows the nation as a whole isn't keeping pace with others such as Canada and Japan, which are seeing significant gains in life expectancy.

The study doesn't conclusively identify causes for declining life expectancies. However, researchers cited smoking and obesity as likely suspects, along with high blood pressure, which more often goes undiagnosed and untreated among women.

Those factors are certainly in play in Missouri.

According to statistics from the U.S. Department of Health and Human Services, Missouri ranks 44th among the states for the prevalence of obesity in women. It ranks 38th for the number of women diagnosed with high blood pressure.

As for smoking, Missouri does more than any other state to *encourage* citizens to puff away.

At 17 cents a pack, its cigarette tax is by far the nation's lowest. State funding for prevention and cessation efforts is less than 2 percent of the amount recommended by the Centers for Disease Control and Prevention.

Missouri is one of only 11 states to have no statewide smoke-free law for non-governmental buildings. Significantly, six of the seven states that show the most alarming decreases in life expectancy for women appear on the list of smoking ban holdouts.

Economics and barriers to care may also play a role in decreasing life expectancies.

Missouri is plagued by a shortage of physicians and health care workers. The state's Medicaid eligibility limits for adults are shamefully low. Its immunization rate for young children is far below the national average.

"We hope that local policymakers will use these new life expectancy numbers to see where they are and to create targeted policies to make real improvements in health outcomes," Mokdad said.

In Missouri, that probably will require an investment of funds. An advocacy group, Trust for America's Health, recently calculated that Missouri spent $9.26 per person on public health in the 2008-09 fiscal year.

The national average for states was $28.92 per person.

It's no stretch to connect the state's smoke-friendly policies and tight purse strings with the startling decrease in women's life expectancies. The real question is: Who will take the lead in reversing the trend?

KansasCity.com
THE KANSAS CITY STAR.
June 5, 2011

The Star's editorial | Missouri's rejection of insurance 'exchanges' makes no sense

A big piece of the new federal health care reform law is the creation of statewide insurance exchanges — marketplaces in which consumers can compare and purchase private plans that have been vetted for consumer protections.

The Affordable Care Act calls for the exchanges to come on line in 2014. States can either design their own or wait for the federal government to design one for them.

Missouri doesn't take well to having Washington tell it what to do.

So Republican House Speaker Steve Tilley sensibly assigned a committee to write a bill creating a state exchange .

Chaired by Chris Molendorp, a Cass County Republican, the committee all but moved mountains. Its bill received the blessing of health insurers, consumer advocates, hospitals, doctors groups and insurance agents.

The proposed legislation creates a quasi-public agency with a 17-member board. Its purpose is to assist individual consumers and small employers with the purchase of qualified health and dental plans. The bill calls for a toll-free hotline, enrollment periods, a website that provides easily understandable information about available plans and an electronic calculator that shows consumers how much a particular plan would cost them.

Regardless of one's opinion about federal health care reform, exchanges are a good idea. They provide transparency and empower individual consumers and small businesses with the bargaining clout now enjoyed mostly by larger employers.

The Missouri House passed the Show-Me Health Insurance Exchange Act by a vote of 157-0. It looked like smooth sailing all the way to the governor's desk.

But a funny thing happened on the way to the Senate floor. Sen. Jane Cunningham, a Republican from Chesterfield, got a look at the bill. She wasn't pleased.

Cunningham was the driving force behind the Health Care Freedom Act, the 2010 ballot proposition that creates a statute prohibiting governments from forcing individuals and businesses to purchase health insurance , as required by the federal Affordable Care Act.

The way Cunningham saw it, the insurance exchange bill violated the Health Care Freedom Act and Missouri's very sovereignty.

“What constitutional authority does Kathleen Sebelius have to come into our state and say, ‘You have to set up an exchange ’?” Cunningham asked, referring to the former Kansas governor and now secretary of the U.S. Department of Health and Human Services.

Plenty, actually. The federal government requires states to do many things, usually with the threat of states losing a portion of funding if they don’t comply.

But no matter. A couple of other senators joined Cunningham’s cause and the Show-Me Health Insurance Exchange Act never came up for a vote on the Senate floor.

Missouri has another year to create an exchange , but right now the prospects don’t look bright. “That same language will never fly,” Cunningham proclaimed. But the language she rejects is what the parties with the most stake in the exchange have agreed upon.

While Missouri’s exchange is temporarily derailed, Kansas is moving forward.

State officials applied for, and received, a $31 million federal “innovator” grant to build the technological base needed to make the exchange work.

Gov. Sam Brownback, though a strident opponent of the Affordable Care Act, supports the general idea of an insurance marketplace.

The Kansas Legislature is expected to draft a bill creating a statewide exchange in 2012.

Although fewer than a dozen states have passed laws creating exchanges so far, most, like Kansas, are moving forward. It’s the pragmatic thing to do. The portion of the Affordable Care Act requiring people to purchase insurance is being challenged in court, but few knowledgeable people expect the entire law to be overturned.

Missouri’s legislative leaders face the tough job of convincing Cunningham and others to set aside their ideological biases and allow an insurance exchange that works for the state.

Either that, or learn to like whatever Washington comes up with.

News Release

FOR IMMEDIATE RELEASE
July 11, 2011

Contact: HHS Press Office
(202) 690-6343

HHS and states move to establish Affordable Insurance Exchanges, give Americans the same insurance choices as members of Congress

Proposed rules offer states flexibility, choices, competition and clout for consumers and small businesses

Today, the U.S. Department of Health and Human Services (HHS) proposed a framework to assist states in building Affordable Insurance Exchanges, state-based competitive marketplaces where individuals and small businesses will be able to purchase affordable private health insurance and have the same insurance choices as members of Congress. Starting in 2014, Exchanges will make it easy for individuals and small businesses to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP), and enroll in a health plan that meets their needs.

"Exchanges offer Americans competition, choice, and clout," said HHS Secretary Kathleen Sebelius. "Insurance companies will compete for business on a transparent, level playing field, driving down costs; and Exchanges will give individuals and small businesses the same purchasing power as big businesses and a choice of plans to fit their needs."

Today's announcement is designed to help support and guide states in their efforts to implement Exchanges. HHS proposed new rules offering states guidance and options on how to structure their Exchanges in two key areas:

- Setting standards for establishing Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange, and certifying health plans for participation in the Exchange, and;
- Ensuring premium stability for plans and enrollees in the Exchange, especially in the early years as new people come in to Exchanges to shop for health insurance.

These proposed rules set minimum standards for Exchanges, give states the flexibility they need to design Exchanges that best fit their unique insurance markets, and are consistent with steps states have already taken to move forward with Exchanges.

Forty-nine states, the District of Columbia and four territories accepted grants to help plan and operate Exchanges. In addition, over half of all states are taking additional action beyond receiving a planning grant such as passing legislation or taking Administrative action to begin building exchanges. States will continue to implement exchanges on different schedules through 2014.

"States are leading the way in implementing health reform, and today's announcement builds on that momentum by giving states flexibility to design the Exchange that works for them," said Center for Consumer Information and Insurance Oversight Director Steve Larsen. "This regulation allows us to meet states where they are."

Today's proposals build on over a year's worth of work with states, small businesses, consumers and health insurance plans and offer states substantial flexibility. For example, it allows states to decide whether their Exchanges should be local, regional, or operated by a non-profit organization, how to select plans to participate, and whether to partner with HHS to split up the work.

In drafting these proposals, the administration examined models of Exchanges, held numerous meetings with stakeholders and consulted closely with state leaders, consumer advocates, employers and insurers. To continue that conversation, HHS is accepting public comment on the proposed rules over the next 75 days to learn from states, consumers, and other stakeholders how the rules can be improved and HHS will modify these proposals based on feedback from the American people. To facilitate that public comment process, HHS will convene a series of regional listening sessions and meetings.

To reduce duplication of effort and the administrative burden on the states, HHS also announced that the federal government will partner with states to make Exchange development and operations more efficient. States can choose to develop an Exchange in partnership with the federal government or develop these systems themselves. This provides states more flexibility to focus their resources on designing the right Exchanges for their local insurance markets.

For more information on Exchanges, including fact sheets, visit http://www.healthcare.gov/exchanges.

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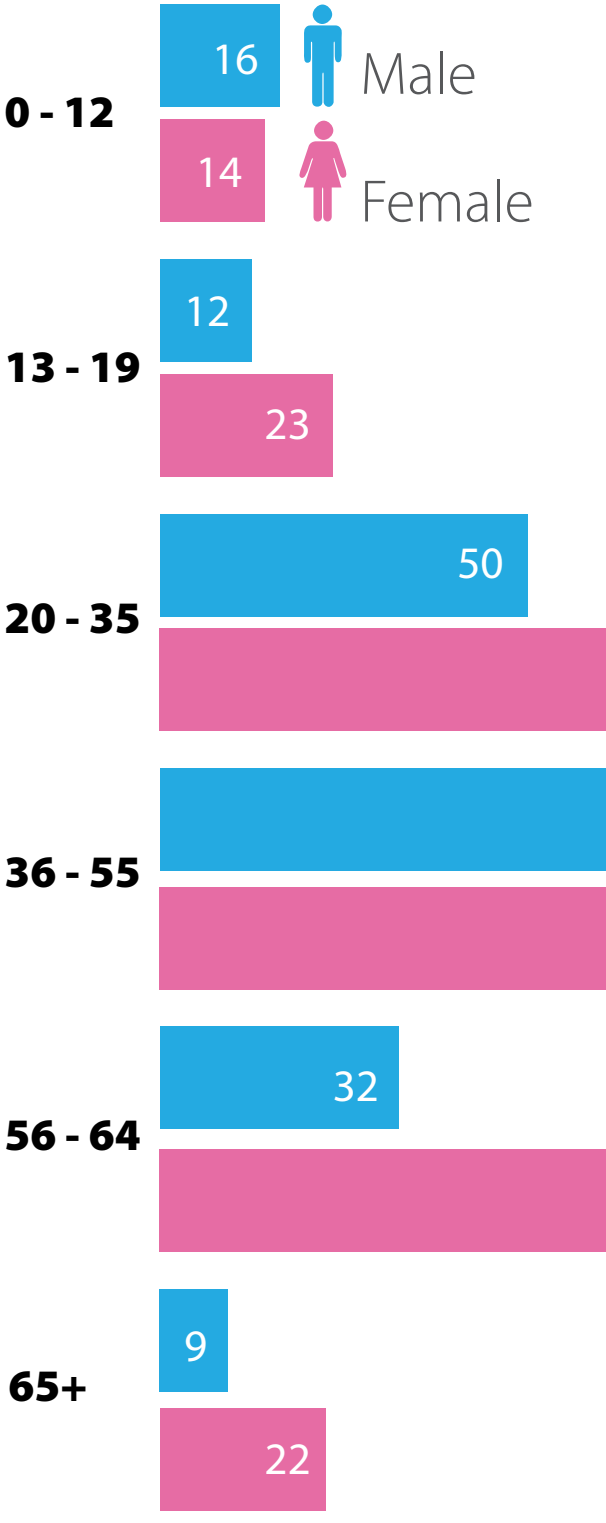
Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

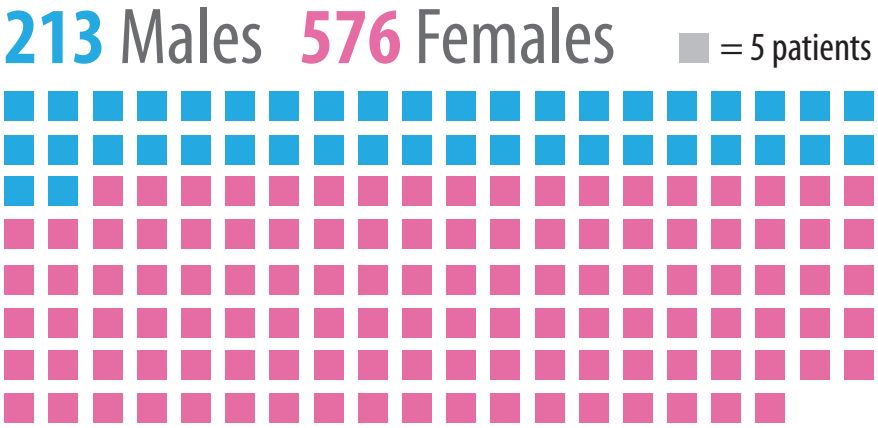
Last revised: July 11, 2011

Swope Health South Clinic

Patient Demographics Jan. 1 - March 31, 2011

Age & Sex

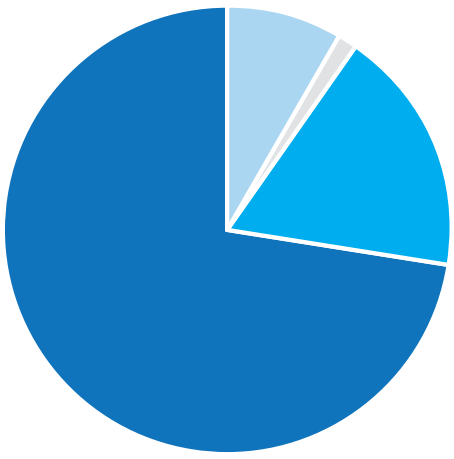




96 Routine Gynecological Exams

Women ages 20 - 35 were **4x** as likely to use services as males.

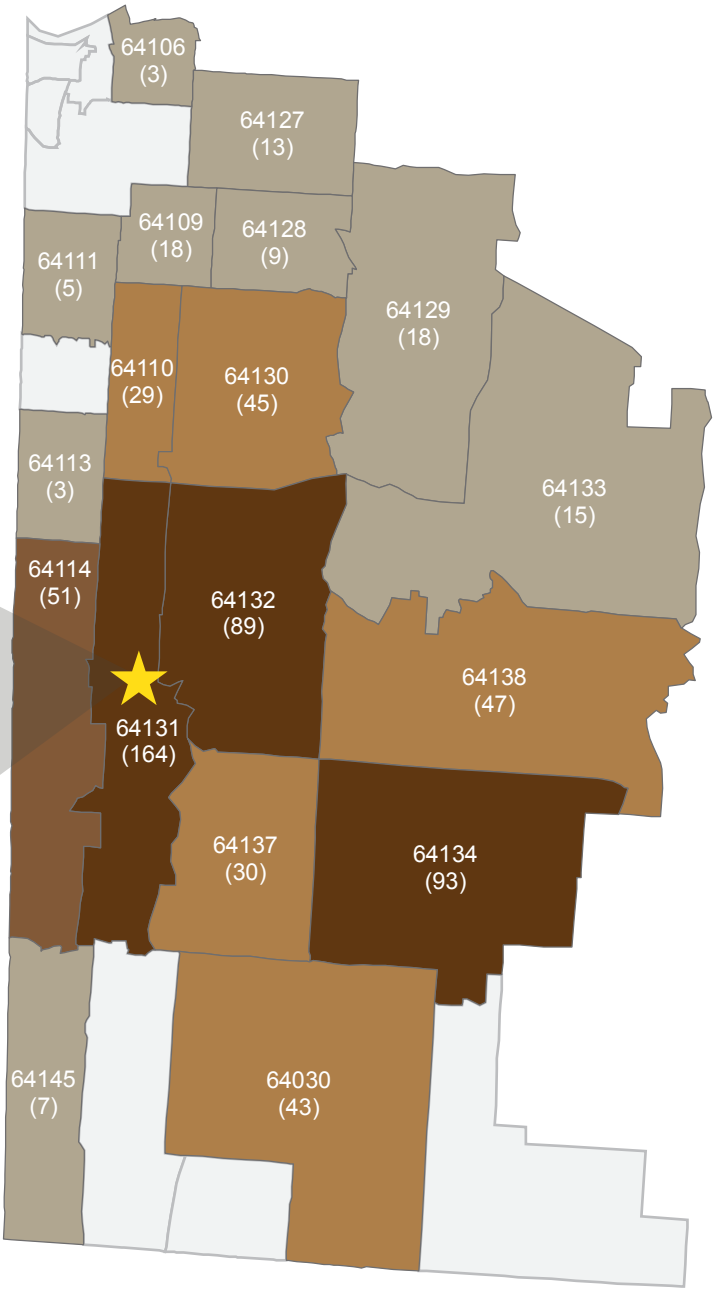
Race



72%	African American
18%	White
8%	Other or Unknown
2%	Hispanic

Where do patients live?

789
Total



245

Medical Issues

46% Hypertension

21% High Cholesterol

17% Diabetes

16% Pain / Fatigue

The Swope Health South Clinic was made possible by financial support from the City of Kansas City, Missouri, the Health Care Foundation of Greater Kansas City and other sources. The clinic opened its doors in January 2011.

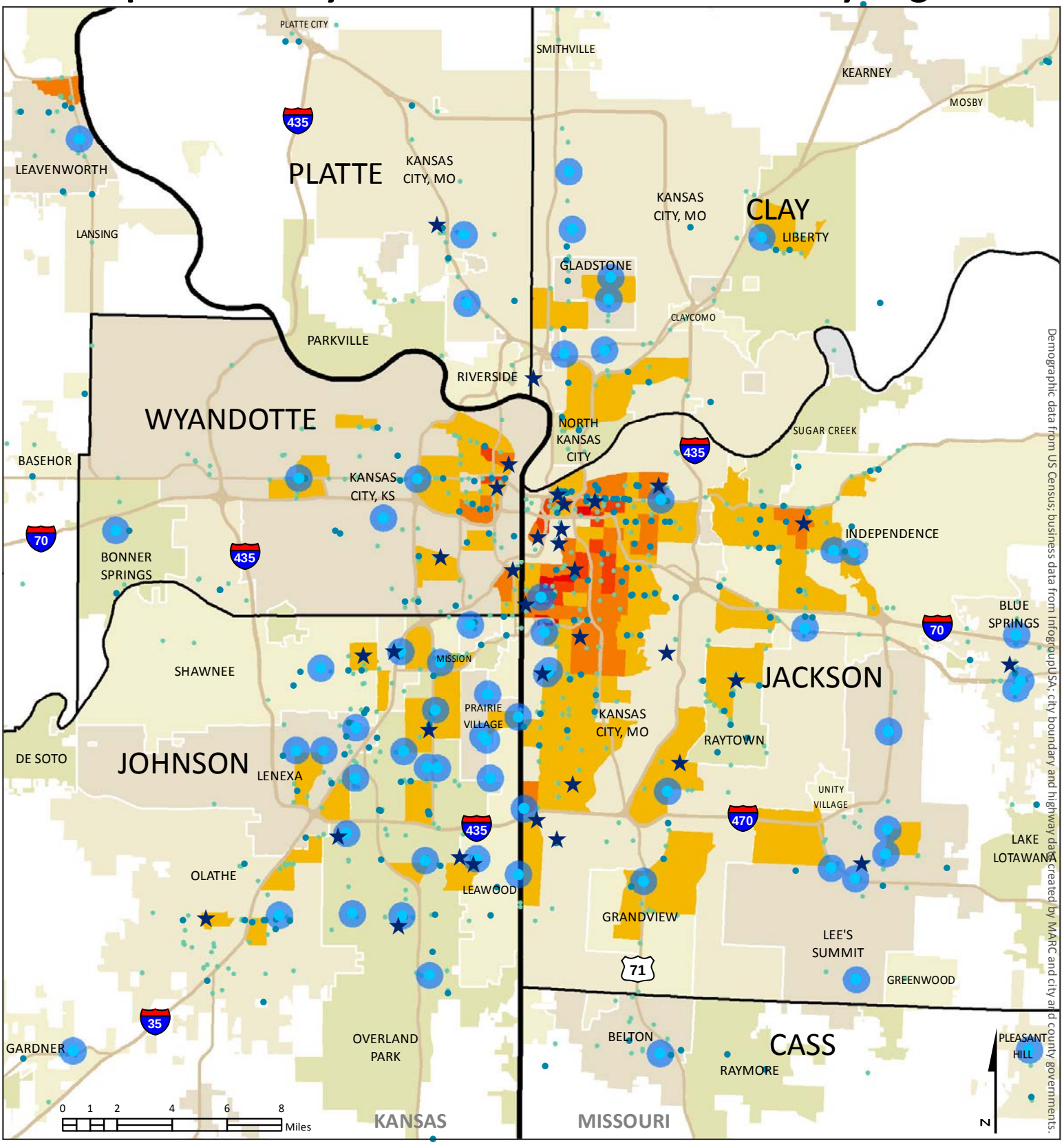
Health Care Foundation
OF GREATER KANSAS CITY

CITY OF FOUNTAINS
HEART OF THE NATION
KANSAS CITY
MISSOURI

SWOPE HEALTH SERVICES℠
Member Swope Community Enterprises

LINC
Local Investment Commission

Gaps in Healthy Food Access in the Kansas City Region



Demographic data from US Census; business data from InfogroupUSA; city boundary and highway data created by MARC and city and county governments.

- Large Grocery Stores (40,000+ sq.ft.)
- Small Grocery Stores
- Food Stores (No Fresh Produce)
- Generalized 1/2 mile walkable area
- Farmers Markets

Zero-vehicle households per square mile

- 76 - 300
- 301 - 600
- 601 - 1,200
- 1,201 - 2,228

JUNE 2011

MARC
Mid-America Regional Council
Geographic Information Systems

More information and data use policy is available at www.marc.org/gis

KansasCity.com
THE KANSAS CITY STAR.

July 7, 2011

Summer lunch programs for children fill a growing need

By JOE ROBERTSON and TRACI ANGEL
The Kansas City Star

These last boys in the free-lunch line came with their hair and shirts soaked in the rich smells of hot summer.

Their spoons raked in the baked beans. Their hands gripped their chicken sandwiches. And the way they came shyly sniffing for seconds from the Fort Osage School District's food servers made this much clear as well:

They came hungry.

"I rode my bike … from Baker," a 9-year-old said, indicating a street at least a mile away from the First Baptist Church of Buckner, one of the sites where the school district is serving up free breakfast and lunch for children.

Summertime always puts children at more risk of missing out on healthy meals. The danger has risen this summer in a harsh economy that has more families in need at the same time that districts are cutting back on summer school.

Many area schools and social service agencies are trying to bridge the gap.

The children typically won't say what this food might mean to them — whether it's just a free meal, or the only real meal they'll get that day.

But Tammy Potter, manager of the Buckner Elementary School cafeteria, said she has heard the quiet thanks from some parents since the district began offering the meals last summer.

"They told us all summer, 'It's a blessing,' " Potter said. "Some lost jobs. Some had to walk a distance because they didn't have cars. I heard it over and over, 'It's a blessing.' "

This summer, school districts and community service organizations are working harder to spread the word about the meals for children available through the U.S. Department of Agriculture's summer food programs.

Fort Osage, Kansas City, Hickman Mills and Kansas City, Kan., are just some of the school districts advertising their food programs to their communities. Social service groups such as Harvesters and church organizations including the Summit Lunch Program in Lee's Summit are increasing their roles.

Harvesters' Kids Cafe program is serving about 3,300 children daily to help fill the deepening need.

School records in Missouri and Kansas show that the number of families considered economically stressed has risen sharply over the past four years.

At the same time, budget pressures have compelled many districts to reduce their summer school programs.

Families who rely on subsidized school meals to help feed their children often struggle through the summer months when classes are out.

But in many school districts, free meals are waiting for all children, not just those who qualified for subsidized meals during the school year. Adults can eat, too, breakfast and lunch for prices ranging from $2 to $3.50.

The Kansas City School District is continuing food service at four sites spaced around the district and is putting out the word to all its families.

"It's to serve my students throughout the year," said Ellen Cram, the district's child nutrition director. "I worry about them in the summer."

Kansas City isn't alone. It's not just districts that have long had higher poverty rates that see more need. Since 2007, larger school districts across the area have seen significant increases in the number of families qualifying for free or reduced-price lunches.

Shawnee Mission rose to 33.2 percent in 2011 from 19.2 percent in 2007. Olathe rose to 25.5 percent from 16.8 percent, North Kansas City to 46 percent from 37.2 percent, Blue Springs to 27.2 percent from 16.4 percent.

Without the free meals being served at Gladstone Elementary School in Kansas City's Northeast neighborhood, Maria Ibarra would have made sure her six children were fed, but finding a way is "*muy difícil*," she said.

Very hard.

Hers was one of several families who came by recently for a lunch of spaghetti, bread, salad and apple slices. Her husband's work at construction sites supports the family, but is sporadic.

The food program, she said in Spanish, will put her in a better position to provide clothes and school supplies in the fall.

Same goes for Maria Hernandez and her four children. She will be able to provide "*ropa por los niños, y zapatos*."

Clothes for the children, and shoes.

Nationwide, federal records show, schools and community groups served 134 million meals last summer, up from 120 million in 2007.

But the program wants to reach more children, said U.S. Department of Agriculture spokeswoman Jean Daniel. More providers are needed as schools and community services facing budget cuts shut down.

“Not as many sites are available,” Daniel said. “That is a constant issue.”

The number of Missouri students enrolled in summer school dropped dramatically in 2010 because of state budget cuts, from 782,771 in 2009 to 485,106. That drop was the primary reason that the number of summer meals served fell from 4.1 million to 2.9 million.

Kansas, which involves fewer students in summer school, saw its numbers decline from budget pressures after 2008. Its enrollment fell in two years from 60,344 to 43,123 last summer.

Becky Iloilo is thankful that the Fort Osage School District is carrying on its summer nutrition program. Last year, when her husband’s work was more off and on, she was one of those calling the program “a blessing,” she said.

With work steadier this year, the meals still help families in a rough economy keep children eating nutritiously during hectic summers.

Kids can get into bad habits, she said, but the school meals “allowed us to keep fruits and vegetables in our diet.”

The boys on their bicycles — who’d come without any parents — bolted back into the summer steam, their bellies filled with chicken sandwiches, baked beans, peaches and milk.

More families in need

The number of children from economically stressed families has been increasing sharply the past three years after remaining flat through most of the 2000s in Kansas and Missouri school districts.

Percentage of students who qualify for free or reduced-price lunches in some of the area's largest districts.

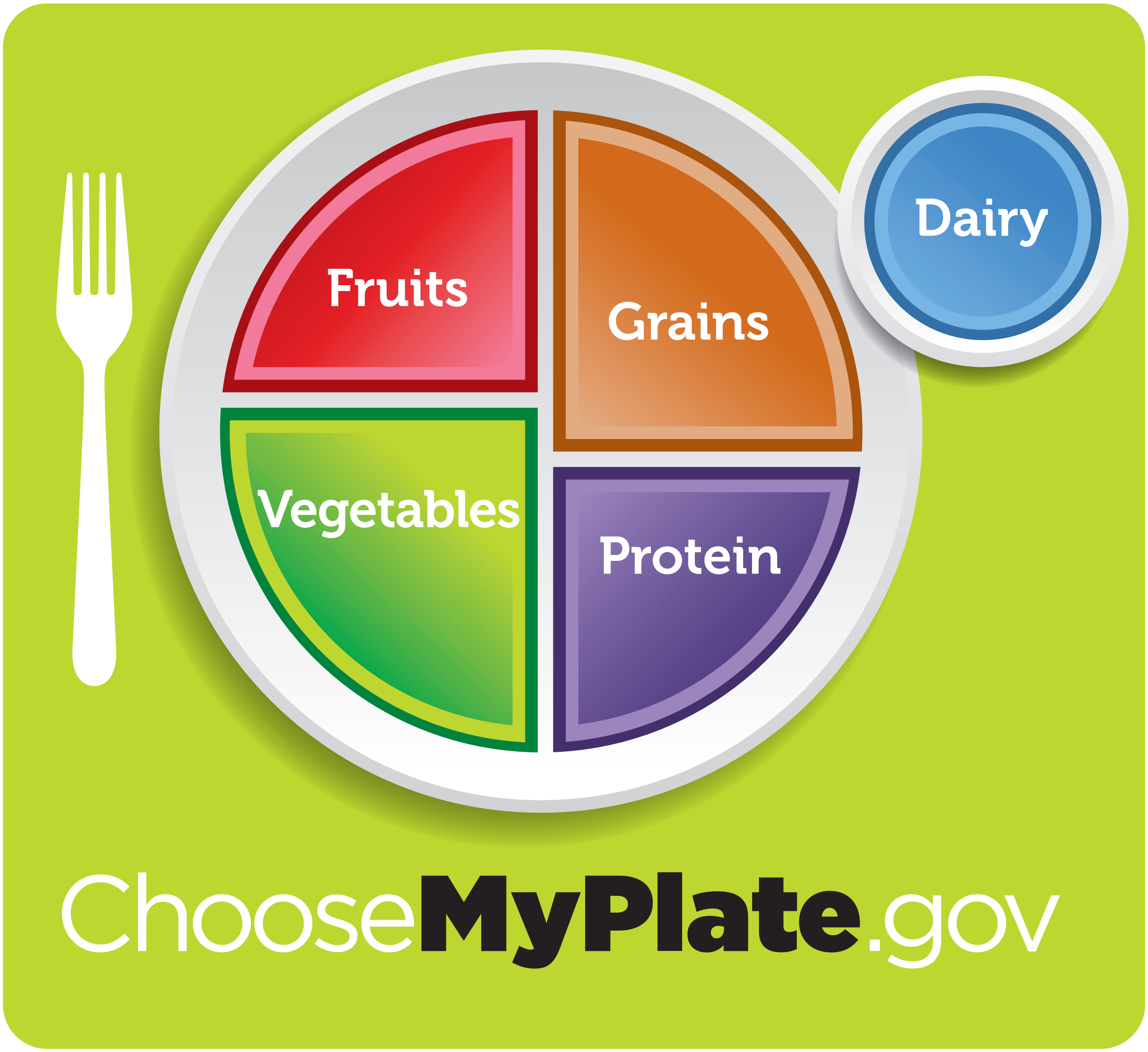
State	Percent who qualify, 2011	Percent change since 2006
Blue Springs	27.2	73.2
Hickman Mills	82	18.3
Independence	62.5	31.0
Kansas City	84.2	5.9
Lee's Summit	18.2	64.0
Liberty	19.8	38.5
North Kansas City	46	25.7
Park Hill	25.1	37.2
Raytown	54.9	34.6
Blue Valley	7.4	117.6
Kansas City, Kan.	87.8	19.9
Olathe	25.5	59.4
Shawnee Mission	33.2	93.0

Meal locations

To find summer meal locations in your neighborhood, call the National Hunger Hotline at 1-866-3-HUNGRY (348-6479) or 1-877-8-HAMBRE (842-6273).

To reach Joe Robertson, call 816-234-4789 or send email to jrobertson@kcstar.com.

Sources: U.S. Department of Agriculture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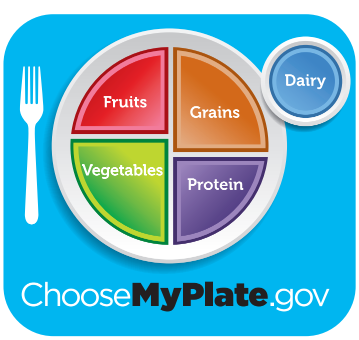
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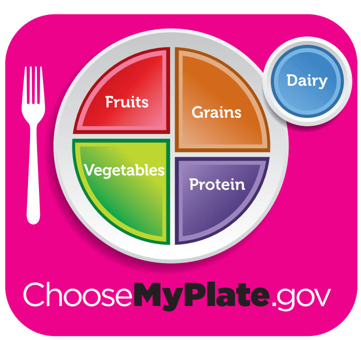
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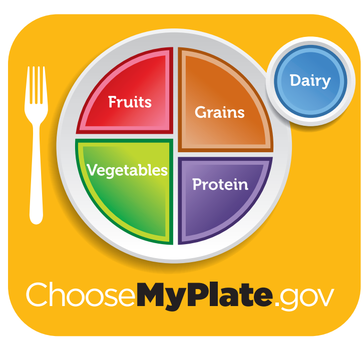
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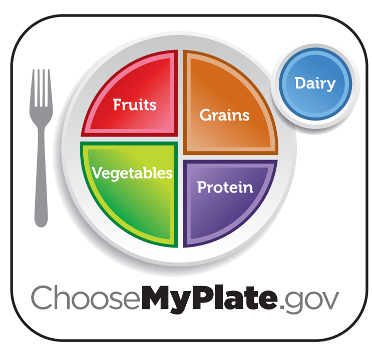
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Dairy
Vegetables
Protein
ChooseMyPlate.gov

Dietary Guidelines 2010
Selected Messages for Consumers

Take action on the Dietary Guidelines by making changes in these three areas.

Choose steps that work for you and start today.

Balancing Calories

- Enjoy your food, but eat less.
- Avoid oversized portions.

Foods to Increase

- Make half your plate fruits and vegetables.
- Make at least half your grains whole grains.
- Switch to fat-free or low-fat (1%) milk.

Foods to Reduce

- Compare sodium in foods like soup, bread, and frozen meals—and choose the foods with lower numbers.
- Drink water instead of sugary drinks.

USDA

ChooseMyPlate.gov

June 2011

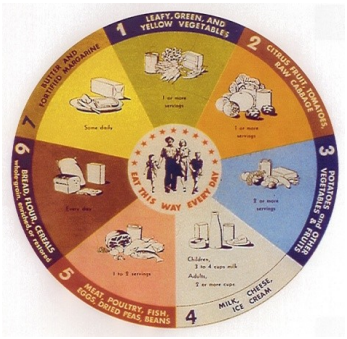
A Brief History of USDA Food Guides

1916 to 1930s: "Food for Young Children" and "How to Select Food"

- Established guidance based on food groups and household measures
- Focus was on "protective foods"

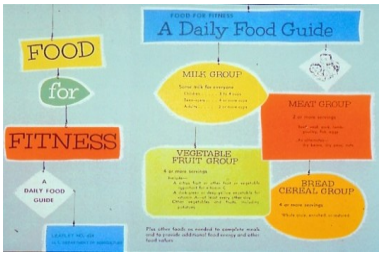
1940s: A Guide to Good Eating (Basic Seven)

- Foundation diet for nutrient adequacy
- Included daily number of servings needed from each of seven food groups
- Lacked specific serving sizes
- Considered complex



1956 to 1970s: Food for Fitness, A Daily Food Guide (Basic Four)

- Foundation diet approach—goals for nutrient adequacy
- Specified amounts from four food groups
- Did not include guidance on appropriate fats, sugars, and calorie intake

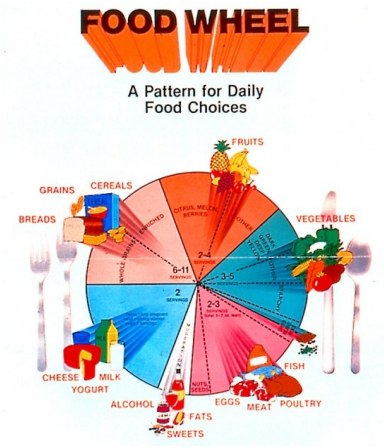


1979: Hassle-Free Daily Food Guide

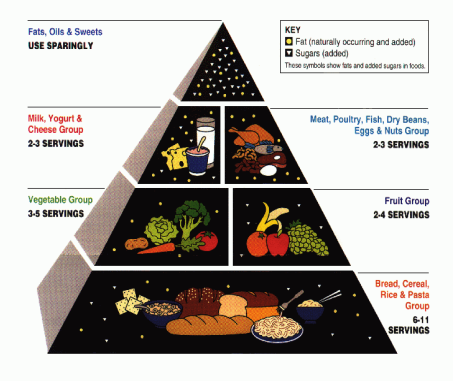
- Developed after the 1977 Dietary Goals for the United States were released
- Based on the Basic Four, but also included a fifth group to highlight the need to moderate intake of fats, sweets, and alcohol

1984: Food Wheel: A Pattern for Daily Food Choices

- Total diet approach—Included goals for both nutrient adequacy and moderation
- Five food groups and amounts formed the basis for the Food Guide Pyramid
- Daily amounts of food provided at three calorie levels
- First illustrated for a Red Cross nutrition course as a food wheel



1992: Food Guide Pyramid



- Total diet approach—goals for both nutrient adequacy and moderation
- Developed using consumer research, to bring awareness to the new food patterns
- Illustration focused on concepts of variety, moderation, and proportion
- Included visualization of added fats and sugars throughout five food groups and in the tip
- Included range for daily amounts of food across three calorie levels

2005: MyPyramid Food Guidance System

- Introduced along with updating of Food Guide Pyramid food patterns for the *2005 Dietary Guidelines for Americans,* including daily amounts of food at 12 calorie levels
- Continued "pyramid" concept, based on consumer research, but simplified illustration. Detailed information provided on website "MyPyramid.gov"
- Added a band for oils and the concept of physical activity
- Illustration could be used to describe concepts of variety, moderation, and proportion

2011: MyPlate

- Introduced along with updating of USDA food patterns for the *2010 Dietary Guidelines for Americans*
- Different shape to help grab consumers' attention with a new visual cue
- Icon that serves as a reminder for healthy eating, not intended to provide specific messages
- Visual is linked to food and is a familiar mealtime symbol in consumers' minds, as identified through testing
- "My" continues the personalization approach from MyPyramid

For more information:

- Welsh S, Davis C, Shaw A. A brief history of food guides in the United States. *Nutrition Today* November/December 1992:6-11.
- Welsh S, Davis C, Shaw A. Development of the Food Guide Pyramid. *Nutrition Today* November/December 1992:12-23.
- Haven J, Burns A, Britten P, Davis C. Developing the Consumer Interface for the MyPyramid Food Guidance System. *Journal of Nutrition Education and Behavior* 2006, 38: S124–S135.

Back to the report

New Report: Missouri is 11th Most Obese State in the Nation

Washington, D.C. July 7, 2011 - Missouri was named the 11th most obese state in the country, according to the eighth annual *F as in Fat: How Obesity Threatens America's Future 2011*, a report from the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF). Missouri's adult obesity rate is 30.3 percent.

Adult obesity rates increased in 16 states in the past year and did not decline in any state. Twelve states including Missouri now have obesity rates over 30 percent. Four years ago, only one state was above 30 percent. Obesity rates exceed 25 percent in more than two-thirds of states (38 states)

This year, for the first time, report examined how the obesity epidemic has grown over the past two decades:

- Over the past 15 years, seven states have doubled their rate of obesity. Another 10 states nearly doubled their obesity rate, with increased of at least 90 percent, and 22 more states saw obesity rates increase by at least 80 percent
- Fifteen years ago, Missouri had an obesity rate of 16.9 percent and was ranked seventh most obese state in the nation. The obesity rate in Missouri increased 80 percent over the last 15 years.
- Since 1995, obesity rates have grown the fastest in Oklahoma, Alabama, and Tennessee, and have grown the slowest in Washington, D.C., Colorado, and Connecticut.
- Ten years ago, no state had an obesity rate above 24 percent, and now 43 states have higher obesity rates than the state that was the highest in 2000.

"Today, the state with the lowest adult obesity rate would have had the highest rate in 1995," said Jeff Levi, Ph.D., executive director of TFAH. "There was a clear tipping point in our national weight gain over the last twenty years, and we can't afford to ignore the impact obesity has on our health and corresponding health care spending."

In addition, for many states, their combined rates for overweight and obesity, and rates of chronic health problems, such as diabetes and high blood pressure, have increased dramatically over the past two decades. For Missouri, long-term trends in rates include:

- Fifteen years ago, Missouri had a combined obesity and overweight rate of 52.9 percent. Ten years ago, it was 57.1 percent. Now, the combined rate is 65.6 percent.
- Diabetes rates have doubled in ten states in the past 15 years. In 1995, Missouri had a diabetes rate of 5.7 percent. Now the diabetes rate is 8.8 percent.
- Fifteen years ago, Missouri had a hypertension rate of 23.9 percent. Now, the rate is 29.1 percent.

Racial and ethnic minority adults, and those with less education or who make less money, continue to have the highest overall obesity rates:

- Adult obesity rates in Missouri were 38.2 percent for Blacks. Nationally, obesity rates for Blacks topped 40 percent in 15 states, 35 percent in 35 states, and 30 percent in 42 states and D.C.
- Rates of adult obesity for Latinos were 29 percent in Missouri. National Latino obesity rates were above 35 percent in four states (Mississippi, North Dakota, South Carolina, and Texas) and at 30 percent and above in 23 states.
- Meanwhile, rates of adult obesity for Whites topped 30 percent in just four states (Kentucky, Mississippi, Tennessee, and West Virginia) and no state had a rate higher than 32.1 percent. The rates of adult obesity for Whites were 29.5 percent in Missouri.
- Nearly 33 percent of adults who did not graduate high school are obese compared with 21.5 percent of adults who graduated from college or a technical college.
- More than 33 percent of adults who earn less than $15,000 per year were obese compared with 24.6 percent of adults who earn $50,000 or more per year.

The most recent state-by-state data on obesity rates for youth 10 to 17 are from 2007 and also were included in last year's report. According to the data, 13.6 percent of children and adolescents in Missouri are considered obese.

"The information in this report should spur us all – individuals and policymakers alike – to redouble our efforts to reverse this debilitating and costly epidemic," said Risa Lavizzo-Mourey, M.D., M.B.A, RWJF president and CEO. "Changing policies is an important way to provide children and families with vital resources and opportunities to make healthier choices easier in their day-to-day lives."

To enhance the prevention of obesity and related diseases, TFAH and RWJF provide a list of recommended actions in the report. Some key policy recommendations include:

The report also examines a range of policy efforts that the federal and state governments are taking to prevent

and control obesity.

Some state efforts include:

- Twenty states now have school meal standards that are stricter than the U.S. Department of Agriculture (USDA) requirements.
- Twenty-nine states not including Missouri limit when and where competitive foods (foods and beverages sold outside of the formal meal programs, through à la carte lines, vending machines and school stores) may be sold beyond federal requirements.
- Every state has some physical education requirements for students. However, these requirements are often limited or not enforced, and many programs are inadequate.
- Twenty-one states including Missouri now have legislation that requires body mass index (BMI) screening or weight-related assessments other than BMI for children and adolescents. Seven years ago, only four states required BMI screening or other weight-related assessments.
- Twenty-six states not including Missouri have now established farm-to-school programs. Five years ago, only New York had a law establishing a farm-to-school program.
- Sixteen states not including Missouri now have Complete Streets laws. "Complete streets" are roads designed to allow all users – bicyclists, pedestrians, drivers, and public transit users – to access them safely. Seven years ago only five states had these laws.

Some federal efforts include:

- The Patient Protection and Affordable Care Act (ACA) authorizes new resources and strategic planning initiatives aimed at reducing obesity and increasing opportunities for physical activity and improved nutrition, including the Prevention Fund, the National Prevention Strategy, Community Transformation Grants, greater coverage for preventive services, a Childhood Obesity Demonstration Project, and strategic new approaches through the Center for Medicare and Medicaid Innovation.
- The Healthy, Hunger-Free Kids Act, the Agriculture Appropriations Act, and the Healthy Food Financing Initiative also include a number of important nutrition and obesity-related provisions

This year's report also includes a series of recommendations from TFAH and RWJF on how policymakers and the food and beverage industry can help reverse the obesity epidemic.

The recommendations for policymakers include:

1. Protect the Prevention and Public Health Fund: TFAH and RWJF recommend that the fund not be cut, that a significant portion be used for obesity prevention, and that it not be used to offset or justify cuts to other Center for Disease Control and Prevention (CDC) programs.
2. Implementing the Healthy, Hunger-Free Kids Act: TFAH and RWJF recommend that the USDA issue a final rule as swiftly as possible regarding school meal regulations and issue strong standards for competitive food and beverages.
3. Implementing the National Physical Activity Plan: TFAH and RWJF recommend full implementation of the policies, programs, and initiatives outlined in the National Physical Activity Plan. This includes a grassroots advocacy effort; a public education program; a national resource center; a policy development and research center; and dissemination of best practices.
4. Restoring Cuts to Vital Programs: TFAH and RWJF recommend that the $833 million in cuts made in the fiscal year 2011 continuing resolution be restored and that programs to improve nutrition in child care settings and nutrition assistance programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children be fully funded and carried out. If fully funded these programs could have a major impact on reducing obesity.

"Creating healthy environments is key to reversing the obesity epidemic, particularly for children," remarked Dr. Lavizzo-Mourey. "When children have safe places to walk, bike and play in their communities, they're more likely to be active and less likely to be obese. It's the same with healthy food: when communities have access to healthy affordable foods, families eat better."

Additionally, for the food and beverage industry, TFAH and RWJF recommend that industry should adopt strong, consistent standards for food marketing similar to those proposed in April 2011 by the Interagency Working Group, composed of representatives from four federal agencies – the Federal Trade Commission, CDC, Food and Drug Administration and the USDA – and work to implement the other recommendations set forth in the 2005 Institute of Medicine report on food marketing to children and youth.

The full report with state rankings in all categories is available on TFAH's website at www.healthyamericans.org and RWJF's website at www.rwjf.org. The report was supported by a grant from RWJF.

STATE-BY-STATE ADULT OBESITY RANKINGS

Note: 1 = Highest rate of adult obesity, 51 = lowest rate of adult obesity. Rankings are based on combining three years of data (2008-2010) from the U.S. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System to "stabilize" data for comparison purposes. This methodology, recommended by the CDC, compensates for any potential anomalies or usual changes due to the specific sample in any given year in any given state. States with statistically significant ($p<0.05$) increases for one year are noted

with an asterisk (*), states with statistically significant increases for two years in a row are noted with two asterisks (**), states with statistically significant increases for three years in a row are noted with three asterisks (***). Additional information about methodologies and confidence intervals is available in the report. Individuals with a body mass index (BMI) (a calculation based on weight and height ratios) of 30 or higher are considered obese.

1.Mississippi (34.4%); 2. Alabama (32.3%); 3. West Virginia* (32.2%); 4. Tennessee (31.9%); 5. Louisiana (31.6%); 6. Kentucky** (31.5%); 7. Oklahoma** (31.4%); 8. South Carolina* (30.9%); 9. Arkansas (30.6%); 10. Michigan* (30.5%); 11. Missouri* (30.3%); 12. Texas** (30.1%); 13. Ohio (29.6%); 14. North Carolina (29.4%); 15. Indiana* (29.1%); 16. Kansas** (29.0%); 17. (tie) Georgia (28.7%); and South Dakota (28.7%); 19. Pennsylvania (28.5%); 20. Iowa (28.1%); 21. (tie) Delaware (28.0%); and North Dakota (28.0%); 23. Illinois** (27.7%); 24. Nebraska (27.6%); 25. Wisconsin (27.4%); 26. Maryland (27.1%); 27. Maine** (26.5%); 28. Washington (26.4%); 29. Florida** (26.1%); 30. (tie) Alaska (25.9%); and Virginia (25.9%); 32. Idaho (25.7%); 33. (tie) New Hampshire (25.6%); and New Mexico (25.6%); 35. (tie) Arizona (25.4%); Oregon (25.4%); and Wyoming (25.4%); 38. Minnesota (25.3%); 39. Nevada (25.0%); 40. California (24.8%); 41. New York (24.7%); 42. Rhode Island** (24.3%); 43. New Jersey (24.1%); 44. Montana (23.8%); 45. Vermont** (23.5%); 46. Utah (23.4%); 47. Hawaii (23.1%); 48. Massachusetts** (22.3%); 49. Connecticut (21.8%); 50. District of Columbia (21.7%); 51. Colorado* (19.8%).

STATE-BY-STATE ADULT OBESITY RANKINGS IN 1995

Note: 1 = Highest rate of adult obesity, 51 = lowest rate of adult obesity. Data for this analysis was obtained from the Behavioral Risk Factor Surveillance System (BRFSS) dataset (publicly available on the web at www.cdc.gov/brfss). States that have increased their obesity rate by at least 80 percent since 1995 are noted with an asterisk (*), states that have increased their obesity rate by at least 90 percent are noted with two asterisks (**), states that have doubled their obesity rate over the past 15 years are noted with three asterisks (***). Additional information about methodologies and confidence intervals is available in the report. Individuals with a body mass index (BMI) (a calculation based on weight and height ratios) of 30 or higher are considered obese.

1. Mississippi (19.4%); 2. Indiana (18.3%); 3. West Virginia* (17.7%); 4. Michigan (17.2%); 5. (tie) Arkansas* (17.0%); and Louisiana* (17.0%); 7. Missouri (16.9%); 8. (tie) Kentucky** (16.6%); and South Carolina* (16.6%); 10. (tie) Tennessee** (16.4%); and Wisconsin (16.4%); 12. North Carolina* (16.3%); 13. (tie) Iowa (16.2%); and Pennsylvania (16.2%); 15. Ohio* (16.1%); 16. Texas* (16.0%); 17. (tie) Alabama*** (15.7%); and Alaska (15.7%); 19. Illinois* (15.3%); 20 (tie) Delaware* (15.2%); Nebraska* (15.2%); and North Dakota* (15.2%); 23. Maryland* (15.0%); 24. Minnesota (14.6%); 25. South Dakota** (14.5%); 26. (tie) Florida* (14.3%); Maine* (14.3%); and New York (14.3%); 29. Virginia* (14.2%); 30. Idaho* (14.1%); 31. Wyoming* (14.0%); 32. (tie) California (13.9%); and Washington** (13.9%); 34. Georgia*** (13.8%); 35. Oregon* (13.6%); 36. Kansas*** (13.5%); 37. Vermont (13.4%); 38. Nevada** (13.1%); 39. Montana* (13.0%); 40. (tie) New Hampshire (12.9%); and Oklahoma*** (12.9%); 42. (tie) District of Columbia (12.8%); and Rhode Island** (12.8%); 44. Arizona*** (12.6%); 45. New Jersey** (12.3%); 46. Utah** (12.0%); 47. Connecticut* (11.8%); 48 (tie) Massachusetts** (11.6%); and New Mexico*** (11.6%); 50. Colorado* (10.7%); 51. Hawaii*** (10.6%).

STATE-BY-STATE ADULT OBESITY GROWTH RANKS SINCE 1995

Note: 1 = Fastest rate of growth in adult obesity, 51 = lowest rate of growth in adult obesity. Data for this analysis was obtained from the Behavioral Risk Factor Surveillance System (BRFSS) dataset (publicly available on the web at www.cdc.gov/brfss).

1. Oklahoma; 2. Alabama; 3. Tennessee; 4. Kansas; 5. Mississippi; 6. (tie) Georgia; and Kentucky; 8. (tie) Louisiana; and West Virginia; 10. South Carolina; 11. South Dakota; 12. (tie) New Mexico; and Texas; 14. Arkansas; 15. Ohio; 16. Missouri; 17. Michigan; 18. North Carolina; 19. (tie) Arizona; Delaware; and North Dakota; 22. New Hampshire; 23. (tie) Hawaii; and Washington; 25. (tie) Illinois and Nebraska; 27. Pennsylvania; 28. Maine; 29. Maryland; 30. Nevada; 31. Iowa; 32. (tie) Florida; New Jersey; and Oregon; 35. Virginia; 36. (tie) Idaho; and Rhode Island; 38. Wyoming; 39. Utah; 40. Wisconsin; 41. California 42. (tie) Indiana; and Montana; 44. (tie) Massachusetts; and Minnesota; 46. New York; 47. Alaska; 48. Vermont; 49. Connecticut; 50. Colorado; 51. District of Columbia.

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ISSUE REPORT

F as in Fat:

HOW OBESITY THREATENS AMERICA'S FUTURE 2011







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JULY 2011

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F AS IN FAT 2011 MAJOR FINDINGS

Adult Obesity Rates and Trends (2008-2010)

- Adult obesity rates rose in 16 states over the past year. No state decreased.
- Twelve states now have obesity rates above 30 percent: Alabama, Arkansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Oklahoma, South Carolina, Tennessee, Texas, and West Virginia. Four years ago, only one state was above 30 percent.
- Obesity rates exceed 25 percent in more than two-thirds of states (38 states).
- Obesity rates rose for a second year in a row in six states (Illinois, Kentucky, Massachusetts, Missouri, Rhode Island, and Texas) and rose for a third year in a row in five states (Florida, Kansas, Maine, Oklahoma, and Vermont).
- Mississippi had the highest rate of obesity at 34.4 percent. Colorado had the lowest rate at 19.8 percent and is the only state with a rate below 20 percent.
- Obesity and obesity-related diseases such as diabetes and hypertension continue to remain the highest in the South. Except for Michigan, the top 10 most obese states in the country are all in the South. In addition, nine of the 10 states with the highest rates of diabetes and physical inactivity are in the South, as are the 10 states with the highest rates of hypertension. Northeastern and Western states continue to have the lowest obesity rates.
- Adult diabetes rates increased in 11 states and Washington, D.C. in the past year. In eight states, more than 10 percent of adults now have type 2 diabetes.
- The number of adults who report they do not engage in any physical activity rose in 14 states in the past year. Two states (California and Texas) saw a decline in adult physical inactivity levels.
- Obesity increased for men in nine states, and for women in ten states, and decreased for women in one state (Nevada).
- Those who did not graduate high school have the highest rates of obesity (32.8 percent). Those who graduated high school but did not go on to college or a technical school have the second highest obesity rate (30.4 percent), and those who went to college/technical school had an obesity rate of 29.6 percent. Those who graduate from college/technical school had the lowest obesity rate (21.5 percent).
- Households that make less than $15,000 have a 33.8 percent obesity rate. They are followed closely by households that make between $15,000 and $25,000 (31.8 percent), $25,000 and $35,000 (29.7 percent) and $35,000 and $50,000 (29.5 percent). However, households that have an income above $50,000 have a 24.6 percent obesity rate.

Changes in Adult Obesity, Overweight, Diabetes, and Hypertension Over Time

- Twenty years ago, no state had an obesity rate above 15 percent. Fifteen years ago, Mississippi had the highest obesity rate, at 19.4 percent, which is lower than the lowest ranking state today, (Colorado at 19.8 percent).
- Twenty years ago, the state with the highest combined obesity and overweight rate was 49 percent. Ten years ago, only two states had a combined rate above 60 percent. Now, the lowest rate is 54.8 percent, and 44 states are above 60 percent.
- Twenty years ago, 37 states had hypertension rates over 20 percent. Now, every state is over 20 percent, with nine over 30 percent.
- Over the past 15 years, seven states have doubled their rate of obesity. Another 10 states nearly doubled their obesity rate, with increases of at least 90 percent. And 22 more states saw obesity rates increase by at least 80 percent.
- Since 1995, obesity rates have grown the fastest in Oklahoma, Alabama, and Tennessee, and have grown the slowest in Washington, D.C., Colorado, and Connecticut.
- Over the past 15 years, diabetes rates have doubled in ten states. In 1995, only four states had diabetes rates above six percent. Now, 42 states and Washington, D.C. have diabetes rates over seven percent and 31 states and Washington, D.C. have rates above eight percent.
- Ten years ago, no state had an obesity rate above 24 percent, and now 43 states have higher obesity rates than the state that was the highest in 2000.

Childhood and Adolescent Obesity Rates and Trends

The childhood and adolescent findings are from the 2007 National Survey of Children's Health (NSCH) and reflect the same data reported in the 2010 edition of *F as in Fat*. No newer findings are available on a state-by-state basis.

- More than one-third of children ages 10–17 are obese (16.4 percent) or overweight (18.2 percent). State-specific rates ranged from a low of 9.6 percent in Oregon to a high of 21.9 percent in Mississippi.
- Nine states, plus D.C., have childhood obesity rates greater than 20 percent: Arkansas, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Tennessee, Texas, and West Virginia.
- Nine of the 10 states with the highest rates of obese children are in the South, as are nine out of the 10 states with the highest rates of poverty.
- Recent studies have shown that the number of obese children and adolescents may have leveled off since 1999, except among the very heaviest boys ages 6–19, but the rates remain startlingly high.[1]
- Nationwide, less than one-third of all children ages 6–17 engage in vigorous activity, defined as at least 20 minutes of physical activity that makes the child sweat and breathe hard.
- The percentage of children engaging in daily, vigorous physical activity ranged from a low of 17.6 percent in Utah to a high of 38.5 percent in North Carolina.

State Legislation Trends

- Twenty states and Washington, D.C. have stricter standards than the U.S. Department of Agriculture (USDA). Seven years ago, only four states had school meal standards that were stricter than USDA requirements.
- Thirty-five states and Washington, D.C. have nutritional standards for competitive foods. Seven years ago, only six states had nutritional standards for competitive foods.
- Twenty-nine states and Washington, D.C. limit when and where competitive foods may be sold beyond federal requirements. Seven years ago, 17 states had laws about when and where competitive foods can be sold that were stricter than federal requirements.
- Every state has some physical education requirements for students. However, these requirements are often limited or not enforced, and many programs are inadequate.
- Twenty-one states have legislation that requires BMI screening or weight-related assessments other than BMI. Seven years ago, only four states required BMI screening or other weight-related assessments for children and adolescents.
- Twenty-six states and Washington, D.C. currently have established farm-to-school programs. Five years ago only New York had a law that established a farm-to-school program.
- Sixteen states have passed Complete Streets laws. Seven years ago only five states had Complete Streets laws.
- Thirty-four states and Washington, D.C. have sales taxes on sodas.
- Five states have laws requiring the posting of nutrition information on menus and menu boards in chain restaurants with 20 or more in-state locations.

Major Federal Efforts

- The *Let's Move* initiative has raised the issue's profile and has brought together public officials, the food industry, advocacy groups, and others to address the epidemic.
- The Affordable Care Act (ACA) provides a number of opportunities to enhance obesity-prevention efforts, such as through the Prevention and Public Health Fund, Community Transformation Grants, expanding benefits and coverage of preventive services, nutrition labeling, programs by the Center for Medicare and Medicaid Innovation, and the Children's Health Insurance Program Childhood Obesity Demonstration Project.
- The Healthy, Hunger-Free Kids Act, the Agriculture Appropriations Act, the Healthy Food Financing Initiative, the 2010 Dietary Guidelines for Americans, the National Physical Activity Plan, the revised Strategic Plan for NIH Obesity Research, and other new or updated policies and programs can have a significant impact on obesity, nutrition, and physical activity policies in the United States.

Top Recommendations

The report includes recommendations for policies to help leverage change quickly and efficiently, by providing individuals and families with the resources and opportunities to make healthier choices in their daily lives. For instance, the report calls for the strategic implementation of the ACA, the Healthy, Hunger-Free Kids Act, and other federal and state policy changes to help prevent and control obesity in America.

Obesity Rates and Related Trends

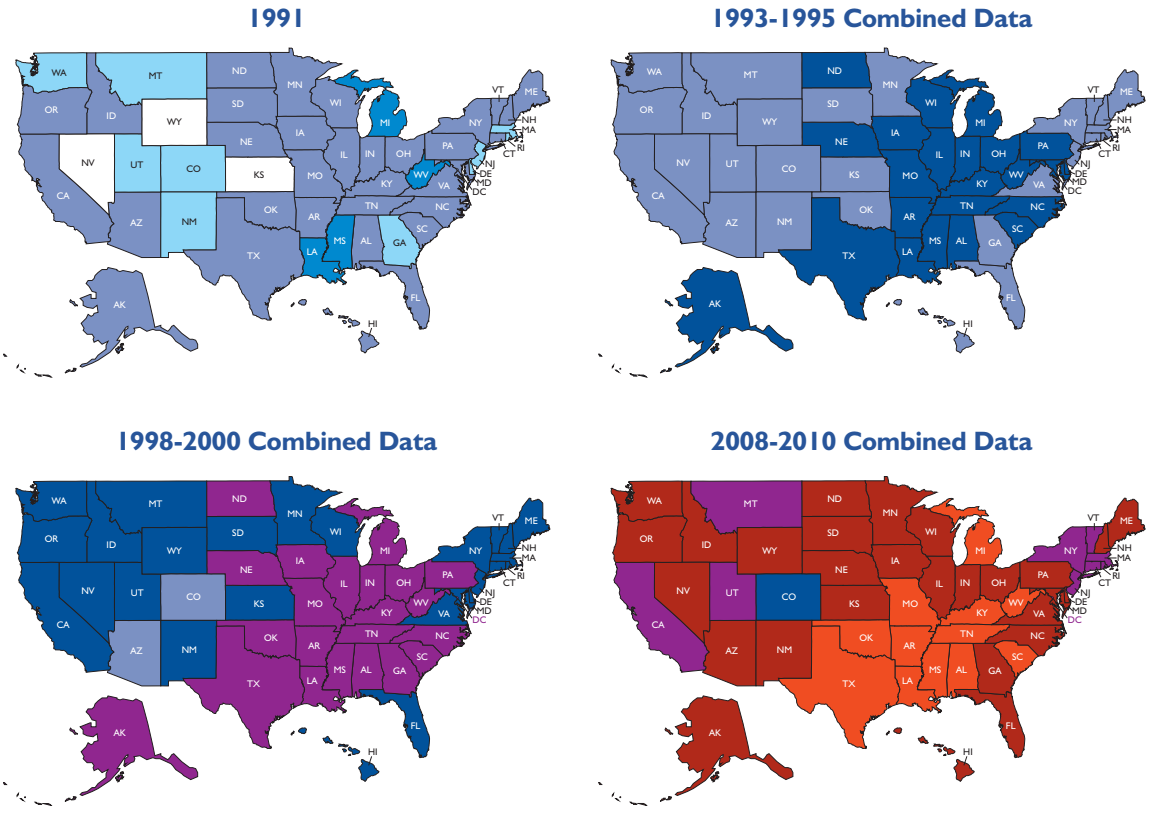
More than two-thirds (68 percent) of American adults are either overweight or obese.[2] Adult obesity rates have grown from 15 percent in 1980 to 34 percent in 2008, based on a national survey. [3, 4]

Rates of obesity among children ages 2–19 have more than tripled since 1980.[5,6] According to the most recent National Health and Nutrition Examination Survey (NHANES), 16.9 percent of children ages 2–19 are obese and 31.7 percent are overweight or obese.[7] This translates to more than 12 million children and adolescents who are obese and more than 23 million who are either obese or overweight. Researchers at CDC report that during the period between 1999 and 2008, there was no statistically significant change in the number of children and adolescents with high BMI-for-age, except among the very heaviest boys ages 6–19.[8]

OBESITY TRENDS* AMONG U.S. ADULTS

BRFSS, 1991, 1993-1995,1998-2000, and 2008-2010 Combined Data

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



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