MARYLAND
Governor's Office for Children
Promoting the Well-Being
of Maryland's Children

State of Maryland Executive Department

Larry Hogan
Governor

Boyd K. Rutherford
Lieutenant Governor

Arlene F. Lee
Executive Director

May 2, 2016

The Honorable Edward J. Kasemeyer
Budget and Taxation Committee, Chair
Miller Senate Office Building, 3 West Wing
11 Bladen St., Annapolis, MD 21401

The Honorable Richard S. Madaleno, Jr.
Budget and Taxation Committee, Vice Chair
Miller Senate Office Building, 3 West Wing
11 Bladen St., Annapolis, MD 21401

RE: Joint Chairmen's Report – Addressing Childhood Obesity (2015, page 111)

Dear Chairman Kasemeyer and Vice Chairman Madaleno:

As requested in the Joint Chairmen's Report (2015, page 111), the Governor's Office for Children respectfully submits the attached report that evaluates State-level initiatives to address childhood obesity and teen diabetes.

The report also provides information on initiatives targeted at educating children and youth on healthy eating and recommendations of additional actions that the State could undertake to educate children and youth on healthy eating, and reduce child obesity and teen diabetes.

Should you have any questions regarding the report, please do not hesitate to contact me at 410.767.8675.

Sincerely,

Arlene F. Lee

cc: Jared Sussman, Department of Legislative Services
Cathy Kramer, Department of Legislative Services
Carolyn Ellison, Department of Budget and Management
Sarah Albert, Department of Legislative Services

301 West Preston Street, 15th Floor · Baltimore, Maryland 21201
410-767-4160 · www.goc.maryland.gov · info.goc@maryland.gov

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Governor's Office for Children

Promoting the Well-Being of Maryland's Children

2015 Joint Chairmen's Report

State-level Initiatives Addressing Childhood Obesity

Submitted by the

Governor's Office for Children

May, 2016

WORKGROUP MEMBERS

In January 2016, the Governor's Office for Children convened a time-limited workgroup to respond to the Joint Chairmen's Report request (2015, page 111) that the "Governor's Office for Children should work with member agencies of the Children's Cabinet, community stakeholders, and outside experts to evaluate State-level initiatives to address child obesity and teen diabetes."

Patricia E. Arriaza
Governor's Office for Children

Marly Cardono Moz
Share Our Strength/Partnership to End Childhood Hunger in Maryland

Jackie Douge
Howard County Health Department

Candy Edwards-Roach
Governor's Office for Children

Christopher Hersl
Maryland State Department of Education

Erin Kennedy Hysom
Maryland State Department of Education

Mike Korbey
Department of Human Resources

Lisa Lachenmayr
Food Supplement Nutrition Education (FSNE), University of Maryland Extension

Alan Lake
Maryland Chapter, American Academy of Pediatrics

Marilyn Lorenzo
Department of Human Resources

William McCurry
Special Projects Coordinator

Kristi Pier
Department of Health and Mental Hygiene

Robi Rawl
Sugar Free Kids

Glenn Schneider
The Horizon Foundation

The workgroup met five times: January 20, February 3, February 17, March 2, and March 16.

CONTENTS

EXECUTIVE SUMMARY

A 2015 Joint Chairmen's Report required the Governor's Office for Children to assemble member agencies of the Children's Cabinet, community stakeholders, and outside experts to evaluate State-level initiatives to address child obesity and teen diabetes, as well as, initiatives targeted at educating children and youth on healthy eating. The results of this effort provide recommendations of additional actions that the State could undertake to educate children and youth on healthy eating, and reduce child obesity and teen diabetes.

This report presents a conceptual and policy framework to anchor the work of increasing the health and wellness of Maryland's child and teen populations. The framework is comprised of three core principles for Maryland:

- A focus on the importance of all aspects of good health, including promoting and utilizing the language of wellness over obesity;
- A limited focus on a single aspect of health is insufficient to address wellness and wellbeing; and
- Collective efforts are required to improve the overall good health and reduce all aspects of poor health in Maryland's children and teens.

A healthy lifestyle for children and adolescents necessarily includes physical activity, proper nutrition, access to quality health care, and awareness of healthy lifestyle choices. Reducing instances of obesity and diabetes among the children and adolescent population is therefore dependent upon addressing the myriad of issues related to child "wellness" and not just the sole focus on a healthy weight indicator.

High rates of obesity, especially in children and adolescents, is linked to long-term impacts of poor health-related behaviors, including unhealthy diets and lack of physical activity. These poor behaviors often are the result of systemic issues which prevent the healthier choice from being the most available choice, i.e. lack of available foods, limited recreational opportunities for safe outdoor play, etc. Various studies also provide data which supports that childhood obesity is also more common among certain racial and ethnic groups.

Despite recent declines in the prevalence among preschool-aged children, obesity among all children is still high. Within Maryland, limited data on childhood obesity prevalence continues to be a challenge addressing the wellness of children, most especially in the 6-19 year age range. Children and adolescents who are obese are likely to be obese as adults. Currently, ranked 26th in adult obesity in the United States, Maryland continues to follow the national trend of rising rates of obesity.

Following national initiatives such as the Federal Supplemental Nutrition Program for Women, Infants, and Children and the Healthy, Hunger-Free Kids Act of 2010, Maryland has implemented several strategies which infuse nutrition guidelines and protocols to

improve the health and wellbeing of Maryland's children by decreasing rates of childhood obesity and teen diabetes, and increasing food security.

Positive changes are occurring in Maryland, nevertheless the overall rate of childhood obesity remains high. Recognizing that public health challenges are extremely complex in nature, efforts to continue the comprehensive efforts to improving the health and wellness of Maryland's children must remain a priority. Many of the Maryland programs and initiatives developed to combat childhood obesity remain new, and some, not yet fully implemented.

To support and continue the multi-level efforts toward an integrated approach in combatting childhood obesity in Maryland, the workgroup recommends the following actions:

1.) Enhance the collaborative focus on the issue by transitioning the workgroup discussion to the Partnership to End Childhood Hunger in Maryland, as the expertise of the members of the Partnership make it best suited to serve as the hub for continued discussion and coordination aimed at improving nutrition outcomes for Maryland's children and youth;
2.) Use existing local councils, coalitions, and workgroups to coordinate work and messaging at the local level to disseminate information, coordinate policy, and champion healthy lifestyle choices and messaging campaigns; and
3.) Study the feasibility and benefit of developing and collecting body mass index data across the state in order to assess the extent of the state's childhood obesity epidemic, notably due to the little objective data that does exist suggesting Maryland's childhood obesity prevalence is higher than what national data might suggest.

Multi-level strategies addressing individual, interpersonal, and societal barriers to wellness are imperative to improving the health of Maryland's youth. While many agencies and organizations work collaboratively to improve pediatric health outcomes, reversing the epidemic of childhood obesity and teen diabetes in our State will require ongoing action. Continuing the work through the Partnership to End Childhood Hunger and other existing local councils, while expanding membership to include families and the broader community, is a positive step to maintaining a coordinated focus on the issue of childhood obesity. Although an important component, research shows that education alone does not change behavior; only combined with systemic change does education result in measurable impacts.

STATEMENT OF CHARGE

The 2015 Joint Chairmen's Report required the Governor's Office for Children to "work with member agencies of the Children's Cabinet, community stakeholders, and outside experts to evaluate State-level initiatives to address child obesity and teen diabetes, as well as, initiatives targeted at educating children and youth on healthy eating." The workgroup was directed to provide information on "the results of its evaluation and recommend additional actions that the State should undertake to educate children and youth on healthy eating, and reduce child obesity and teen diabetes."

METHODOLOGY

Five workgroup meetings were held between January 2016 and March 2016. The members established the purpose of the workgroup, their work plan, and a timeline for producing the required report. The workgroup identified and evaluated the current definitions of childhood obesity in relation to individual and interpersonal barriers to wellness. Impacts of childhood obesity and teen diabetes were reviewed in the context of institutions, organizations and the community. The workgroup examined and synthesized the strengths and challenges associated with State-level initiatives to address child obesity and teen diabetes. Finally, the members developed recommendations for educating children and youth on healthy eating, in order to reduce child obesity and teen diabetes.

While the workgroup determined that it is important to be mindful of the focus on the language and model of "wellness" as the most comprehensive assessment of a child's health, it is still necessary to define how this report uses the terms "obesity" and "overweight". Overweight and obesity are identified from the Body Mass Index score, which is calculated using height and weight and compared across the normal healthy weight range for that age group. Body Mass Index scores are considered in terms of percentiles by age and gender for the child and adolescent populations.[1] The Centers for Disease Control and Prevention uses the term "childhood overweight" to indicate a Body Mass Index relative to a child's age that is at or above the 85th percentile but lower than 95th percentile and "childhood obesity" to indicate a Body Mass Index relative to a child's age that is at or above the 95th percentile.[2] Both the Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend using the Body Mass Index as a screening tool for overweight and obesity in children beginning at age two.[3]

FRAMEWORK

This report presents a conceptual and policy framework to anchor the work of increasing the health and wellness of Maryland's child and teen populations. The framework is comprised of three core principles:

- Maryland should focus on the importance of all aspects of good health (proper nutrition, physical activity, access to quality health care, etc.) including promoting and utilizing the language of "wellness" over "obesity",
- A limited focus on a single aspect of health is insufficient to address wellness and wellbeing; and,
- Collective effort is required to improve the overall health and reduce all aspects of poor health in Maryland's children and teens.

BARRIERS TO CHILD AND ADOLESCENT WELLNESS

The focus on "wellness" is a more accurate and useful model for child health as it encompasses all factors that impact a child's well-being. A healthy lifestyle for children and adolescents necessarily includes physical activity, proper nutrition, access to quality health care, and awareness of healthy lifestyle choices. Reducing child and adolescent obesity and diabetes prevalence is therefore dependent upon addressing the myriad of issues related to child "wellness" and not just the sole focus on a healthy weight indicator.

Individual Barriers to Wellness

For younger children and adolescents, food intake is often dictated by parental purchasing decisions and preference rather than the nutritional value of the food consumed. Quality food preparation and early introduction to fresh fruits and vegetables are often related to healthy weight beginning at a young age.

In addition to age, other barriers to wellness among youth include a lack of self-confidence and motivation, and lack of knowledge about the health benefits of being physically active.[4] While studies indicate that proper nutrition has a great impact on childhood obesity rates, the importance of physical activity is equally important to diabetes prevention. A holistic approach to achieving overall wellness includes the encouragement of physical activity, which can reduce barriers for children and youth to healthier lifestyles overall, thus reducing the rates of childhood obesity and teen diabetes.

Interpersonal Barriers to Wellness

Studies show that children's food intake is related to their parents' nutrition knowledge and food intake, and it is also influenced by their peers.[5] Additionally, young people tend to associate healthy foods with parents and fast food with pleasure, friendship, and socializing, [6] and they expect negative reactions from their peers about eating healthier foods.[7] Lack of social and peer supports involving healthy eating and physical activity are barriers to wellness in all age groups. Young people, who feel supported by friends and families or are surrounded by others interested in physical activity, are more likely to participate in both structured and non-structured activities.

Family education, income and occupation may also present barriers for child and youth wellness. Some studies link socio-economic status with significant correlations of health and wellness in aspects of family life. Healthier foods may take more time to prepare and are often more expensive, creating barriers to family meal time. The reduced availability of fresh fruits and vegetables for family meals creates other barriers. Lower frequency of weekly family meals has been reported among children whose mothers worked full-time (versus those who were not employed).[8]

Societal Barriers to Wellness

Many lower income families live in areas designated as "food deserts"[1] with limited access to healthy food options. In Baltimore City, 25% of city residents and 30% of all children live in food deserts. African Americans are disproportionately more likely to live in a food desert neighborhood.[9] Access to supermarkets is associated with a reduced risk for obesity.[10] Choosing healthy foods is difficult for people who live in areas with an overabundance of food retailers that tend to sell less healthy food, such as convenience stores and fast food restaurants.[11] In public spaces, the use of vending machines can also contribute to poor nutrition as vending machine options are "generally high in calories, sugar, and saturated fat."[12] Sugar-sweetened beverages such as sodas and juices are common sources of excess sugar consumption.[13]

Additionally, communities are often built in ways that make it difficult or unsafe to be physically active. For some families, getting to parks and recreation centers may be difficult, and public transportation may not be available, and for many children safe routes for walking or biking to school or play may not exist.[14] High rates of neighborhood crime and violence limit the ability to play safely and be physically active outdoors in many low-income communities.[15]

[1]A food desert is defined as an area where the distance to a supermarket or supermarket alternative is more than ¼ mile, the median household income is at or below 185% of the Federal Poverty Level, over 30% of households have no vehicle available, and the average Healthy Food Availability Index score for all food stores is low.

Race/ethnicity, sex, age, geographic location (e.g., rural vs. urban), education, income, and disability have been tied to both disparities in access to healthy food and in obesity prevalence.[16]

CHILDHOOD OBESITY AND ITS IMPACTS

High rates of obesity, especially in children and adolescents, are linked to long-term impacts of poor health-related behaviors, including unhealthy diets and lack of physical activity. These poor behaviors often are the result of systemic issues which prevent the healthier choice from being the most available choice, i.e. lack of available foods, limited recreational opportunities for safe outdoor play, etc. Overweight and obesity places children at current and future risk of serious health problems, including cardiovascular disease, type 2 diabetes, and mental health conditions such as anxiety and depression.[17] Historically, type 2 diabetes was found mainly in adults who were overweight and older than 40 years.[18] Now, as more children and adolescents in the United States become overweight or obese and inactive, type 2 diabetes is occurring more often in young people age 10 or older.[19] Further, research shows that childhood obesity is best prevented in early childhood, perhaps as early as kindergarten. If a child enters kindergarten at an unhealthy weight, chances are much more likely that they will remain at an unhealthy weight throughout their childhood.[20]

Current Trends in Childhood Obesity

Nationally, data from the National Health and Nutrition Examination Survey tracks prevalence of overweight and obesity among America's youth. The most recent survey of 2011-2014 concludes that childhood obesity continues to be a serious problem in the United States.[21] Despite recent declines in the prevalence among preschool-aged children, obesity among children is still high. A 2013 report from the Centers for Disease Control and Prevention shows widespread progress in reducing obesity among preschool children enrolled in federal health and nutrition programs, citing several factors that may have helped contribute to the declines: updates to the food package for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that emphasized healthy foods and beverages, such as whole grains, fruits, vegetables and low-fat milk; new nutrition and physical activity standards for early childcare programs; and increased support for breastfeeding mothers.[22] Following the benefits associated with the WIC food package changes, efforts toward modifications in State and local nutrition policies which target all ages of children may prove to impact Maryland's childhood obesity rates

In Maryland, obesity rates among 2- to 4-year-olds dropped from 15.7% in 2008 to 15.3 percent in 2011.[23] For children and adolescents aged 2-19 years, the prevalence of

obesity has remained fairly stable at about 17% and has affected about 12.7 million children and adolescents for the past decade.[24] Various studies also provide data which supports that childhood obesity is also more common among certain racial and ethnic groups. In 2011-2012, the prevalence among children and adolescents was higher among Hispanics (22.4%) and non-Hispanic blacks (20.2%) than among non-Hispanic whites (14.1%).[25] The greater declines observed in white children compared with other ethnic groups emphasize that intensified efforts to identify and implement effective strategies to address ethnic disparities are essential.[26]

Table 1. National Changes in Childhood Obesity, National Health and Nutrition Examination Survey

Ages	NHANES II 1976-1980	NHANES III 1988-1994	NHANES 1999-2002	NHANES 2003-2006	NHANES 2011-2014	Percent Change NHANES II to NHANES
2 - 5	5%	7.2%	10.3%	12.4%	8.9%	3.3%
6 - 11	6.5%	11.3%	15.8%	17.0%	17.5%	11%
12 - 19	5%	10.5%	16.1%	17.6%	20.5%	15.5%

Changes noted in young children in the National Health and Nutrition Examination Survey are supported by the decreases in prevalence that have been reported in a number of states and communities in the Pediatric Nutrition Surveillance System, an annual state-based survey of 2- to to 4-year-old, low-income children, most of whom were enrolled in the WIC Program.[27]

Maryland Data

Within Maryland, limited data on childhood obesity prevalence continues to be a challenge addressing the wellness of children, most especially in the 6-19 year age range.[2] In an effort to assess the prevalence of overweight and obesity among children and teens enrolled in Maryland Medicaid or the Maryland Children's Health Program (MCHP) from 2005-2010, investigators from the Maryland Department of Health and Mental Hygiene computed Body Mass Index percentiles for age and sex on a random sample of 10,882 Maryland Medicaid or MCHP participants aged 2–19 years whose height and weight were measured during a well-child visit.[28]

[2] In 2007, the American Academy of Pediatrics published Expert Committee recommendations for universal screening for overweight and targeted laboratory screening for metabolic disorders among children and adolescents (2-18 years of age) with a Body Mass Index at or above the 85th percentile based on age or presence of certain risk factors.

The study found that 21.4% of participants were obese. Obesity prevalence among this population was significantly elevated compared with National Health and Nutrition Examination Survey data, which include children and teens with all types of health insurance.[29] Obesity was highest among those aged 12–19 years (25.6%) and among Hispanics (28.1%).[30] The diagnosis of obesity-related conditions increased significantly with increasing Body Mass Index, with 33.5% of obese participants diagnosed with asthma, 7.9% diagnosed with dyslipidemia, and 7.2% diagnosed with depression.[31]

Table 2: Childhood Obesity in Maryland

2- to 4-year olds from low income families Current obesity rate (2011)	**10- to 17-year olds** Current obesity rate (2011)	**High school students** Current obesity rate (2013)
15.3%	15.1%	11.0%

Data source: stateofobesity.org

Many national reports show widespread progress in reducing obesity among preschool children enrolled in federal health and nutrition programs. Maryland has shown signs of progress in addressing childhood obesity by being one of 19 states and U.S. territories showing small declines in obesity among low-income preschoolers from 2008 to 2011.[32] Following decades of rising rates nationally, Maryland decreased from 15.7% in 2008 to 15.3% in 2011.[33] The Centers for Disease Control and Prevention identifies this decline to be the first time in decades that rates dropped among young children from low-income families, who typically have higher rates of childhood obesity. Despite the drop in obesity rates among this population, 1 in 8 preschoolers remain obese.[34] Children who are overweight or obese as preschoolers are five times as likely as normal-weight children to be overweight or obese as adults.[35]

Maryland Youth Risk Behavior Survey

Maryland's participation in the Maryland Youth Risk Behavior Survey (YRBS) began in 2005, when the Maryland General Assembly (Md. EDUCATION Code Ann. § 7-420) mandated the survey be conducted every two years.[36] The YRBS includes a representative sample of public middle and high school students throughout Maryland. The Maryland Department of Health and Mental Hygiene supports the Maryland State Department of Education in administering the Youth Risk Behavior Survey, develops and publishes a report of findings, and maintains publicly available state and local data on the Maryland Department of Health and Mental Hygiene website. According to the 2013 Youth Risk Behavior Survey, 25.8% of Maryland high school students were overweight or obese based on body mass index estimates calculated from self-reported height and weight, 21.6% were physically active for at least 60 minutes each day during the past 7 days, and 20.1% ate fruits and vegetables 5 or more times per day during the past 7 days. At the middle school level, data on body mass index and fruit and vegetable consumption were not available; however, 29.4% of Maryland middle school students were physically active for at least 60 minutes each day during the past 7 days.

Long-Term Challenges of Childhood Obesity

Children and adolescents who are obese are likely to be obese as adults and are therefore more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.[37] Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma.[38]

Recent epidemiologic studies have found that higher maternal gestational weight gain is associated with higher weight and consequent risk for obesity and elevated blood pressure amongst children.[39] These considerations highlight the importance of two-generational health approaches that focus on both the health of the mother and unborn child. Successful wellness strategies start with prenatal care and carry on through childhood and adolescence, instilling habits and lifestyle choices that can lead to overall wellness. In other studies, data suggests that if a child is in the 99th percentile at age 9 for weight, they have a 100% chance of high blood pressure, diabetes, and high cholesterol before the age of 35-40.

Currently ranked 26th in adult obesity in the United States, Maryland continues to follow the national trend of rising rates of adult obesity. Maryland adults ages 45-64 are ranked as the highest obesity rate by age for 2014, with an overall prevalence of non-Hispanic Black at 37.9% while White and Latino populations ranked equally at 26%.

RECENT FEDERAL AND STATE ACTIVITIES

Since 2009, the Federal Supplemental Nutrition Program for Women, Infants, and Children food package has included fruits and vegetables, increases in whole grains, and low-fat milk, suggesting that increased fruit and vegetable consumption might be expected to displace more calorically dense foods.[40] More families are turning to public health programs, such as the Special Supplemental Nutritional Program for Women, Infants and Children Program, to meet the needs of their children younger than 5 years old.[41]

National efforts to solve the challenge of childhood obesity resulted in the local school wellness policy requirement established by the Child Nutrition and Women, Infant, Children Reauthorization Act of 2004, and further strengthened by the Healthy, Hunger-Free Kids Act of 2010.[42] The intent of the 2010 update[43] was to provide nutrient dense meals, high in nutrients, but low in calories to combat the trend of rising child and adolescent obesity. These "changes to school meal standards added more fruits, vegetables, whole grains, fat-free and low-fat milk to school meals; and are based on recommendations released in October 2009 by the National Academies' Institute of

Medicine and presented in their report, School Meals: Building Blocks for Healthy Children".[44] Since 2012, schools are required to limit the levels of saturated fat, sodium, calories, and trans fats in meals.[45]

As of the 2006-2007 school year, all local school wellness policies are required to have goals for at least four components: nutrition guidelines, nutrition/health education, physical education/activity and other school-based activities. The 2010 Healthy, Hunger-Free Kids Act required each Local Education Agency participating in the National School Lunch Program and/or School Breakfast Program to develop a local school wellness policy that promotes the health of students and addresses the growing problem of childhood obesity. The Local Education Agencies are responsible for developing the local school wellness policy to address the unique needs of each jurisdiction.

Maryland Initiatives

Through strong leadership and commitment to improving the health and wellbeing of Maryland's children, many strategies have been implemented to decrease rates of childhood obesity and teen diabetes and increase food security. Benefits to children and their families are occurring through integrated program models which promote education and access to healthier foods and opportunities for physical activity. As children spend considerably more time in school than most other environments in their young lives, the Maryland State Department of Education recognizes the primary impacts to a youth's ability to learn when faced with challenges of food insecurity, poor nutrition and lack of physical activity. To promote environments which allow youth to excel in learning, several Maryland initiatives have been implemented.

School Nutrition Programs

The Maryland State Department of Education, Office of School & Community Nutrition Programs administers the federal Child Nutrition Programs at the state-level, including the National School Lunch and School Breakfast Program. A primary focus of the Office of School & Community Nutrition Programs' work toward nutritional wellness for children since 2010 has been supporting school implementation of, and compliance with, the updated nutrition standards for meals and a la carte items. The Office of School & Community Nutrition Programs' objectives include enhancing the quality and appearance of school meals, and improving student acceptance of the meal pattern changes, particularly the increased provision of vegetables, whole grains, and fruit, and the reduction of calories, fat, sodium, and sugar.

To support improvements in child wellness, The Maryland State Department of Education provides training and technical assistance to school nutrition staff on meeting the United States Department of Agriculture's meal pattern requirements, and incorporating best practices and recommendations from the Dietary Guidelines for Americans. In the form of Culinary Boot Camp trainings, the Office of School & Community Nutrition Programs strengthened school food professionals' knife skills and

production planning techniques, as well as the batch cooking principles necessary to produce high quality, appealing menu items for Maryland students. Nearly all counties participated in this training project, which also helped counties purchase essential kitchen supplies such as knives and cutting boards. Key partners in these efforts included the Restaurant Association of Maryland-Education Foundation and the Maryland School Nutrition Association.

To further impact overall health foods for Maryland's children, the Office of School & Community Nutrition Programs helps Maryland schools create a health-promoting environment, where healthy choices are made easy, and access to less healthy items is limited. School and District-level staff received training on evidence-based strategies for customer service, and use of behavioral economics concepts such as placement of healthier items in highly visible places on the service line, and other "Smarter Lunchrooms" strategies. Student perception of the meal pattern changes were also addressed in this project and their exposure to healthy foods increased through multiple tasting events. Again, utilizing Maryland resources as partners, the Office of School & Community Nutrition Programs joined with the University of Maryland College Park, School of Public Health, University of Maryland Extension - Food Supplement Nutrition Education, and the University of Maryland Extension - Family & Consumer Science.

Nutrition education is invaluable for young children to promote and establish healthy behaviors at an early age, as evidence shows this improves the likelihood of continuing healthy habits through adolescence and into adulthood. The Office of School & Community Nutrition Programs collaborated with staff from the Food Supplement Nutrition Education program in 2010 to create ReFresh, a series of eight nutrition education units aligned with the common core for math and language arts, and related to themes within social studies, science, technology, engineering, math, and art. Each unit includes a healthy food demonstration and tasting activity. Four key behavior-focused messages are emphasized through each unit

- Make half your plate fruits and vegetables
- Make at least half your grains whole grains
- Increase physical activity, and
- Maintain calorie balance.

In 2013, the curriculum was updated to include more cafeteria-classroom connections, and introduce the new meal patterns.

Interagency Efforts

The Maryland Wellness Policies & Practices Project is an interagency initiative[46] of representatives from the Maryland State Department of Education, Maryland Department of Health and Mental Hygiene, University of Maryland School of Medicine,

University of Maryland College Park, and Johns Hopkins Bloomberg School of Public Health. This multi-year evaluation project enhances opportunities for healthy eating and physical activity for Maryland students by helping schools and school districts develop and implement strong and comprehensive written wellness policies. Since the inception of the Wellness Policies & Practices Project, the partnership between Education and Health and Mental Hygiene has garnered statewide collaboration involving State leaders, school administrators, school personnel, parents, students, as well as, community organizations and groups committed to health and wellness. To date, this collaboration has yielded several resources for Maryland school districts, including Making Wellness Work: A Guide to Implementing and Monitoring School Wellness Policies in Maryland, and a "Guide for School-Level Implementation of Wellness Policies and Practices".[47]

Building upon this interagency collaboration, in 2014 the Maryland Child Care Wellness Policies and Practices Project was implemented to assess healthy eating, infant/breastfeeding, and physical activity policies and best practices in child care settings. Evidence-based recommendations for training, education, and technical assistance to create health-promoting environments in child care settings were developed and informed state agency collaboration with community partners including local health departments and child care organizations.

Health and Mental Hygiene also collaborates with Education to administer and report Maryland's Youth Risk Behavior Survey. This school-based surveillance system tracks several priority health risk behaviors among youth as well as behaviors that support health. In 2013, the Maryland Youth Behavior Risk Survey was combined with the Maryland Youth Tobacco Survey and administered to both middle school and high school students with an increased sample size. The 2013 survey includes overweight/obesity (based on self-reported height and weight), nutrition, and physical activity related questions. However, overweight/obesity based on Body Mass Index is not included in the middle school questionnaire or findings.

The Department of Juvenile Services in collaboration with Education has developed the Juvenile Services Wellness Plan to meet the requirements set forth in the Healthy Hunger-Free Kids Act of 2010. This Wellness Plan establishes goals for Juvenile Services facility schools for nutrition education, physical activity, and other school-based activities designed to promote student wellness. The Wellness Plan includes nutrition guidelines for all foods available on the facility school campus during the school day. Facility meal programs meet or exceed State and U.S. Department of Agriculture requirements for participation in the federal Child Nutrition Program. Meals include only those foods allowed on the Juvenile Services menus planned by a Registered Dietitian/Nutritionist.

Education, in conjunction with the Maryland Department of Agriculture, has supported the Jane Lawton Farm to School Program, also known as the Maryland Farm to School

Program, (§10-1601 Agricultural Article). The Maryland Farm to School Program was authorized in 2008 as a way to promote and facilitate the sale of Maryland farm products to schools and to educate students on agriculture and the benefits of a healthy diet. Farm to School strives to bring locally produced foods into school cafeterias; provides students with hands-on learning activities, such as farm visits, school gardening, and culinary classes; and supports the integration of food-related education into the standards-based classroom curriculum. Research shows that Farm to School programs contribute to an improvement in early childhood and K-12 eating behaviors, including selecting healthier items in the cafeteria; reduce students' consumption of less healthy items, such as soda; and increase physical activity. Additionally, studies indicate that Farm to School programs increase students' knowledge and awareness of agriculture and nutrition, while increasing their willingness to try new foods.[48]

The Maryland Farm to School Program has the support of more than 60 different Maryland farms, providing fresh Maryland-grown products to the 24 school districts. Farm to school includes all types of producers and food businesses, including farmers and waterman, as well as food processors, manufacturers, and distributors. Local fruits, vegetables, eggs, dairy, and meat provide excellent sources of nutrients and can contribute to an overall healthier diet. Collaborations on the effort also involve the Maryland Agricultural Education Foundation, Food Supplement Nutrition Education program, University of Maryland Extension, Future Farmers of America, and the Maryland Farm Bureau.

Community-Based Activities

It is important for young children to understand and learn about the foods they are being served and establish healthy behaviors at a young age. Stepping outside of the formal school day environment, Education's Office of School & Community Nutrition Programs administers the Child and Adult Care Food Program. This program contributes to the overall health and well-being of children by providing snack and meal reimbursements, and offers Early Care and Education settings access to resources and training that support the development and maintenance of a healthy environment. The Early Care and Education nutrition environment shapes a child's development and growth, often providing a setting that supports the prevention of obesity and chronic diseases (Harvard School of Public Health, 2012).[49] On January 9, 2015, the U.S. Department of Agriculture released a proposed rule to update the Child and Adult Care Food Program meal patterns, to include a wider variety of fruits and vegetables, whole grains, and less sugar and fat.[50] These proposed changes will improve children's access to healthy, balanced meals and may serve as a foundation for a lifetime of health.

The Office of Childcare and the Office of School and Community Nutrition Programs at the Maryland State Department of Education provide training and technical assistance to childcare staff on meeting United States' Department of Agriculture meal pattern requirements and incorporating best practices from the Dietary Guidelines for

Americans. Education developed a nutrition education toolkit in 2015 as part of the Maryland's Building Blocks Project. The toolkit has 24 lessons on fruits, vegetables, and whole grains, and focuses on shaping positive food preferences and eating habits among preschoolers three to five years of age. Training on the toolkit was provided to childcare center teachers and other staff. One of the primary goals of the Maryland State Department of Education's work is to enhance and improve nutrition and physical activity in the childcare setting.

These program activities include childcare centers evaluating their current policies and practices in nutrition and physical activity through approved assessments, such as Let's Move Childcare Checklist and the Nutrition and Physical Activity - Self-Assessment for Childcare. Furthermore, these activities also include training on one or more of the following topic areas: menu planning; mealtime environment and family style dinning; physical activity standards and practices; education to staff, parents/caregivers and children; and outreach to parents/caregivers. The Department of Health and Mental Hygiene also supports childcare wellness through state and local partner collaboration and provide guidance to local health departments to engage in childcare wellness initiatives in jurisdictions throughout Maryland.

Complimentary to the work at Education towards reducing rates of childhood obesity and increasing greater health and wellness for children, Maryland's Department of Human Resources and the University of Maryland Extension operate the Food Supplement Nutrition Education Program, providing the School Community Sites Initiative. The Food Supplement Nutrition Education Program provides nutrition education to help low income individuals and families make healthy food choices, develop food preparation skills, handle food safely, improve shopping skills, and increase their physical activity. The School Community Sites initiative is a comprehensive, multi-level intervention that addresses the school environment to impact behavior change among children, teachers, families and other members of the school community.

The Food Supplement Nutrition Education Program collaborates with schools and school-related organizations to improve the school nutrition environment. Its educators provide nutrition education classes to youth and adults, including teachers and families of enrolled children. Classroom and school gardens and linkages to farm-to-school programs involving youth, teachers, and families are examples of projects established in comprehensive school community sites. Children spend most of their time in schools and consume many of their meals at these sites.

Through the joint efforts associated with the Food Supplement Nutrition Education Program, Human Resources and the University of Maryland Extension facilitate The Preschool and Childcare Center initiative, a comprehensive approach to educating the preschool child, the daycare provider, and the parent while working to improve and change the daycare environment.

As we know, preventing childhood obesity is critical at an early age and can have a lasting impact on the health and well-being of a child. Interventions within this initiative aim to improve feeding practices, increase access to water, provide opportunities for healthy snacks and meals, and increase physical activity while simultaneously decreasing sedentary behavior. The Food Supplement Nutrition Education Program educators provide direct education to youth and also train childcare providers/teachers in these sites to educate the youth in their care. Training collaborators on curriculum delivery extends the reach of the Food Supplement Nutrition Education Program across the state of Maryland. Indirect resources such as newsletters, text messages, and educational displays provide additional reinforcement for key nutrition concepts to parents and other adults who serve as change agents in a preschooler's life.

The Department of Human Resources and the University of Maryland's Youth Out of School Sites Initiative builds multi-level interventions in out of school time settings serving low-income youth. The efforts in this initiative focus on changing the food and physical activity environment of out of school sites through trainings and worksite wellness programming emphasizing healthy staff role modeling. Many out of school sites, such as Boys and Girls Clubs, Police Athletic League Centers, and Young Men's Christian Associations (YMCAs) are Maryland Food Bank afterschool or summer meal sites. While nutrition education may occur during the school day, it is critical to support low-income youth when they are away from school. The Maryland Out of School Time Network and the Alliance for a Healthier Generation partner with the Food Supplement Nutrition Education Program to promote nutrition and healthy behaviors in out of school time sites statewide. Through partnerships with University of Maryland Extension Master Gardener volunteers, on-site gardens are grown and used to provide hands-on experiences of growing and harvesting fresh produce and raise farm to school awareness.

The University of Maryland Extension's Food Supplement Nutrition Education Program and the Department of Human Resources also collaborate on educating Food Supplement Program parents and youth on healthy food nutrition by mailing a flyer with monthly re-determination letters. Approximately 375,000 flyers are mailed yearly.

The Department of Health and Mental Hygiene's Center for Chronic Disease Prevention and Control works collaboratively with statewide and community partners to increase access to healthy foods and physical activity. Supporting health and wellness, inclusive of healthy and available foods, Health and Mental Hygiene collaborates with the Food Supplement Nutrition Education Program to pilot Market to Mealtime, a nutrition education program designed to promote healthful food consumption, in food banks in Western Maryland and the Eastern Shore and facilitate systematic changes for healthy food procurement as it relates to community food donations and food bank distribution purchases.

Health and Mental Hygiene collaborates with statewide and community partners to align priorities and further the reach and impact of youth physical activity opportunities. Physical inactivity is a leading chronic disease risk factor. Youth physical activity guidelines recommend that children and adolescents age 6-17 engage in 60 minutes or more of daily physical activity.[51] The Comprehensive School Physical Activity Program is a multi-component approach by which school districts and schools: 1) use all opportunities for students to be physically active before, during, and after the school day, and 2) help students achieve 60 minutes of daily physical activity.[52]

Partnerships

Furthering efforts to healthier Marylanders, Maryland Market Money has been the cornerstone program of the Maryland Farmers Market Association since its launch in 2013. The program provides a dollar-for-dollar match (Maryland Market Money) of up to 5 dollars a household per market day for purchases made with federal nutrition benefits at participating farmers markets. Participation in Maryland Market Money is available to any low-income individual or household participating in the Supplemental Nutrition Assistance Program; the Woman, Infants, and Children Program; or Farmers Market Nutrition Program for WIC participants and income-eligible seniors.

Maryland Market Money is distributed in the form of dollar-value tokens that may only be spent at the farmers market to purchase Supplemental Nutrition Assistance Program eligible foods. The objectives and impact of Maryland Market Money are threefold: to incentivize low-income households to spend their benefits on fresh, locally produced foods; to double the purchasing power of food-insecure Marylanders to access nutritious foods; and to generate revenue for local farmers, increasing the viability of farmers markets in communities where fresh food options are otherwise scarce. Maryland Market Money currently operates at 24 farmers markets in Baltimore City and five Maryland counties: Allegany, Anne Arundel, Baltimore, Montgomery, and Prince George's.

Maryland is fortunate to have a strong advocate community. Sugar Free Kids Maryland is a statewide coalition of nearly 200 diverse organizations, spearheaded by MedChi, the Maryland State Medical Association, National Association for the Advancement of Colored People (NAACP), American Heart Association, The Horizon Foundation, and the Maryland Association of Student Councils. Its mission is to reverse the epidemic of diet-related chronic disease in Maryland's children by educating Marylanders on the dangers of sugary drinks, and by passing policies to make healthy food and drink choices the easiest and most affordable choices in the places Marylanders live, work, and play. Launched in 2014, the coalition has pursued various evidence-based strategies to level the playing field by making healthy choices the easy choices.

In 2014, Sugar Free Kids worked alongside Education to pass the Childcare Centers – Healthy Eating and Physical Activity Act, which strengthened obesity-prevention

strategies in licensed childcare settings, including better supports for breastfeeding mothers, limits on computer and television screen time, and provision of beverages without added sugar. The regulations were implemented by Education in the Spring of 2015. Sugar Free Kids has also worked alongside State partners towards healthy default drinks in restaurant kids' meals, promoting water as a beverage choice through pricing incentives, and healthy vending on State owned and operated property. At the city and county level, Sugar Free Kids has worked alongside local government, health departments, and others to implement healthy vending on government property in Howard County and Baltimore City, as well as to introduce sugary drink warning labels at point-of purchase in Baltimore City.

NEXT STEPS AND RECOMMENDATIONS

Positive changes are occurring in Maryland, nevertheless the overall rate of childhood obesity remains high. Recognizing the need for multi-sectoral collaboration and approaches to improve the health and wellness of Maryland's children must remain a priority. Many of the Maryland programs and initiatives developed to combat childhood obesity remain new, and some, not yet fully implemented. To support and continue the multi-level efforts toward an integrated approach in combatting childhood obesity in Maryland, the workgroup recommends the following actions:

1. **Enhance the collaborative focus on the issue**. This will be accomplished by transitioning the workgroup discussion to the Partnership to End Childhood Hunger in Maryland. Created in 2008, the Partnership to End Childhood Hunger in Maryland is a collection of State agencies (including the Departments of Human Resources, Education, and Health and Mental Hygiene), non-profit organizations, advocates, service providers, faith-based groups, community leaders, and members of the business and philanthropic communities (for full membership roster see Appendix 2) committed to ending childhood hunger in Maryland by increasing participation in, and awareness of, federal nutrition programs. In that time, it has established Maryland as a leader in increasing school breakfast participation and providing innovative ways to connect children and families to nutrition resources across the State.

   As its membership has grown over the last several years, the Partnership has truly become a coalition of experts in a multitude of nutrition and food access issues, recently forming a nutrition education workgroup – the Maryland Wellness Workgroup. Moving forward, the Maryland Wellness Workgroup will continue to convene those interested in the issue of childhood nutrition and obesity in order to develop sound policy, messaging, data sharing agreements,

and other necessary strategies to ensure the issue of childhood obesity in Maryland continues to be addressed.

The expertise of the members of the Partnership to End Childhood Hunger in Maryland make it best suited to serve as the hub for continued discussion and coordination aimed at improving nutrition outcomes for Maryland's children and youth. Continued discussion and coordination of State-level efforts is critically needed to reduce the rate of childhood obesity in Maryland.

Though the workgroup was unable to fully explore the following actions given the tight report deadline, the feasibility of developing policy recommendations and implementing practices based on guidelines issued by national health authorities such as the Centers for Disease Control and Prevention, the Institute of Medicine, and the American Heart Association to reduce or prevent childhood obesity and teen diabetes can be explored through the work of the Partnership. While not an exhaustive list, the following includes areas that the Partnership, as it develops a workplan to address childhood obesity and continues to work towards the wellbeing of Maryland's children and families, may choose to focus on during the coming year.

a. Nutrition-Related Approaches
    i. Continue work led by the Departments of Education and Health and Mental Hygiene to improve school system wellness policies that govern the food and physical activity environment of local schools. As feasible, partners should publish a statewide analysis of school district wellness policies to measure changes in comprehensiveness and strength.
    ii. Continue and expand the work led by the Department of Health and Mental Hygiene that supports and promotes breast feeding.
    iii. Promote and support childcare centers in creating wellness promoting environments by adopting and implementing policies and practices which reflect evidence-based recommendations from the Centers for Disease Control and Prevention, U.S. Department of Agriculture Food and Nutrition Services, and other national leaders in child health.
    iv. Continue with existing efforts to incentivize the purchase of fruits and vegetables by participants in the Supplemental Nutrition Assistance Program and Women, Infants, and Children Program.
    v. Encourage making healthier food and drink options more widely available in vending machines, canteens, and cafeterias located on state property.

vi. Develop policies and implement practices to reduce overconsumption of sugary drinks, one of the largest contributors to childhood obesity.
vii. Provide Maryland families and children with increased access to formal nutrition education programs and curriculum.

b. Physical Activity-Related Approaches
   i. Increase the amount of time dedicated towards physical education in elementary and middle schools to meet best practices.
   ii. Promote and support child care centers to adopt and implement policies and practices which reflect evidence-based recommendations for physical activity among children.
   iii. Encourage and support jurisdictions to adopt local "complete streets" transportation policies that enhance access to and availability of safe walking and biking routes.

c. Dual Approaches
   i. Continue to explore collaborations and partnerships (e.g. sports teams, universities, businesses) to leverage existing resources to develop social marketing campaigns. Additionally, Maryland is fortunate to have two world-class health and teaching hospitals and universities located in Baltimore. Their cutting edge expertise in wellness including nutrition, obesity and the challenges associated with children and teens being "overweight" provides an avenue that opens many doors that might otherwise remain shut.

2. **Use existing local councils, coalitions, and workgroups to coordinate work and messaging at the local level.** While the Partnership can help to coordinate State-level work and discussions, to connect the work statewide will require coordinated efforts at the local level. Local Health Councils and School Health Councils in every jurisdiction work to implement policies and practices in support of child and family health and wellness in the State. The Departments of Education, Health and Mental Hygiene, Juvenile Services, and Human Resources should identify opportunities to connect their work with these local councils to disseminate information, coordinate policy, and champion healthy lifestyle choices and messaging campaigns.

3. **Study the feasibility and benefit of developing and collecting body mass index data across the state in order to assess the extent of the state's childhood obesity epidemic.** National data suggests that childhood obesity is best prevented in early childhood, perhaps even before a child enters kindergarten, yet few objective data sources currently exist or are readily available to help determine both the true extent of the problem in Maryland and the impact of current programs and policies. The little objective data that does exist suggests that Maryland's childhood obesity prevalence is higher than what national data

might suggest. The State School Health Council should work with its agency partners and community stakeholders to assess the availability of body mass index data across the state, determine data gaps, and assess the benefit and feasibility of collecting body mass index information from pre-school-aged and school-aged children by age, gender, race, ethnicity, grade, and free and reduced meals program participation.

CONCLUSION

Multi-level strategies addressing individual, interpersonal, and societal barriers to wellness are imperative to improving the health of Maryland's youth. While many agencies and organizations work collaboratively to improve pediatric health outcomes, reversing the epidemic of childhood obesity and teen diabetes in our State will require ongoing action. Although an important component, research shows that education alone does not change behavior; only combined with systemic change does education result in measurable impacts.

While programs and strategies that seek to improve child well-being in Maryland exist, the ability to quantify the number of children who are overweight/obese remains a problem. The workgroup discussed potential solutions to this challenge; however, more time is needed to create a feasible data collection, analysis, and utilization strategy. A data strategy, which includes input from families, providers, communities, and other collaborative partners, will allow State agencies to better hone wellness initiatives, and ensure policies, practices, and programs result in the desired health outcomes.

While there are already many programs and strategies in place in Maryland, better coordination of these existing efforts is needed in order to impact this chronic health issue. Continuing the work through the Partnership to End Childhood Hunger and other existing local councils, while expanding membership to include families and the broader community, is a positive step to maintaining a coordinated focus on the issue of childhood obesity.

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APPENDICES

APPENDIX 1 - WORKPLAN

Joint Chairmen's Report
Work plan for Developing the Report on Addressing Childhood Obesity
Submitted December 15, 2015

According to the Centers for Disease Control and Prevention, childhood obesity is associated with immediate and long-term negative physical and mental health consequences that can put a child at immediate risk for "bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem."[1] Preventing childhood diabetes can stave off negative long-term health effects such as heart disease, type 2 diabetes, and stroke.

Although the rate of childhood obesity has been increasing in recent decades nation-wide, Maryland has seen a decrease in the prevalence of obesity in children.[2] Additionally, data from the 2013 Maryland Youth Risk Behavior Survey saw a decline in the percentage of overweight or obese youth (27.4% in 2011 and 25.8% in 2013).[3]

While the above indicate positive changes are occurring, the overall rate of childhood obesity remains high. As a result, State agencies have developed and implemented initiatives that address the issue of childhood obesity and encourage healthier lifestyles through proper nutrition and physical fitness.

The attached work plan details the steps the Governor's Office for Children will use to respond to the Joint Chairmen's Report (2015, page 111) request that the "Governor's Office for Children should work with member agencies of the Children's Cabinet, community stakeholders, and outside experts to evaluate State-level initiatives to address child obesity and teen diabetes."

The workgroup will also review the initiatives currently in place to educate children and youth on healthy eating for further actions that State agencies can take to educate children and youth on healthy eating, and reduce child obesity and teen diabetes.

1 http://www.cdc.gov/healthyschools/obesity/facts.htm
2 Morbidity and Mortality Weekly Report, Vital Signs: Obesity Among Low-Income, Preschool-Aged Children — United States, 2008–2011, August 9, 2013 / 62(31);629-634
3 2013 Maryland Youth Risk Behavior Survey, Department of Health and Mental Hygiene. The percentage is calculated using the self-reported height and weight of middle and high school students responding to the 2013 Survey. http://phpa.dhmh.maryland.gov/OIDPCS/CSTIP/CSTIPDocuments/MD-YRBS-Report.pdf

Joint Chairmen's Report
Work plan for Developing the Report on Addressing Childhood Obesity

	Goal & Sub Tasks	Collaboration Needs	Resource Needs	Date Due or Frequency	Progress Made
1.	**Goal** Create time-limited workgroup to respond to Joint Chairmen's Report request. **Sub-tasks** • Develop workgroup participant list • Determine State agency staff participation • Send invitations • Create timeline • Discuss workgroup responsibilities	Meet with staff from the Department of Health and Mental Hygiene's Center for Chronic Disease Prevention and Control to discuss key stakeholders/community partners interested on childhood obesity, teen diabetes issue. Send inquiry to agency leadership to determine agency staff participation: • Department of Health and Mental Hygiene • MD State Department of Education • Department of Human Resources During first workgroup meeting, discuss the purpose of report, responsibility of each workgroup member, and makeup of workgroup. Invite any public comments for consideration by the workgroup.	Discuss Joint Chairmen's Report request at Children's Cabinet Implementation Team meeting: • Requirements • Timeline • Agency participation Set up recurring meetings with workgroup members January to March to address Goals 2, 3 and 4.	December, 2015 First workgroup meeting: January 20, 2016	Met with staff from Center for Chronic Disease Prevention and Control – received list of potential workgroup participants. Sent inquiry to State agencies requesting staff participation. Developed timeline for report development.
2.	**Goal** Evaluate Maryland's State-level initiatives to address child obesity and teen diabetes. **Sub-tasks** • Compile information on current Maryland State-level initiatives • Childhood obesity	Each workgroup member will share information on current initiatives aimed at addressing the two issue areas.	Set up recurring meetings with workgroup members January to March to address Goals 2, 3 and 4.	Meeting dates: January 20, 2016 February 3, 2016	

	Goal & Sub Tasks	Collaboration Needs	Resource Needs	Date Due or Frequency	Progress Made
	• Diabetes • Determine workgroup methods for review of current initiatives				
3.	**Goal** Review initiatives targeted at educating children and youth on healthy eating. **Sub-tasks** • Compile information on current initiatives. • Determine workgroup methods for review of current initiatives aimed at educating children and youth on healthy eating.	Each workgroup member will share information on current initiatives aimed at educating children and youth on healthy eating.	Set up recurring meetings with workgroup members January to March to address Goals 2, 3 and 4.	Meeting date: February 17, 2016	
4.	**Goal** Identify possible further actions that the State could undertake to educate children and youth on healthy eating, and reduce child obesity and teen diabetes. **Sub-tasks** • Determine needs/gaps in Maryland State-level initiatives. • Examine relevant examples of state-level	Each workgroup member will contribute time to the development of recommendations. Each workgroup member will participate in the research of relevant state-level initiatives in other states.	Set up recurring meetings with workgroup members January to March to address Goals 2, 3 and 4.	Meeting dates: March 2, 2016 March 16, 2016	

	Goal & Sub Tasks	Collaboration Needs	Resource Needs	Date Due or Frequency	Progress Made
	initiatives in other states.				
5.	**Goal** Develop Response to Joint Chairmen's Report. **Sub-tasks** • Compile information from Goals 2, 3, and 4 • Develop draft report • Request feedback of draft report from workgroup members • Final revisions/edits to report • Review by Department of Budget and Management/Governor's Legislative Office • Submission of Report	Each workgroup member will play an active role in the development of the draft report, providing feedback as needed. State agency staff will share the draft report with agency leadership as appropriate.	Timely feedback from workgroup members to inform the development of the response to Joint Chairmen's Report request.	March 17, 2016 to May 2, 2016 (see attached timeline for exact dates)	

APPENDIX 2 - TIMELINE

Joint Chairmen's Report
2015 Session
Report on Addressing Childhood Obesity

Date	Action	Staff
December 2015	Send invitations to State agencies, community stakeholders	Governor's Office for Children
January 20, 2016 Workgroup Meeting	Discussion: • Purpose of report • Makeup of workgroup • Available data o Childhood obesity o Diabetes • Invite public comment	Workgroup members
February 3, 2016 Workgroup Meeting	Discussion: • Agency/community initiatives o Childhood obesity o Diabetes • Invite public comment	Workgroup members
February 17, 2016 Workgroup Meeting	Discussion:	Workgroup members
March 2, 2016 Workgroup Meeting	Discussion: • Possible Recommendations	Workgroup members
March 16, 2016 Workgroup Meeting	Discussion: • Possible Recommendations	Workgroup members
March 17, 2016	Draft of report started	Workgroup members/Governor's Office for Children
April 4, 2016	Report shared with workgroup	Governor's Office for Children
April 11, 2016	Feedback due	Workgroup members
April 12 – 17, 2016	Report Review/Edit	Governor's Office for Children
April 18, 2016	10 Day Department of Budget and Management/Governor's Legislative Office Review	Department of Budget and Management/Governor's Legislative Office
May 2, 2016	Report Submission	

APPENDIX 3 – PARTNERSHIP TO END CHILDHOOD HUNGER IN MARYLAND

Member Organizations

MD Partnership Vision and Mission
Vision: A state where all children have reliable access to the nutritious food required to thrive throughout their lives.

Mission: Collaboratively engage civic and community partners to end hunger for all children and families in Maryland

MD Partnership Background
The Partnership to End Childhood Hunger in Maryland began to develop in 2008, with Share Our Strength & the Governor's Office for Children serving as co-chairs. By 2010, the membership was fully developed, engaged and in pursuit of program goals. In 2015, Governor Hogan reaffirmed the state's commitment to the mission of providing relief to kids who face food insecurity (268,000 statewide), and to the efforts of the state partnership. Governor Hogan also included over six million dollars in FY16 state budget funding for Maryland Meals for Achievement.

The Maryland State Department of Education and the Department of Human Resources serve as co-chairs with Share our Strength

MD Partnership Membership

- ACY (Advocates for Children and Youth)
- Baltimore CASH Campaign
- Baltimore Partnership to End Childhood Hunger
- Capital Area Food Bank
- CASA de Maryland
- Catholic Charities of Baltimore and of DC
- Comptroller of Maryland
- Department of Human Resources
- End Hunger in Calvert County
- Family League of Baltimore City
- University of Maryland Extension FSNE (Food Supplement Nutrition Education)
- Maryland CASH Campaign
- Maryland Family Network
- Maryland Food Bank
- Maryland Hunger Solutions
- Maryland PTA
- Maryland State Education Association (MSEA)
- Maryland WIC Program at MD DHMH (Department of Health and Mental Hygiene)
- MOST Network (Maryland Out of School Time Network)
- MSDE (Maryland State Dept. of Education)
- Seedco
- Share Our Strength
- Sodexo
- United Way of Central MD
- USDA/FNS