Jason Hooley

From: Sen. Fred Dyson
Sent: Tuesday, February 07, 2006 5:19 PM
To: Jason Hooley
Subject: FW: HB 109

-g

From: Lisa Owens [mailto:lisa@akspeechclinic.com]
Sent: Friday, February 03, 2006 5:34 PM
To: Sen. Fred Dyson
Subject: HB 109

Dear Senator Dyson,

I am currently in Washington DC attending the Early Hearing Detection and Intervention conference. After meeting with several other state officials I am writing again to ask for your support for HB 109. Thirty nine states now have legislation in this area. Several other states have pending legislation. The results from the states which now have mandatory screening are fantastic. They are screening on a national level 92% of babies born in the United States. They are catching more infants than ever with hearing loss and intervention is beginning by 3-6 months of age. This has reduced the amount of therapy and other intervention services which will be a hugh savings to the state. I would love to share the information that I learned at this conference. Rep. Walsh from New York, who sponsored the federal legislation spoke and is committed to providing additional funding to states which are actively working to establish EDHI programs.

Please schedule this bill for the HESS committee as soon as possible. I strongly believe in the democratic process. I feel that this bill deserves to be heard and the citizens of Alaska deserve a chance to testify in support of this bill. There is no objection from insurance companies or any other individuals to my knowledge. Why is this bill not getting scheduled for a hearing? I would welcome the opportunity to speak with you on the information we gathered while attending this important conference on newborn hearing and intervention (EDHI).

Thank you for your time and consideration.

Lisa Owens, M.A., CCC-SLP/A
Alaska Speech & Hearing Clinic, LLC
4048 Laurel Street, #303
Anchorage, AK 99508
(907) 562-4550

Cheryl L. Scott
5000 Country Club Lane
Anchorage, AK 99516

Representative
State Capitol
120- 4th
Juneau, AK 99801

Dear Representative,

In Alaska each year, approximately 1[illegible]00 babies are born and according to national statistics, about 30 - [illegible] them will have some type of congenital hearing loss. My son is one of those babies. Hearing [illegible]airment is the m[illegible]t common birth defect, more common than cerebral palsy, Down Syndrom[illegible]d severe mental retardation.

Mandatory newborn hearing screening of all babies born in the state allows them to be screened for hearing loss. Without mandatory screening in the newborn period, the ave.age age of identification of a hearing impairment is 2-3 years of age. Since the most important period of speech and language development is from birth to age three, delay in diagnosis can impair a child's language, speech, psycho-social, and cognitive development. Through early identification, children identified at birth with a hearing loss can learn and progress at a rate comparable to those with normal hearing.

My son's hearing loss was not diagnosed until he was 10 and 1/2 years old, due to his other complex medical issues. If he had been screened at birth and his hearing loss detected, hearing aids, sign language training and other needed supports could have been provided during his early years. Maybe he wouldn't even be considered mentally retarded if he had been provided the opportunity to learn to communicate and to access a whole world of sound during those vital early years. He will be 19 in two days and we grieve for his lost potential every time he struggles to make himself understood or to fit in with hearing and speaking people that have little patience with his few words and halting signs.

Mandatory reporting by birthing facilities of hearing screening results to the State of Alaska's, Early Hearing Detection & Intervention (EHDI) Program, will help to ensure that children with possible hearing loss receive timely diagnostic evaluation and, if necessary, are enrolled into early intervention services at the earliest possible time.

I want to ensure .hat all children have what they need to become productive members of our communities. Please support the addition of HB 109 requiring newborn hearing screening, reporting and follow up. Let me know how I can assist you or your staff with additional information. Thanks for your attention to this important matter.

Sincerely,

Cheryl L. Scott, (Justin's mom)

Wood, Thalia

From: Sue Benson [Sue_Benson@matsuk12.us]
Sent: Friday, January 20, 2006 8:08 AM
To: Senator_Lyda_Green@legis.state.ak.us
Cc: Thalia_Wood@health.state.ak.us; Rep_Vic_Kohring@legis.state.ak.us
Subject: HB109

1050 Onyx Circle
Wasilla, AK 99654
January 20, 2006

Senator Lyda Green
State Capitol, Room 516
Juneau, AK 99801-1182
Senator_Lyda_Green@legis.state.ak.us

Dear Representative,

As one of your constituents I am writing to ask you to support the addition of HB 109 requiring newborn hearing screening, reporting and follow up. As a parent of a child with hearing loss I want other children to have earlier diagnostics and intervention than my child had.

My son was diagnosed with a hearing loss in one ear when he was almost two years of age. He had several risk factors for hearing loss at birth, but newborn screening was not done at that time. Without mandatory screening in newborns, the average age of identification of hearing impairment is 2-3 years of age. Since the most important period of speech and language development is from birth to age three, delays in diagnosis can impair a child's speech, language, psycho social and cognitive development. Through early identification, children identified at birth can learn and progress at a rate comparable to those without hearing loss.

As an audiologist I still see children that are not diagnosed with hearing loss until they are three years of age or older. With mandatory screening and reporting by birthing facilities to the State's Early Hearing Detection & Intervention (EHDI) Program, children with possible hearing loss will receive timely diagnostic evaluation, amplification and/or medical intervention and, if necessary, enrolled into early intervention services.

January has been designated as Birth Defects Prevention Month. Please support HB109 requiring universal newborn hearing screening, reporting and follow up, so more children have a better chance in the first few years of development.

Thank you for your attention to this important matter.

Sincerely,

Susanne Benson

Susanne Benson, MS, CCC-A
Educational Audiologist
Mat-Su Borough School District
Wasilla High School, 701 Bogard Rd
Wasilla, AK 99654

907-352-8279

Daniel E. Knudsen
P.O. Box 35426
Juneau, AK 99803

February 24, 2006

Senator Fre. Dyson
State Capitol, Room 121
Juneau, AK 99801-1182

Dear Senator:

Birth defects are the leading cause of infant mortality in the United States. I am writing as one of your constituents concerned about the public health importance of the major birth defect, congenital hearing loss.

January has been designated as Birth Defects Prevention Month. In Alaska each year, approximately 10,000 babies are born and according to national statistics, about 30 of them will have some type of congenital hearing loss. Hearing impairment is the most common birth defect, more common than cerebral palsy, Down Syndrome and severe mental retardation.

Mandatory newborn hearing screening of all babies born in the state allows them to be screened for hearing loss. In the absence of mandatory screening in the newborn period, the average age of identification of a hearing impairment is 2-3 years of age. Since the most important period of speech and language development is from birth to age three, delay in diagnosis can impair a child's language, speech, psycho-social, and cognitive development. Through early identification, children identified at birth with a hearing loss can learn and progress at a rate comparable to those with normal hearing.

In addition, mandatory reporting by birthing facilities of hearing screening results to the State of Alaska's Early Hearing Detection & Intervention (EHDI) Program, will help to ensure that children with possible hearing loss receive timely diagnostic evaluation and, if necessary, are enrolled into early intervention services at the earliest possible time.

I want to ensure that all children are given what is needed to become productive members of our communities. I know you do also. Please support the addition of HB 109 requiring newborn hearing screening, reporting and follow up. Let me know how I can assist you or your staff with additional information. I can be contacted by email at; nomeaudiology@yahoo.com, or by telephone at (907) 957-1828.

Thanks for your attention to this important matter.

Sincerely,

Daniel E. Knudsen, M.S., CCC-A
Audiologist

I work as an audiologist at the Alaska Native Medical Center. I have lived in Alaska for a long time. I previously worked in the Anchorage School District as an audiologist and as a teacher of preschool deaf children. I also am the mother of an adult deaf woman.

I am writing in support of HB 109, Newborn Hearing Screening and Reporting for Alaska's Children. The State of Alaska, since 1999, has been building the hospital programs to screen hearing for all newborns and insure timely diagnostic evaluation and early intervention. This work has been done by people who passionately believe in the program and through federal grants. The voluntary compliance has been great. However, soon the grants will expire and we need to have legislation that will ensure the continuation of the program. Currently, 38 states have legislation in place mandating newborn hearing screening.

I have worked with persons with hearing impairment for a long time and have seen the positive changes early diagnosis and intervention makes. Before newborn hearing screening, the average age of diagnosis of hearing loss was 2 to 3 years of age. Even with mild/moderate losses of hearing, but especially with severe to profound hearing losses, the impact on speech and language development was devastating. Hearing impaired children maintained lower language levels than their peers and deaf children often left high school with less than 4th grade reading levels. Good research in the last five years has shown that babies who have newborn hearing screening and receive early diagnosis and intervention develop speech and language that is age appropriate by age 5 to 6 years, no matter the level of their hearing loss. Included in this intervention is the improvement in cochlear implants for young children. If diagnosed with profound hearing loss and receiving a cochlear implant before age 2 years, many children are developing age appropriate speech and language skills and are being included successfully in regular education classes.

Early diagnosis is even more important for children who live in remote villages. These children already have more limited access to early intervention. By receiving early diagnosis and intervention, their access to normal speech and language development will be greatly enhanced. This is so important for these children. Without this access to auditory intervention, rural Alaskan deaf children either are sent to Anchorage to live in group homes in order to attend the State School for the Deaf, stay in their villages with no one to communicate with, or their families move to Anchorage and lose their community support system.

On a personal note, my daughter who is deaf is married to a deaf man. They have three children who are hearing. My daughter has worked hard and completed a college degree. However, the opportunities for employment for her are limited due to her communication abilities. She and several of her friends who went to the Alaska State School for the Deaf and completed college degrees are either unemployed or under-employed (e.g. engineering degree working as a teacher assistant). If she was identified today, I would opt for a cochlear implant for her in a heartbeat because I have seen how much they improve a deaf person's access to auditory communication.

The key to an improved quality of life for children with hearing loss is early identification and intervention. We need to ensure that our hospitals are required to screen hearing of newborns and that diagnosis and intervention occurs in a timely manner. Please pass this bill.

Robin M.Gibson
631 W. Gail Drive
Wasilla, AK 99654
March 4, 2006

Representative
State Capitol
120- 4th
Juneau, AK 99801

Dear Representative,

In Alaska each year, approximately 10,000 babies are born and according to national statistics, about 30 of them will have some type of congenital hearing loss. Hearing impairment is the most common birth defect, more common than cerebral palsy, Down syndrome and severe mental retardation.

Mandatory newborn hearing screening of all babies born in the state allows them to be screened for hearing loss. Without mandatory screening in the newborn period, the average age of identification of a hearing impairment is 2-3 years of age. Since the most important period of speech and language development is from birth to age three, delay in diagnosis can impair a child's language, speech, psycho-social, and cognitive development. Through early identification, children identified at birth with a hearing loss can learn and progress at a rate comparable to those with normal hearing.

My daughter was born with mild hearing loss, though we were lucky enough to be diagnosed early, we have still encountered language and speech development issues. We have as a family, learned some sign language that would allow her more opportunity to communicate. I can't imagine what the consequences might have been like if this had not been detected within the imperative time frame.

Mandatory reporting by birthing facilities of hearing screening results to the State of Alaska's, Early Hearing Detection & Intervention (EHDI) Program, will help to ensure that children with possible hearing loss receive timely diagnostic evaluation. If necessary, the child can be enrolled into early intervention services at the earliest possible time.

I want to ensure that all children have what they need to become productive members of our communities. Please support the addition of HB 109 requiring newborn hearing screening, reporting and follow up. Let me know how I can assist you or your staff with additional information. I can be contacted at Gibson6@mtaonline.net.

Thanks for your attention to this important matter.

Sincerely,

Robin M. Gibson

AARP Alaska

March 3, 2006

The Honorable Fred Dyson, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 121
Juneau, AK 99801-1182

RE: HB 109-- (Ramras)--Support

Dear Chair Dyson:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health, Education and Social Services Committee to support HB 109, authored by Representative Jay Ramras and co-sponsored by your Committee colleague Kim Elton as well as Senators Ellis, Davis, Guess and Kookesh. Twenty House members signed on as co-sponsors, including twelve Republicans and eight Democrats.

AARP is not only a "senior organization." We are also an organization of grandparents concerned about the quality of health of all Alaskans of all ages.

The goal of HB 109 is to have all children born in Alaska screened for hearing problems soon after birth. If screening is not done early, very often hearing losses or problems will not be detected until a child is two or three years of age. The most important period for speech and language development is from birth to three. Most of our newborns are offered this screening. AARP hopes you will enable us to have 100% of them screened at birth. We are pleased to join the March of Dimes in support of this bill.

AARP members often were not fortunate enough to be born when newborn screening was readily available. Many of our members have hearing losses that have been exacerbated by age but they originated at birth. Any efforts to assure that all Alaskans are screened at birth and treatment made available will enhance their lives as long as they live.

AARP urges an "AYE" vote on HB 109.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866 227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Gary Wilken
Senator Lyda Green
Senator Kim Elton
Senator Donny Olson
Representative Jay Ramras

Wood, Thalia

From: Sherris, Carl
Sent: Wednesday, March 01, 2006 11:51 AM
To: Birch, Stephanie; Wood, Thalia; 'Lisa@aktherapedics.com'
Subject: FW: A plea from a constituent- Letter to Senators

From: "Stephen Popichak" <spopichak@catg.org>
To:
<Senator_Lyda_Green@legis.state.ak.us>, <Senator_Fred_Dyson@legis.state.ak.us>, <Senator_Kim_Elton@legis.state.ak.us>, <Senator_Donald_O
CC: "Christina Keenan" <ckeenan@catg.org>, "Carl Sherris" <csherris@msn.com>, "Craig L. Fleener" <cfleener@catg.org>
Subject: A plea from a constituent
Date: Wed, 1 Mar 2006 11:11:21 -0900

Honorable Senators-

I am writing to you to implore you to vote to have mandatory hearing screening on all newborns, which is to be addressed in HB 109 on Monday, March 6. My name is Stephen Popichak and I am hearing impaired. I was born with German Measles in 1965, and my hearing loss is a result of that disease. I was not diagnosed as being hearing impaired until I entered kindergarten. I was not fitted for hearing aides until I was 16 years old.

Why is this important? What did it do to my school life and home life? It is very simple, I struggled in almost every aspect of my life. Learning was a struggle for me, as I was unable to hear instructors and had to ask repeatedly to have things shown to me. I could not hear my friends who were trying to help me. It made learning and living very very difficult. Had I been diagnosed earlier and fitted for hearing aides earlier, I believe that my life, both in school and outside, would have been much easier. The need for early detection of possible hearing loss can greatly help children. If parents and teachers are made aware of problems with a child, they can compensate so that learning is individualized making the child feel included, not special or different, thereby providing them with an environment that will help them more efficiently. Having hearing loss detected at birth would increase the chances that a child can get the help they need so they do not lag in school and life.

I cannot stress how important early detection of hearing loss can be. No, you can't make the hearing come back, but you can get hearing aides and teach children. As a child, I felt so different and so alone because I could not understand what was going on around me. When I did get hearing aides, it was at a point where they did nothing but confuse me because I had been used to hearing one way and suddenly I was overwhelmed by the new sounds. Had I gotten them earlier my perception of sound and hearing would have been something that I could have adjusted to easier and it would have made my chances of learning and understanding that much better. Getting the hearing aide at an early age allows for adjusting to new sounds and being accustomed to them.

I hope that you truly consider making the screening of hearing a mandatory requirement from birth onward. Give the children a fighting chance to do the best that they can in school and in life. Every day, hour, minute that is wasted not screening a child, is pushing that child's learning back farther. I treasure the sounds that I hear...give newborns that opportunity as well.

Thank You--

Stephen Popichak

Early Head Start Family Services Manager

Council of Athabascan Tribal Governments

PO Box 33 , Fort Yukon, AK 99740 907.662.3266 spopichak@catg.org

PO Box 367, Fort Yukon, AK 99740-0367 907.662.6440

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSHB 109(FIN)
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Screening Newborn For Hearing/Audiologist
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Sponsor: Ramras, et al
Requester: Senate Health & Social Services
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation amends the Audiology statute Sec 3. AS 08.11.120(b). It does not have a fiscal impact the operations of the division.

Prepared by: Katherine Mason, Administrative Manager
Phone: (907) 465-2144
Division: Corporations, Business and Professional Licensing
Date/Time: 3/3/06 5:14 PM
Approved by: William C. Noll, Commissioner
Date: 3/3/2006
Agency: Commerce, Community, and Economic Development

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB109CS(FIN)-DHSS-DPH-03-06-06
( ) Publish Date:

Revision Date/Time (Note if correction): Updated 3/3/06
Dept. Affected: Health & Social Services

Title: RELATING TO NEWBORN HEARING SCREENING
RDU: Public Health
Component: Women, Children and Family Health

Sponsor: RAMRAS
Requester: SENATE (HES)
Component No.: 2788

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	39.4	47.4	55.8	64.6	64.6	64.6
Miscellaneous						
TOTAL OPERATING	**39.4**	**47.4**	**55.8**	**64.6**	**64.6**	**64.6**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		(29.7)	(111.6)	(115.9)	(119.8)	(126.2)
1003 GF Match						
1004 GF	39.4	77.1	167.4	180.5	184.4	190.8
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**39.4**	**47.4**	**55.8**	**64.6**	**64.6**	**64.6**

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The intent of this bill is to ensure all newborns are provided with hearing screening within 30 days of their birth, and that those identified with a positive screen or high risk factors receive a second screen or diagnostic work-up, are enrolled in early intervention and receive treatment as needed. Projected costs associated with maintenance of the Early Hearing Detection and Intervention program (EHDI) are based on the following assumptions: 1) The number of newborns screened is based on the average number of births currently at 10,000 per year. 2) The diagnostic rate of hearing loss is estimated to be at 0.3% of the 10,000 births=30 newly diagnosed infants per year, however, not all newborns with hearing loss will be immediately identified. 3) 95% of newborns would be screened by FY 07; and 98% by FY 08 and beyond.
(Continued on P.2)

Prepared by: Richard Mandsager, M.D. Phone 465-3090
Division: Public Health Date/Time 03/03/2006
Approved by: Karleen Jackson, Commissioner Date 03/06/2006
Agency: Department of Health and Social Services

ANALYSIS CONTINUATION

4) There is a need to follow an additional 10% of all newborns each year who are at high risk for later onset hearing loss during their first three years of life. Thus, the program requires a reporting and surveillance system for tracking all newborns and assisting them with ongoing hearing screening, diagnostic and intervention services.

At present the Division of Public Health is receiving two federal grants to support the maintenance of this program. One grant, scheduled to expire in March 2008, covers the expenses associated with maintaining the newborn hearing program, including assisting hospitals with implementation and education, and professional and public educational information. The second grant will end in August of 2008 and covers costs associated with the statewide early detection/intervention surveillance and tracking system. This provides funds for infrastructure costs through FY08. General Funds are also being requested in FY08 to fund the fourth quarter activities after the expiration of the continuation grant. This portion is shown as a fund switch from Federal to GF.

The increased line item expenditures shown on page 1 will be utilized for:
GRANTS AND CLAIMS ($39.4 in FY 07): Additional funds for special hearing resources would be needed for the existing Early Prevention/ILP programs to work with the anticipated increased volume as children are identified earlier and thus require services during the 0-3 period. The additional grant funds would be awarded incrementally over the next five fiscal years to allow for increased capacity-building to support special hearing services for children identified with hearing loss in preparation for school readiness and learning. The dollar figure is based on:

1) An average FY 05 cost of $3,100 per newly enrolled infant, with a 3% inflation factor built in annually. 2) Only assumes about 50% of the newly diagnosed infants would enroll in the early intervention hearing resources program (12 new infants in FY 07; 14 in FY 08; 16 in FY 09; and 18 in FY 10, FY 11 and FY12).

The General Funds replacing Federal Funds (and so not shown as line item expenditures on page 1) will be allocated by cost category as follows:

PERSONAL SERVICES ($72.0 covers all of these personnel expenses in FY 09 and assumes a 3.5 percent annual merit increase):
a) 0.5 FTE - EHDI Health Program Manager II (R/19). This position oversees the maintenance of the reporting and surveillance activities of the program, assures early intervention referrals, tracks high-risk infants through the age of 3, provides outreach education to providers, and technical assistance to health care facilities throughout the state.
b) 0.5 FTE - Administrative Clerk III (R/ 9). This position provides administrative support and data entry for the activities required for maintenance of a statewide newborn hearing screening program.

TRAVEL ($1.0 in FY 08): Travel costs are included for the EHDI manager to visit screening sites for TA and program compliance. Additional travel funds would be required in FY 09 with the termination of federal funding.

(Continued on P. 3)

ANALYSIS CONTINUATION

SUPPLIES ($1.0 in FY 08): This includes the cost of postage to mail brochures and technical assistance resources.

CONTRACTUAL ($27.7 in FY 08): Includes the actual cost of supporting web-based data and surveillance system. Cost averages at $3.00 per newborn. Costs also include those needed for the reprinting of educational materials for parents and providers. Slight increases in contractual costs are included in FY09 and beyond.

Comments presented at Senate HES hearing on March 6, 2006 regarding HB 109 – An act relating to establishing a screening, tracking and intervention program related to the hearing ability of newborns and infants..."
Prepared by: Leena Ongley, Ed. CCC-A/SLP, PO Box 1005, Barrow, AK 99723
907.852-4525 ongley@barrow.com

FOR HB 109

My name is Leena Ongley and I work as an Early Intervention Specialist on the North Slope. I have a Master's Degree in Early Childhood Education and hold Certificates of Clinical Competence in both Audiology and Speech and Language Pathology.

In the absence of mandatory hearing screening in the newborn period, the average age of identification of a communicatively significant hearing impairment is around the child's second or third birthday. In many parts of rural Alaska this may not happen until the child reaches school age. Since the most important period for speech and language development occurs during the time between birth and the child's second birthday, research has clearly demonstrated that a delay in diagnosing a hearing problem will have a serious negative impact on the child's long-term educational outcome that can last a lifetime.

Each year about 10,000 babies are born in Alaska, and about 30 of them will have some type of congenital hearing loss, a fact based on national statistics. The number sounds small and insignificant, however, hearing impairment is one of the few birth defects where highly specialized methodology of language and communication intervention in the early years prevents future problems and enables these individuals to function as productive adults in literate modern societies.

Furthermore, being able to refer to a normal newborn hearing screening result when evaluating children for hearing loss associated with middle ear fluid provides critically important data on a change in the child's hearing status. Baseline data provided by the newborn hearing screening helps parents understand there has been a change in the baby's hearing, and a timely medical evaluation by a specialist is indicated.

Having provided early intervention services in rural Alaska for years, our program data indicate that five out of ten children living in many villages have chronic ear pathology accompanied by mild to moderate hearing loss by the time they turn one. The most serious long term consequence of frequent ear infections is a language delay that in many cases contributes to difficulty learning to read and write. It is uncanny that schools in this region also report that only about half of their high school graduates read and write at grade level.

Getting back to the early identification of hearing problems, mandatory reporting infant hearing screening results to the State of Alaska's Early Hearing Detection & Intervention Program helps ensure that children with potential hearing loss receive timely diagnostic evaluation and, if necessary, are enrolled into early intervention services as soon as the communicatively significant hearing problem is identified.

In case of hearing impairment, early services make the difference between an adult who has problems reading and writing, and those who can read and write with ease.

Please support HB 109 that mandates newborn hearing screening, reporting and follow up services as needed, and thank you for your attention to this important matter.

SENATE COMMITTEE REPORT

DATE: 4/22/05

FURTHER: Finance

DATE TURNED IN TO OFFICE: 5.6.06

Health, Education and Social Services Committee considered CS FOR HOUSE BILL NO. 109(FIN)

HB 109 SCREENING NEWBORNS FOR HEARING ABILITY

"An Act relating to establishing a screening, tracking, and intervention program related to the hearing ability of newborns and infants; providing an exemption to licensure as an audiologist for certain persons performing hearing screening; relating to insurance coverage for newborn and infant hearing screening; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

CS Senate Bill:
[ ] Same Title
[ ] New Title

SCS House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

HSS	3/3	X			

PREVIOUS FISCAL NOTE(S):

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	DO PASS	DO NOT PASS	NO REC	AMEND
			✓	
			✓	
CHAIR:	✓			

Senate HES Committee Hearing
March 6th, 2006

Testimony

I'm Debbie Golden, Director of Program Services for the Alaska Chapter of March of Dimes. I've been an Alaskan resident for 26 years, a registered nurse for 24 years and have worked as a public health nurse in Alaska for 15 years. I've lived in Fairbanks, Fort Yukon, and Anchorage, so I've had the opportunity to see health care systems in action in different settings in Alaska.

I'm here to ask you to pass HB 109! For 50 years experts have emphasized the need to detect hearing loss early in life. March of Dimes has a long history of advocating for healthy babies and supports mandatory newborn hearing screening. I think the benefits of babies being able to hear probably go without saying at this point. HB 109 is a very good bill that does 3 things –

- Requires that all newborns are screened for hearing loss
- Tracks follow-up to be sure children who need confirmatory diagnostic testing get it
- Assists parents and health care providers to secure further services for kids who need them

The fiscal note for the bill is a mere $39, 400 for FY 2007.

The beauty of this bill is its simplicity. HB 109 simply will assure the good things we have in place to address newborn hearing loss won't go away. It's not about building complex new systems, because the Early Hearing Diagnosis and Intervention program is in place. It's not about burdening rural health care providers with new duties, because they already have equipment and conduct screening. And it's not about making Medicaid or private insurance companies pay for expensive new services, because they've been covering the small cost associated with newborn hearing screening since 1998 and intend to continue. HB 109 simply will assure:

- we can maintain the effective program we already have
- that screening babies all over the state will not fall by the wayside as time goes by, new duties are added, and staff turnover occurs, and
- new insurance companies that may enter the scene will adhere to state standards

In addition, HB 109 will prevent children from falling between the cracks. Newborns will be less likely to be missed being screened and children less likely to have delayed intervention or be lost to follow-up.

We choose to protect children and promote their health in many ways. We know infants benefit from having their hearing loss identified. Appropriate interventions improve their hearing and language dramatically, improve their performance in school, increase the quality of their lives and decrease economic costs to society. Why would we deprive Alaska and its newborns the benefits accorded by HB 109? Thank you for passing HB 109!

Respectfully submitted,

Debbie Golden

Debbie Golden, MS, RNC
Director of Program Services

The mission of the March of Dimes Birth Defects Foundation is to improve the health of babies by preventing birth defects, premature birth and infant mortality.

HB

120

Alaska State Legislature

Representative Peggy Wilson
House District 2
Putting Alaska's Families First

MEMORANDUM

Date: April 15, 2005

To: Senator Fred Dyson

From: Representative Peggy Wilson

Re: HB 120 Health Care Employee Protection

HB 120 will remove two exemptions for intraoral procedures and for health care organizations with fewer that 25 full-time employees. This bill will bring the Alaska standards into compliance with federal standards for the handling of needles and other sharp instruments. Removing these exemptions is not expected to have a significant impact as these organizations currently do comply with the federal standards. I request that you schedule HB 120 for a hearing before the Senate HESS Committee at your earliest convenience.

I am attaching the most recent sponsor statement, current and all previous versions of the bill, letters of support, and sectional analysis.

Thank you for your consideration.

Jan-May, Juneau: State Capitol • Juneau, AK 99801-1121 • *ph:* (907) 465-3824 • *fax:* (907) 465-3175
June-Dec, Wrangell: PO Box 109 • Wrangell, AK 99929 • *ph:* (907) 874-3088 • *fax:* (907) 874-3055
Rep.Peggy.Wilson@legis.state.ak.us • http://www.akrepublicans.org/wilson/ • 1-800-686-3824

ALASKA STATE LEGISLATURE

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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

Sponsor Statement
HB 120

" An Act relating to safety devices for needles and sharp instruments to prevent the spread of bloodborne pathogens in Alaska's health care workers and establishing an effective date. "

This bill repeals two exemptions from Alaska's bloodborne pathogen protection standards to bring Alaska standards into compliance with federal standards. The bill removes exemptions for intraoral procedures and for health care organizations with fewer than 25 full-time employees. Removing these exemptions is not expected to have a significant impact, as most of these organizations have already made the necessary efforts to minimize exposure to bloodborne pathogens by complying with state and federal standards. The risks associated with bloodborne pathogen exposure demand clear and consistent standards throughout health care organizations in Alaska.

Sectional Analysis
House Bill 120 Health Care Employee Protection

Sectional Analysis

Section 1 repeals AS 18.60.880(h), which exempts operations where the primary use of needles and other sharps is for intraoral procedures from requirements to use safety devices. Removing this exemption will help ensure that the risk of spreading bloodborne pathogens in dentist and oral surgery offices is minimized.

Section 2 repeals AS 18.60.890(3)(B), which exempts employers with fewer than 25 full-time employees from the requirements to use safety devices to help ensure that the risk of spreading bloodborne pathogens in health care occupations is minimized in Alaska.

Sections 1 and 2:

These exemptions conflict with federal regulations (29 CFR 1910.1030) governing occupational protections associated with the use of needles and other sharp devices, as the federal regulations do not contain similar exemptions.

AS 18.60.880(h) and AS 18.60.890(3)(B), as they currently stand, are in direct conflict with AS 18.60.030(6) and Section 18 of the Occupational Safety and Health Act of 1970 (29 USC § 667), which mandate the Alaska Occupational Safety and Health (AKOSH) program to be "at least as effective as" the U.S. Department of Labor, Occupational Safety and Health Administration program. Not only does this conflict create confusion for employers who are not sure which standard to follow, it also jeopardizes federal grant funds for the AKOSH program.

Section 3 establishes an immediate effective date.

Other Speaking Points/Issues:

AS 18.60.880 and AS 16.60.890 were enacted in 2000. The federal regulations on this same subject (29 CFR 1910.1030) were printed in the Federal Register on January 18, 2001 and, in accordance with 8 AAC 61.1010(b), the State of Alaska adopted these federal regulations by reference in June of 2001.

The federal regulations on bloodborne pathogens contain requirements for annual protective device evaluation and require the employer to seek input from front-line health care employees. The Alaska standard for product evaluation is more specific in terms of the degree of front-line health care participation. The Alaska Nurse's Association did not support completely repealing the current statutes and wanted to maintain some of the state-specific requirements that they had worked hard to achieve. Consequently, this proposal only repeals the two exemptions causing a conflict with federal standards.

AS 18.60.880(h) and AS 18.60.890(3)(B), as they currently stand, are in direct conflict with AS 18.60.030(6) and Section 18 of the Occupational Safety and Health Act of 1970 (29 USC § 667), which mandate the Alaska Occupational Safety and Health (AKOSH) program to be "at least as effective as" the U.S. Department of Labor, Occupational Safety and Health Administration program. The state of Alaska currently receives grant funding from federal OSHA to fund the majority of the AKOSH program. Failure to abide by federal minimum standards jeopardizes federal grant funds for the AKOSH program.

The impact of this legislative proposal is not expected to be significant for two reasons. Many of the businesses currently exempt under Alaska law are already complying with the federal requirements. The participation required for front line health care workers in evaluating protective devices should not pose a significant impact.

In addition to the Department of Labor and Workforce Development's support, there is other support for this legislative repeal. Camille Soleil and John Bitney of the Alaska Nurse's Association and Royann Royer of the Alaska Dental Hygienists Association have pledged support for this bill. Jim Towle of the Alaska Dental Society has been provided with a copy of the proposed legislation and has not voiced opposition. Richard Terrill, Regional Administrator for federal OSHA, is willing to testify in support of the bill due to the conflict created by the current statute and the need to safeguard all health care workers from injuries related to the use of sharps and needles.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB120-DOLWD-OSH-02-04-05**
() Publish Date:

Revision Date/Time (Note if correction):
Title: **Health Care Employee Protection**

Department: **Labor and Workforce Development**
RDU: **Labor Standards and Safety**
Component: **Occupational Safety and Health**

Sponsor: **Representative Wilson**
Requester: **House HES**

Component Number: **970**

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2005) cost: None
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

There is no anticipated fiscal impact as a result of this legislation.

Prepared by: **Grey Mitchell, Director** Phone: **465-4855**
Division: **Labor Standards and Safety** Date/Time: **2/4/05 9:43 AM**
Approved by: **Greg O'Claray, Commissioner** Date: **2/4/2005**
Agency: **Department of Labor and Workforce Development**

(Revised 9/23/2004 OMB)

STATE OF ALASKA

Department Of Labor and Workforce Development

FRANK H. MURKOWSKI, GOVERNOR

P. O. Box 21149
Juneau, AK 99802-1149
Phone: (907)465-2700
Fax: (907)465-2784

OFFICE OF THE COMMISSIONER

March 29, 2005

The Honorable Peggy Wilson
Alaska State Legislature
Capitol Building, Room 104
Juneau, AK 99801

Dear Representative Wilson:

During the March 22, 2005, House Labor and Commerce Committee hearing regarding HB 120, Representative Rokeberg asked whether dental instruments used for cleaning teeth would be required to have protective devices under this proposed legislation. I discussed this question with the Labor Standards and Safety Division, Occupational Safety and Health Industrial Hygienists who specialize in health care.

It is important to note that there are several common sense reasons why engineered protective devices are not required as listed in AS 18.60.880(b)(1)(A)-(E) (copy enclosed). There are some dental instruments used for cutting that would require evaluation on an annual basis to determine if there are appropriate protective devices available for use. These instruments are currently equipped with a plastic cover to minimize the risk of exposure and there is no other known protective device on the market for these types of instruments.

Most teeth cleaning instruments are scrapers and do not have sharp points or cutting surfaces that would present a recognized sharps injury risk. Consequently, these scraping instruments would not need to be evaluated for use of engineered sharps injury protective devices. The types of devices that must be evaluated are listed in AS 18.60.880(a)(1)-(8) (copy enclosed).

I hope this resolves the question posed by Representative Rokeberg. If you need any additional assistance with this bill, please let me know.

Sincerely,

Greg O'Claray
Commissioner

Enclosure
cc: Grey Mitchell, LSS Director

Sec. 18.60.880. Needle stick and sharps injury protections for health care workers.

(a) An employer shall conduct product evaluations of needleless systems and sharps with engineered sharps injury protections. The product evaluations shall include the categories of devices that are used in the employer's facilities. For each category of device, the product evaluations shall be performed by front-line health care workers representing all wards and medical specialties where the devices are used. The evaluation committee described in (g) of this section shall determine the amount of time necessary for the front-line health care workers to perform product evaluations under this subsection. **The categories of devices to be evaluated under this subsection include**

(1) IV catheters;

(2) IV access devices and IV connectors;

(3) vacuum-tube blood collection devices;

(4) blood-drawing devices including phlebotomy needle and tube holders, butterfly-type devices, and syringes and other similar devices;

(5) syringes used for purposes other than blood drawing;

(6) suture needles;

(7) scalpel devices; and

(8) any other category of device used at the employer's facilities where there is a sharps injury risk.

(b) The department shall, by regulation, adopt a standard concerning the use of needleless systems and sharps with engineered sharps injury protections for devices listed in (a) of this section. The regulations must provide that

(1) needleless systems and sharps with engineered sharps injury protections must be included as engineering and work practice controls; **however, the needleless systems and sharps with engineered sharps injury protections are not required if**

(A) the devices are not available in the marketplace;

(B) the evaluation committee described in (g) of this section determines by means of objective product evaluation criteria that use of the devices may jeopardize patient safety if used for

(i) a class or type of procedure; or

(ii) a class or type of procedure when performed on a certain type of patient;

(C) a certified or licensed health care worker directly involved in the patient's care determines, in the reasonable exercise of clinical judgment, that use of the devices will jeopardize the patient's safety or the success of the particular medical procedure involving the patient; a health care worker who makes this determination shall file a report with the employer, in writing, including the date, time, patient, and procedure involved, and a statement of the reasons why the employee failed to use an approved needleless system or sharp with engineered sharps injury protections;

(D) the employer can demonstrate by means of objective product evaluation criteria that use of the devices is not more effective in preventing exposure incidents than the alternative used by the employer; or

(E) the employer can demonstrate, with respect to an engineering control that has not been available in the marketplace for at least 12 months, that reasonably specific and reliable information is not available regarding the safety performance of the engineering control for the employer's procedures, and that the employer is actively determining by means of objective product evaluation criteria whether the use of the engineering control will reduce the risk of exposure incidents occurring in the employer's workplace;

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

The Honorable Norman Rokeberg
House of Representatives
State Capitol – Rm. 241
Juneau, AK 99801+1182

30 March 2005

Dear Rep. Rokeberg:

Thank you for your concern regarding the impact of HB-120 on the dentists and dental offices of Alaska.

Compliance with OSHA standards regarding the safe handling of "sharps" has been a concern of organized dentistry for many years. As you know, in the daily practice of dentistry, it is the dentists who are most at risk from injury by sharp instruments that can spread blood borne pathogens. Whereas physicians often delegate procedures that entail the use of hypodermics and other "sharp" instruments to nurses, physicians' assistants phlebotomists and others, it is the dentist who must use needles, drills and other surgical instruments in the treatment of patients.

The federal OSHA standards recognize this reality and organized dentistry has worked diligently to ensure compliance with federal OSHA standards by dentists.

After reviewing HB-120, the officers of the Alaska Dental Society have instructed me to inform you that the society will not oppose this bill. This is based upon the belief that State of Alaska OSHA officials will recognize that it is the dentist who is the front-line provider most at risk in the dental office. In most dental offices in Alaska, the dentist who owns and manages the practice is the front-line provider most at risk and therefore has the most compelling interest in maintaining full compliance with reasonable standards that respect the ability of the doctor to provide treatment in an environment that is safe for the patient, the doctor and auxiliary staff.

Respectfully yours,

James R. Towle
Executive Director

SENATE COMMITTEE REPORT

DATE: 4/13/05

FURTHER: Labor and Commerce

DATE TURNED IN TO OFFICE: 4.27.05

Health, Education and Social Services Committee considered

HOUSE BILL NO. 120

HB 120 HEALTH CARE EMPLOYEE PROTECTION

"An Act relating to safety devices and sharp instruments for the prevention of the spread of bloodborne pathogens in health care employees; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

CS Senate Bill:
[ ] Same Title
[ ] New Title

SCS House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	2/18			X	1
LWF	2/4			X	2

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
	✓			
	✓			
			✓	
CHAIR:	✓			

HB

128

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 118
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Interim
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REPRESENTATIVE LESIL MCGUIRE
HOUSE DISTRICT 28

Chair
Judiciary Committee

Member
House Leadership
Rules Committee
Health, Education
& Social Services
Committee
Oil & Gas Committee
Military & Veterans'
Affairs Committee

MEMORANDUM

To: Senator Dyson
Chair, Health, Education and Social Services Committee

From: Representative Lesil McGuire

Date: April 7, 2005

Re: Request for hearing, HB 128, "*An Act establishing Alaska Schools Physical Activity Task Force*"

I respectfully request that HB 128, "*An Act establishing Alaska Schools Physical Activity Task Force*" be scheduled for a hearing at your earliest convenience. Attached you will find the bill packet containing the latest version of the bill, sponsor statement, sectional analysis, a zero fiscal note, background information and letters of the support.

If you have any questions or concerns please feel free to contact me personally, or my staff, Shalon Szymanski at (907) 465-6841. Thank you for your time and consideration.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 118
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REPRESENTATIVE LESIL MCGUIRE
HOUSE DISTRICT 28

Chair
Judiciary Committee

Member
House Leadership
Rules Committee
Health, Education & Social Services Committee
Oil & Gas Committee
Military & Veterans' Affairs Committee

HB 128: Establishing the Alaska Schools Physical Activity Task Force

Sponsor Statement

According to the American Obesity Association, more than 30% of U.S. children and adolescents are overweight or obese. Overweight and obese children are more likely to become overweight and obese adults plagued by a litany of diseases including diabetes and all its complications, cardiovascular disease, cancers, depression, high cholesterol, hypertension, and severe arthritis.

Evidence has also shown a link between physical fitness and higher academic performance. Alaska does not currently impose any statewide standards for physical education in schools.

HB128 establishes a task force to come up with recommendations for the best approach to effectively and economically maximize physical activity in Alaska's schools within existing infrastructures.

The task force will be made up of school officials (from both urban and rural areas), physicians, a member from the Department of Education and Early Development, and legislators. They will be charged with coming up with a proposal for increasing physical education in schools that works within the existing infrastructure of Alaska's schools.

The task force will be asked to look at several possibilities including whether new laws or regulations are needed to allow schools to provide the maximum amount of physical activity, whether state school construction requirements should be changed to facilitate needed physical activity in the future, and whether after-school activity programs in addition to programs during school hours would be effective.

We believe that too many children suffer from the consequences of diabetes and obesity. By enhancing physical education in Alaska's schools, we can improve children's health and academic performance.

ALASKA STATE LEGISLATURE

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REPRESENTATIVE LESIL MCGUIRE
HOUSE DISTRICT 28

Chair
Judiciary Committee

Member
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Rules Committee
Health, Education & Social Services Committee
Oil & Gas Committee
Military & Veterans' Affairs Committee

SECTIONAL ANALYSIS
HB 128

Section 1 – Amends uncodified law of the State of Alaska by adding a new section that breaks down the findings of the legislature. These findings include statistics that show that a high percentage of children in the United States are unhealthy, overweight or obese and explains associated health problems.

Section 2 – Amends uncodified law of the State of Alaska by adding a new section that explains what the Alaska Schools Physical Activity Task Force is and lists the 11 members that will make up the task force. This section also explains the responsibilities of the task force.

Section 3 – This section clarifies that this act is repealed on the last day of the Second Regular Session of the Twenty Forth Alaska State Legislature.

American Heart Association.

Learn and Live.

A Positive First Step: Establishing the Alaska Schools Physical Activity Task Force (HB 128)

The American Heart Association supports House Bill 128, a bill establishing a task force that would study proposed recommendations for effectively and economically maximizing physical activity in Alaska's schools.

Approximately half of Alaska's children are obese, overweight or are considered at risk for becoming overweight. Nationwide, the percentages of children who are either overweight or obese are on the increase, and Alaska's kids are out-pacing the national average – essentially, our children are getting heavier more quickly.

Obesity puts our kids at risk of heart disease, stroke, certain types of cancers and early onset Type-2 diabetes. Recent studies indicate that many physical conditions that lead to heart disease and stroke begin in childhood. A recent study uncovered an alarming number of adolescents with cardiovascular risk factors usually considered to be conditions of middle-aged adults. (Source: *Circulation*, a medical journal of the American Heart Association, 2003; 108: IV-720).

We know that poor diet and lack of exercise are the two main factors that contribute to obesity. We also know that many schools have responded to budget crunches and pressure to improve test scores by decreasing the time devoted to quality physical education. Yet evidence suggests that time spent in physical education may help improve attention spans in younger children, and that youth who spend less time in other subject to allow for regular physical education do equally well or better in academic classes than their peers who do not receive regular physical education. (Source: The President's Council on Physical Fitness and Sports, 1999).

Additionally, obesity is expensive. Obesity-related pediatric costs have tripled in the past 25 years even when adjusted for inflation. The annual direct cost of obesity in Alaska – including adult obesity-related illnesses – is now estimated at $195 million, with more than $29 million of that amount paid via the state Medicaid program. (Source: *Pediatrics*, vol. 109, May, 2002 & the U.S. Centers for Disease Control and Prevention, 2004).

We also know that in Alaska, as in most states, there is room for improvement when it comes to the existing physical education requirements. In Alaska, there is no current statewide requirement outlining a course of study in physical education at the elementary level. At the high school level, there is a statewide regulatory requirement that every student must complete at least one unit of health or physical education prior to graduation. A "unit," however, may be defined by each local school board, so that there is no statewide articulated standard or definition of what one "unit" must include. In 2003, the Alaska Division of Public Health, Department of Health and Social Services, conducted a statewide poll to assess what physical education policies are in place in local school districts throughout the state. The poll revealed significant inconsistencies in the duration, sustainability, and type of physical education required:

• Only 29.6% of Alaska elementary or middle schools have a written policy on physical education, while 93% of high schools have such a policy.

• The average time requirement for physical education at the elementary level is 2 days per week for 30 minutes. This requirement increases to 5 days per week for 45 minutes in both middle school and high school, but tends to only be required for one year out of three for middle school, and just one year out of four in high school.

• Statewide, in 76.6% of all physical education classes are taught by someone other than a certified physical education teacher. Of the schools using teachers lacking physical education certification, 96.6% failed to require any specific training in physical education.

While this bill does not require a specific course of action, it is a step in the right direction. By establishing a task force to examine the state of physical education in Alaska and make informed and creative recommendations on ways to improve the quantity and quality of physical education, the Legislature would send a clear message that it cares about the health of our children. The American Heart Association supports House Bill 128, and believes that it is a step in the right direction.

March 1, 2005

American Cancer Society

American Diabetes Association.
Cure • Care • Commitment

American Heart Association.
Learn and Live.

Dear Legislator:

As you may know, 11% of Alaska's youth are overweight and another 14% are at risk for becoming overweight. Physical inactivity is a contributing factor to what is fast becoming an epidemic: overweight and obese children. According to the 2003 Alaska Youth Risk Behavior Survey, 82% of high school students reported not attending physical education class daily. In addition, 72% of high school students participated in insufficient moderate physical activity.

Recognizing the growing economic and human costs of obesity in our nation, the American Cancer Society, American Diabetes Association and the American Heart Association, have formed a national partnership to promote physical education in schools. The importance of physical education to a child's long-term health and well-being cannot be overstated. Alarming studies have shown that:

- In 1999, 13% of children aged 6 to 11 years and 14% of adolescents aged 12 to 19 years in the United States were overweight. This prevalence has nearly tripled for adolescents in the past two decades[1]
- Overweight adolescents have a 70% chance of becoming overweight or obese adults.[2]
- Obesity in children and adolescents is generally caused by lack of physical activity and unhealthy eating patterns
- Overweight and obese children are at higher risk for developing severe long-term health problems, including but not limited to type 2 diabetes, cardiovascular disease, high blood pressure and certain cancers
- Beyond the clear health benefit of physical activity and education for children, is the academic benefit. Studies have demonstrated that a reduction of 240 minutes per week in class time for academics to enable increased physical activity led to consistently higher mathematics scores.[3] Additionally, a recent study has shown the correlation between the SAT-9 test results with the Fitnessgram, indicating that the physical well-being of students has a direct impact on their ability to achieve academically. Students with the highest fitness scores also had the highest test scores[4]

Our partnership is supporting House Bill 128, which would establish an Alaska Schools Physical Activity Task Force. This action would be a positive first step in the right direction.

---

[1] The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.

[2] *See* footnote 2.

[3] Shephard, R.J., Volle, M., Lavalee, M., LaBarre, R., Jequier, J.C., Rajic, M. Required physical activity and academic grades: a controlled longitudinal study. In: Limarinen and Valimaki, editors. Children and Sport. Berlin: Springer Verlag; 1984. 58-63; National Association for Sport and Physical Education (NASPE).

[4] Shephard, R.J. Curricular physical activity and academic performance. Pediatric Exercise Science 1997; 9: 113-126.

This piece of legislation would provide the structure to start addressing the issue of physical activity in our schools, a discussion that is long overdue. The State spends $195 million annually on direct costs related to obesity. The problem is expected to increase even more over the next several years, and this is a unique opportunity to determine how we can save lives and money.

We encourage you to support this important piece of legislation and to support both short and long-term solutions to the growing problem of obesity and physical inactivity in our state. We owe it to future generations.

Respectfully,

Emily Nenon
Advocacy Director
American Cancer Society
emily.nenon@cancer.org

Laura Thelander
Advocacy Director
American Diabetes Association
lthelander@diabetes.org

Kristen Richmond
Advocacy Director
American Heart Association
kristen.richmond@heart.org

March 2, 2005

Re: Testimony in support of HB 128

Alaska has a problem and it's getting worse. Simply put, we're killing our kids.

Kids need to move. Because we are all so busy, we sit kids in front of electronic toys, computers and TVs; we're tired and that's easy. But we condemn our kids to unhealthy and diminished futures when we take this easy route, rather than encouraging healthy activity.

When kids don't get enough exercise and vigorous play, we expose them to increased risks for obesity, high blood pressure, high cholesterol, weakened bones, type II diabetes and even psychosocial disorders. In addition, we're setting them up to fail academically.

Joe Herzog, president of the Fresno, CA, Alliance for Physical Education and Athletics, was recently in Anchorage to speak at the Alaska Association of Health, Physical Education, Recreation and Dance Conference. Herzog said there is a growing body of evidence demonstrating that poor nutrition, inactivity and weight problems have a negative effect on student achievement. And inactive kids grow up to be inactive adults, with more health problems than their more active peers.

The Anchorage Daily News recently headlined findings from the Anchorage School District and State of Alaska Division of Public Health collaborative study. This study showed that 36% of ASD students and 32% of all kindergarten and first grade students had above-normal weights. In addition, recent research has shown that childhood and adolescence are prime years for increasing bone density. That means vigorous activity – running, jumping, skipping and hopping for younger kids, and weight-bearing activities like strength training, as well as sports like basketball, volleyball and x-country skiing for older kids. Five year olds need 40 minutes daily of strenuous play to accelerate bone development.

The Healthy Futures initiative, an alliance of state and local agencies, business, nonprofit organizations and volunteers, encourages physical activity for kids through organized events, activity logs and the Local Fitness Hero program. But these grass roots efforts can only do so much. That's why we strongly support the positive proactive steps of HB128 and the heroes behind this bill.

The well being of our kids is essential to the future health and economy of this state. Getting kids to exercise doesn't have to be complicated or expensive, but it does need to be a priority for the State of Alaska.

Alaska and its kids have a problem. Since we created it, we're the only ones who can solve it. We owe our kids their shot at healthy futures and the happiness and opportunities that go with good health.

Bonny Sosa and Sam Young
Community Volunteer Active-ists
Healthy Futures Initiative
1404 West 31st Avenue
Anchorage, AK 99503
bsosa@gci.net

Frontiersman

Tuesday, February 08, 2005

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Representatives seek to enhance physical education in schools

JOEL DAVIDSON/Frontiersman reporter

JUNEAU - Reps. Lesil McGuire, R-Anchorage, and Les Gara, D-Anchorage, introduced legislation last week to create a legislative task force that would address how to best increase physical activity in Alaska's schools.

House Bill 128 brings together school officials, legislators and physicians to address the growing problem of obesity and diabetes among children.

According to the American Obesity Association, more than 30 percent of U.S. children and adolescents are overweight or obese - a fact that is both reversible and preventable.

The medical profession has argued that healthy students simply perform much better academically and socially.

"Overweight children become overweight adults, plagued by a terrible litany of diseases," said Dr. Peter Mjos, an Anchorage doctor.

The task force would determine the best approach for establishing maximum physical activity for Alaska students. Alaska does not currently impose any statewide standards for physical activity in schools.

The task force will be charged with coming up with recommendations for effectively and economically maximizing physical activity within the existing infrastructure of Alaska's schools. The task force will also come up with recommendations for new laws or regulations to allow schools to provide needed physical activity in the long term.

"Too many children suffer because of diabetes and obesity, and we'd like to change that," Rep. McGuire said.

Gara shared the same concern, stating in a press release, "We can help children learn and feel better by improving physical education in this state."

Attorney general resigns

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Students spend little time getting exercise in P.E. classes, even as childhood obesity grows

COLIN FLY
Associated Press Writer

Skye Trammel of Victor, N.Y., does curls with barbells in the weight room at Victor High School in Victor, N.Y. on Wednesday, Jan. 12, 2005. Physical education experts say there's little accountability for P.E. teachers in most schools. Victor Central School District Superintendent Timothy J. McElheran said his teachers are held to specific goals and judged like any math or science teacher would be. (AP Photo/Don Heupel)

NASHVILLE, Tenn. — As American children grow fatter and more out of shape, physical education classes are being found wanting. Experts say there's little accountability for P.E. teachers in most schools. They say the classes are often poorly run, and students don't spend much time in them anyway.

Lisa Lewis, a health professor, heard her two sons talk about how bad their high school P.E. class was, so she went to see for herself.

"It's been terrible," she said. The teacher was a basketball coach, and "that's basically all they did — play basketball between 40 and 50 kids." Many students, especially those who weren't athletic, just stood on the sidelines of the disorganized game.

Nearly one-fifth of all high school P.E. teachers don't have a major and certification in physical education, according to the most recent numbers from the National Center for Education Statistics.

Often the instructor is a coach more interested in winning games than in producing healthy students, experts say.

"That stigma that a coach cares more about the team than his physical education class does exist," said George Graham, professor of kinesiology at Penn State University.

"When a teacher or coach is doing that, it's really up to the principal to get in there and say, 'We want to win ball games, but the kids in P.E. deserve a good education too.'"

The lack of respect for P.E. also appears in the number of students required to take it.

The Centers for Disease Control and Prevention reports that in 2003, only 28 percent of high school students nationwide attended a daily P.E. class, but 38 percent watched television for three hours or more each school night.

While 71 percent of the nation's freshmen were in P.E. at least one day a week — hardly enough to be effective, experts say — those numbers drop to 40 percent by the students' senior year.

But participation varies widely by state. In Tennessee, for instance, only 18 percent of seniors were enrolled in a P.E. class, while New York has better than 90 percent participation.

The National Association for Sport and Physical Education says Illinois is the only state that requires daily physical education K-12, while Alabama requires it for K-8.

In California, Kentucky, Maine, Missouri, New York, South Carolina and Vermont, accountability standards are being developed for health and physical education programs.

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"Unless we hold physical education teachers accountable for the fitness of the student ... there's no way to evaluate who is good or who is bad because we're more concerned with math and reading," Lewis said. "There needs to be some sort of minimal national fitness standard — that would be a very easy thing to establish."

Some schools have done just that — like the Victor Central School District just outside Rochester in Victor, N.Y.

Superintendent Timothy J. McElheran said his teachers are held to specific goals and judged like any math or science teacher would be.

"It's no longer the coach with the whistle around his neck," he said. "Our physical education teachers are highly trained professionals."

Victor's nationally recognized program includes rock-climbing, kayaking, cross-country skiing, archery and aerobic dance as options for students.

"They take what they're doing very seriously," he said.

But not all do, and a new federal education law doesn't give schools much incentive.

"The thought in some schools is, 'If we eliminate P.E., then they will have more time to do better educationally,' but there's nothing to suggest that's the case," Graham said.

"Kids — just like adults at work — need breaks and they need time on their own."

Lewis has seen the poor state of physical education not only in her sons' school, but also at Middle Tennessee State University where she works. The school recently dropped requirements for health and P.E. from the core curriculum.

MTSU general education director Bill Badley said the P.E. requirement went from four hours to zero when the school decided to add classes to the core curriculum while lowering the total number of classes needed to graduate.

Lewis wasn't able to stop the changes at MTSU, but she was able to make a difference at her sons' school.

"I went to the class and actually helped the physical educator," Lewis said. "The non-athletes, they're the ones who need it most."

NASPE president Dolly Lambdin said the cuts in secondary schools and colleges intensify the problem that begins at a young age.

"Whatever belief we teach (children) in elementary school, middle school and high school, those beliefs will carry over in college," she said. "We can't continue the model (that) we have to fix things later. It doesn't work on your car and it doesn't work on your body. Physical maintenance is the key."

Junk food diet + inactivity = overweight kids

Tuesday, November 16, 2004 - by Yvonne Ramsay

Anchorage, Alaska - From kindergarten to senior year in high school, Anchorage students are weighing in heavier than ever.

"A significant percentage of the kids in kindergarten or first grade are either at risk or already overweight," says Dick Hawkins, a physical education instructor at Creekside Elementary School.

A recent study released by the Anchorage School District and the state Division of Health found that 18 percent of children are overweight, while another 18 percent are at risk of becoming overweight. About 62 percent of students are at a normal weight, compared to just 2 percent considered underweight.

Physical education teachers say, with the amount of time students spend in the gym at school, the statistics are not going to improve.

"In 60 minutes a week, you just can't really effect that much of a change," says Hawkins (right). "You can affect their attitude, I think, and the enjoyment they might get out of an activity. But they have to do a lot of it on their own at home."

Doctors say if children don't learn healthy habits early, there will be consequences later in life.

"Obese children become obese adults," says Dr. Peter Mjos of the Anchorage Neighborhood Health Clinic. "We've heard that this trend, according to the CDC, is actually magnified in rural Alaska."

It's a trend that's not only growing in Alaska, but across the nation.

"Shortly, the number of deaths attributable to obesity and being overweight will overtake smoking as the most common cause of death in this country," Dr. Mjos says. "This is a tragedy. The bottom line -- it's reversible and it's preventable."

From the skinny kids to those who are big boned, school officials say it's important all children learn the importance of maintaining a healthy lifestyle.

"I think also pediatricians, health care providers, the neighborhood health clinics need to work together with us to emphasize, literally from the day a child is born, how important good nutrition is, and exercise," says School Superintendent Carol Comeau.

Read the report by the Anchorage School District and the state Division of Public Health about overweight children.

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Anchorage Daily News

Third of city's students at risky weight, study finds

ANCHORAGE: Most of them are heavy before the first grade.

By ANN POTEMPA
Anchorage Daily News

(Published: November 16, 2004)

A new study shows that more than one-third of Anchorage School District students are overweight or at risk for weighing too much.

Further, the study shows that almost one in three children entering kindergarten or first grade are overweight or headed that way -- a strong indicator that parents and doctors must address children's weights before they enter school.

"I think this is a major eye-opener for all of us," said Dr. John Middaugh, a medical epidemiologist in Alaska.

"Until we looked at the data, I think most of us didn't have a clue of the scope of the problem at such a young age."

Children who weigh too much are at risk for other health problems. Some are physical problems, like diabetes, high blood pressure and high cholesterol, while other times they're psychological or social in nature.

Family practitioner Peter Mjos said he's watched more and more children develop chronic health conditions during his three decades of work.

"So much of it is simply related to the fact that we've become inactive and obese," said Mjos, who has long advocated more physical activity among Alaska students.

The study was made public at Monday's School Board meeting.

The new research was a joint project between the Anchorage School District, which collected heights and weights for 41,261 students, and the state Division of Public Health, which analyzed the information.

Erin Peterson, manager for the state's Obesity Prevention and Control Program, said school nurses from all schools in the district took height and weight measurements between the 1998-99 and 2002-03 school years. They also recorded other information, including age, sex, grade and race. Middaugh said the study provides a robust set of measurements on thousands of youths and a good look at weight problems among young children.

During the five-year period, the study found 2 percent of students were underweight and 62 percent were at a normal weight, while 18 percent were at risk of weighing too much and another 18 percent were overweight.

The study deemed children overweight or in danger of getting there if their body weight measurements were higher than those of most of the other kids of similar age and gender.

The study found white students were less likely to be overweight or at risk for weighing too much than students of other races, which is consistent with national research. Middaugh, however, issued a caveat: Body types may vary for children of different races, and that variation could wrongly suggest those children are overweight.

"More work needs to be done on that," he said.

Health authorities call the growing girth of children and adults nationwide an epidemic. Studies show that 59 percent of U.S. adults are overweight or obese; results are similar in Alaska, where 62 percent of adults weigh too much.

An independent health agency, the Institute of Medicine, focuses on the problem in children. In a recent report, the institute says the prevalence of obesity nationwide has more than doubled for children 2 to 5 and 12 to 19 since the 1970s, and has more than tripled for 6- to 11-year-olds.

Annual obesity-related hospital costs for children have more than tripled during the past two decades, the institute reported.

Overweight kids are at more risk of becoming overweight adults, the district study said. Doctors say overweight kids also are more likely to have sleep problems and social problems.

Dr. Bruce Chandler, a pediatrician and Anchorage's city medical officer, said overweight teens sometimes struggle with friends. "They become more isolated and less involved in normal kids' activities," he said.

Kids are fatter today because they're less active and eat too much food, Mjos said at the School Board meeting. Federal health officials, he said, estimate that students spend 32 hours a week in front of televisions, computers, games and other electronic toys.

And while they're sitting there, they're snacking, he said.

"I have some kids who will drink a six-pack of soda after school while they're watching TV," Chandler said.

"And there's also a lot of kids who get absolutely no exercise."

The School District plans to improve how it monitors children's body weights, and Middaugh said he hopes other districts in the state will also take body size measurements to track childhood obesity.

After hearing the health department's presentation Monday, several School Board members discussed vending machines and the difficulty of adding more physical activity to a child's already-packed school day.

Board member John Steiner said it's ironic that the money raised from vending machines goes toward funding activities, many of which are healthy.

"But some of the funds to pay for them are coming from things that aren't necessarily healthy," said Steiner, who wants the board to keep talking about vending machines.

Carol Comeau, School District superintendent, said she intends to organize a work session so the board can continue its discussion of the new data.

OVERWEIGHT: For the study and Mayo Clinic advice for parents, see www.adn.com/links

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State of Alaska Epidemiology **Bulletin** *Recommendations and Reports*

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Prevalence of Overweight Among Anchorage Children: A Study of Anchorage School District Data: 1998-2003

Anchorage School District

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November 10, 2004

Abstract

The Anchorage School District and the Alaska Division of Public Health collaborated to assess the prevalence of overweight among children in the Anchorage School District. We analyzed routinely collected height and weight measurements for students in grades K-12. Data collected by school nurses from 41,261 students spanning five school years were included in the analysis. A total of 78,303 individual height and weight values were used. We assessed and classified student weight status using BMI-for-age values and the categories defined by the National Center for Health Statistics. Over the five-year time period, 2% of students were underweight, 62% were at a normal weight, 18% were at-risk for becoming overweight, and 18% were overweight. Of students entering kindergarten or first grade, 32% were overweight or at-risk for becoming overweight. Students of a racial or ethnic background other than White were more likely to be overweight or at-risk for becoming overweight than White students. Schools can play a role in helping to address childhood overweight. However, educators cannot solve this problem alone. Parents and community partners must take an active role in preventing and addressing childhood obesity.

Introduction

In the United States, the increase in overweight and obesity has been so substantial and dramatic that it is commonly described as epidemic.[1] The epidemic has spread through all 50 states, within all racial and ethnic subgroups, and among all socioeconomic and age groups. According to the Institute of Medicine, "...we have learned that excess weight has significant and troublesome health consequences", yet "we nevertheless see our population, in general, and our children, in particular, gaining weight to a dangerous degree and at an alarming rate."[2]

The spread of the obesity epidemic among children is especially worrisome, as it threatens to negate many of the gains in children's health that have been made in the past century. Among children, excess weight is associated with numerous health problems. High blood pressure, high cholesterol, orthopedic disorders, type II diabetes, and psychosocial disorders are more common among overweight youth than among those with a healthy body weight.[3] In addition, children and adolescents who are overweight have an increased risk of being overweight or obese as adults. Overweight and obese adults, in turn, have a higher risk of premature death than adults with normal weights. Obesity and overweight among adults are also associated with an increased risk of coronary heart disease, type II diabetes, musculoskeletal disorders, sleep apnea, asthma, and psychological disorders, as well as cancer of the endometrium, colon, kidney, gallbladder, and breast (postmenopausal).[4]

To assess the scope of the obesity epidemic among children and adolescents in Anchorage, the Anchorage School District and the Alaska Division of Public Health collaborated to analyze existing data on the height and weight of students enrolled in the Anchorage School District. Working together, we can begin to explore steps that our community can take to respond to this growing problem that threatens the health and well being of our children.

Background

Over the past several decades, overweight and obesity have become increasingly prevalent among adults and children in the United States. Self-reported national survey data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that in the United States the percentage of adults who are obese, defined as having a body mass index (BMI) of 30 or higher, rose from 13% in 1991 to 22% in 2002. The dramatic increase in obesity has been observed in all states. In 1991 nearly every state in the nation reported that less than 15% of their adult population was obese, while no state reported obesity rates higher than 20%. By 2002, however, a majority of states reported that 20% or more of the population could be classified as obese, with no states reporting obesity rates below 15%.[5] (Figure 1)

In addition to the increasing percentage of adults classified as obese, 37% of adults in the United States

were classified as overweight in 2002, having BMI values between 25-29.9. When the percentages of obese and overweight individuals were combined, they totaled 59%, nearly two-thirds of the U.S. population.[6]

Trends in obesity and overweight among Alaskan adults parallel those found nationally. Since 1991, the percentage of Alaskan adults who are overweight or obese has increased steadily. Three-year moving averages show that 39% of Alaskan adults are classified as overweight, and an additional 23% are considered obese. When combined, these numbers indicate that 62% of Alaskan adults are above a normal weight (Figure 2).

The spread of the obesity epidemic has been equally, if not more, severe among children and adolescents. According to the Institute of Medicine, during the past three decades the rate of childhood obesity in the United States has more than doubled for children and adolescents in the 2-5 and 12-19 age groups, and has more than tripled among children aged 6-11.[7]

In Alaska, data from the 2003 Youth Risk Behavior Survey (YRBS) indicated that 14% of Alaskan high school boys and 8% of Alaskan high school girls were overweight, with BMI values at or above the 95th percentile for their age. An additional 15% of Alaskan high school boys and 14% of Alaskan high school girls were at-risk for becoming overweight, with BMI-for-age values between the 85th and 95th percentiles. When these numbers are combined nearly one-third of high school males and more than one-fifth of high school females were above a normal weight (Figure 3).

Although the BRFSS provides height and weight data for Alaskan adults and the YRBS provides data for high school students, less is known about the prevalence of overweight among younger children. The Anchorage School District has collected student height and weight measurements for many years. Analyzing these existing height and weight data provides an indication of the extent of childhood overweight among students in the district.

Methods

Overweight and obesity are defined using BMI, an index that is calculated using height and weight measurements and is significantly correlated with levels of body fat.[8] The BMI does have limitations; a true measure of body fat can only be obtained through a detailed laboratory assessment of body composition. In public health settings, however, BMI is widely accepted and utilized as an indicator of body weight and adiposity.[9] Adults with BMI values of less than 18.5 are classified as underweight, while BMI values of 18.5 to 24.9 indicate a normal weight. Adults with BMI values from 25.0 to 29.9 are classified as overweight, while those with BMI values above 30 are considered obese.[10]

Among children and adolescents, different language is used to describe body weight and adiposity. BMI is the recommended indicator of weight status and body fat among children and adolescents.[11] However, because BMI varies by height and height changes with age, a consistent numeric cut-off point cannot be used across age groups. As a result, BMI-for-age percentiles are used to identify children and adolescents at risk for weight-related health problems.[12] Children and adolescents aged 2-18 with BMI-for-age percentiles at or above the 95th percentile for their age are classified as overweight. Children and adolescents with BMI values between the 85th and 95th percentiles for their age are considered at-risk for overweight. The Centers for Disease Control and Prevention (CDC) recommends that the term overweight, rather than obese, be used to describe child and adolescent weight status.[13]

The Anchorage School District is the largest district in the state, enrolling approximately 40% of the state's student population. School nursing staff routinely record height and weight measurements during school health screenings, the majority of which are conducted in kindergarten and 1st, 3rd, 5th, and 7th grade. Health information, including height and weight measurements, is recorded in student files and is entered into an electronic database.

Height and weight measurements for students in grades K-12 were extracted from the database and imported into SPSS. All personal identifiers were removed, and students were assigned an identification number. BMI values were computed for all students and BMI-for-age percentile values were calculated based on the reference percentiles provided by the Center for Health Statistics of the Centers for Disease Control and Prevention (Tables 1 and 2; complete growth charts available at http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/charts.htm). Height, weight, and BMI percentile values for five school years (1998-1999 to 2002-2003) were analyzed, along with demographic information on the age, sex, grade, and race/ethnicity of the students. Height and weight values were screened for accuracy, and values that were not biologically plausible were removed. A total of 82,839 values were reported, representing 41,261 students. Of the total 82,839 values reported, 78,303 (94%) were biologically plausible and were included in the final analysis (Table 3). The height and weight values represented 29% of total student enrollment over the five-year time period, with higher percentages for students in kindergarten and grades 1, 3, 5, and 7 (Table 4).

Results

During the 1998-1999 to 2002-2003 school years, 2% of all Anchorage School District male and female students were underweight, 62% were at a normal weight, 18% were at-risk for becoming overweight, and 18% were overweight (Figure 4).

The prevalence of overweight and risk for overweight was similar among male and female students (Figure 5).

Students of a Non-White racial or ethnic background were slightly more likely to be overweight or at-risk for becoming overweight than White students (Figure 6). Slight gender variations in weight status among students of different racial and ethnic backgrounds were also evident. Among female students, White students were the least likely to be overweight or at-risk for becoming overweight, with higher rates of overweight and risk for overweight among Alaska Native and Black students (Figure 7). A slightly different pattern was observed among male students, where the lowest prevalence of overweight and risk for overweight was found among Black males and White males (Figure 8).

The percentage of students who were overweight or at-risk for becoming overweight was high among young children and persisted with age among both male and female students (Figure 9). A similar pattern was evident when overweight and at-risk for overweight were examined separately (Figure 10). Of children entering kindergarten and 1st grade from 1998-2002, 14% were overweight and 18% were at-risk for overweight (Figure 11).

The mean BMI percentile values for students in all grades exceeded the 60th percentile beginning in 1998 and may have increased slightly over time (Figure 12).

The mean BMI percentile values of grade cohorts can be used to assess changes in groups of children over time. Results are shown for two grade cohorts. The mean BMI percentile values of the 1998 kindergarten grade cohort increased slightly between 1998 and 2002. A similar pattern was observed for the 1998 5th grade cohort (Figure 13).

We also looked at changes in weight status in children over time. Among students who were at a normal weight in 1998-1999, 20% were either overweight or at risk for becoming overweight by 2002-2003 (Figure 14). Of the students who were overweight in 1998-1999, 20% decreased their weight by 2002-2003 (Figure 15). Students who were at risk for being overweight in 1998-1999 were more likely to have become overweight by 2002-2003 than to have attained a normal weight (Figure 16).

Conclusion

Over one-third of children in the Anchorage School District were overweight or at-risk for becoming overweight. White male and female students were less likely to be overweight or at-risk for overweight, a finding that is consistent with national results.[14] The percentage of students aged 3-5 years who were

overweight or at-risk for overweight was nearly as high as the corresponding percentage of older students, indicating that weight status is already a concern for many students when they first enter school. Some students changed from one weight category to another over time, although a majority had the same weight classification in 2002-2003 as they did in 1998-1999. Students who were at-risk for overweight in 1998-1999 were more likely to gain weight by 2002-2003 than to lose weight (Table 5).

There are limitations that must be considered when interpreting these data. Height and weight measurements were not collected through a statistically valid sampling procedure but were obtained as part of the routine school health screening process. The available measurements for the 5-year time period, however, represented 29% of students enrolled in all grades. Because health examinations are conducted primarily in kindergarten, first, third, fifth, and seventh grade, height and weight measurements were available for a higher percentage of students in those grades. Measurements were available for over half of the students enrolled in kindergarten, first, third, fifth, and seventh grades for the five-year time frame, with recorded data for up to 90% of students in some grades during an individual year. Because efforts were made to screen all students in the district, it is unlikely that the high prevalence of overweight and risk of overweight is due to a selection bias that resulted in the disproportionate selection of students from groups at high risk for being overweight or at-risk for overweight.

Variations in height and weight measurement may have occurred. The school district has a written protocol for height and weight measurement, and it is made available to school health staff. However, the district did not have the staff or financial resources to guarantee that the measurement procedures were followed at each school. Currently, schools use different types of measurement equipment, and multiple staff members are involved in the measurement process. While the variations in procedure and equipment could result in measurement error, it is unlikely that they could be responsible for systematic over-estimation of weight status.

In spite of the study limitations, the results of this analysis indicate that there is reason to be concerned about the weight status of children in the Anchorage School District and to develop strategies to address this problem. Because a majority of students remained in the same weight category over time, efforts should be made to prevent students from becoming overweight or at-risk for overweight.

To address the high prevalence of overweight and risk for overweight among students, the Anchorage School District is enhancing its capacity for height and weight surveillance. Standardized equipment will be installed in each school, and school nurses will be trained in its use. Training will emphasize the importance of obtaining and recording valid, reliable height and weight measurements. Data analysis will be continued so that trends can be monitored over time.

Schools can also play an important role in supporting physical activity and healthy nutrition among students. As the Institute of Medicine notes, "Both inside and outside of the classroom, schools present opportunities for students to learn about healthful eating habits and regular physical activity; engage in physical education; and make food and physical activity choices during school meal times and through school-related activities."[15]

The fact that a high percentage of students are overweight or at-risk for overweight when they enter school, however, indicates that prevention efforts cannot wait until children enter the school system. Rather, they need to involve the families, health care providers, and community members that interact with children at a young age. The individuals and groups who are involved in efforts to prevent childhood overweight will also play an important role in implementing strategies to treat students who are already overweight or at risk. The observed racial and ethnic disparities in prevalence should be considered when designing interventions, and strategies should be culturally appropriate.

Prevention and treatment strategies will need to target a variety of audiences and should complement efforts

to address obesity and overweight among adults. Overweight and obesity are already taking a substantial toll on the health and economy of Alaska. Based on current national estimates, obesity kills nearly 500 Alaskans each year.[16] In addition, direct medical expenditures for obesity alone are estimated to total $195 million each year in Alaska.[17] It is imperative that action be taken now to keep these costs from growing.

Table 1. Classification of Adult and Youth Weight Status

Adults (BMI Values)	Youth (BMI-for-age percentiles)
• Underweight <18.5	• Underweight ≤ 5th percentile
• Normal Weight 18.5-24.9	• Normal Weight 5th-85th percentile
• Overweight 25.0-29.9	• At-risk for Overweight 85th-95th percentile
• Obese ≥ 30	• Overweight ≥ 95th percentile

Table 2. Body Mass Index Reference Data

	Males		Females	
Age*	85th	95th	85th	95th
3	17.10	17.98	16.95	18.09
4	16.85	17.83	16.76	18.08
5	16.89	18.12	16.9.	18.49
6	17.17	18.73	17.32	19.20
7	17.64	19.55	17.93	20.13
8	18.25	20.53	18.67	21.20
9	18.97	21.57	19.51	22.35
10	19.76	22.64	20.39	23.52
11	20.57	23.69	21.27	24.66
12	21.4	24.67	22.13	25.74
13	22.23	25.59	22.94	26.75
14	23.03	26.42	23.68	27.66
15	23.8	27.18	24.34	28.49
16	24.55	27.88	24.92	29.25
17	25.27	28.57	25.43	29.95
>18	25.98	29.3	25.87	30.64

Source: Kuczmarski RJ, Ogden CL, Gummer-Strawn LM, et al. CDC Growth Charts: United States. Advance data from Vital and Health Statistics; no. 314, Hyattsville, Maryland: National Center for Health Statistics. 2000.

*Percentiles evaluated at mid-point for age.

Table 3. Initial and Final Sample Composition: Anchorage School District Students 1998-2003

Academic Year	Missing Component	<3 or >19 years old	Biologically Implausible	Age/Grade Inconsistency	Height Reversal	Full and Acceptable Values	Total
1987-1988/ 1995-1996	0	0	25	21	1	133	178
1996-1997	1	0	9	4	0	275	289
1997-1998	7	1	26	12	3	1111	1160
1998-1999	59	4	92	52	85	7725	8017
1999-2000	59	35	200	91	196	13437	14018
2000-2001	60	218	245	311	111	14315	15260
2001-2002	68	297	322	310	227	17451	18675
2002-2003	62	385	386	244	208	20708	21993
2003-2004	6	15	44	31	3	3148	3247
2029	0	0	0	1	0	0	1
2033	0	0	0	1	0	0	1
Total	322	955	1349	1076	834	78303	82839
Study %	0.4%	1.2%	1.6%	1.3%	1.1%	94.4%	94.1%

Table 4. Proportion of Students Sampled by Grade: Anchorage School District Students 1998-2003

	PE	KG	1	2	3	4	5	6	7	8	9	10	11	12	Total
1998/ 1999	5%	13%	40%	2%	50%	2%	42%	2%	32%	1%	0%	0%	0%	0%	15%
1999/ 2000	35%	65%	49%	13%	64%	10%	61%	12%	44%	13%	1%	1%	0%	0%	26%
2000/ 2001	23%	72%	50%	10%	68%	10%	65%	9%	51%	8%	6%	5%	0%	0%	28%
2001/ 2002	21%	80%	56%	13%	75%	11%	71%	12%	62%	16%	5%	34%	1%	0%	34%
2002/ 2003	46%	90%	57%	15%	83%	12%	81%	14%	72%	12%	6%	54%	17%	0%	40%
Total	26%	64%	50%	11%	68%	9%	64%	10%	52%	10%	4%	19%	4%	0%	29%

Table 5. Anchorage School District Data Conclusions

- 32% of students were overweight or at-risk for becoming overweight when they enter kindergarten and/or first grade
- 36% of students were overweight or at-risk of overweight
- Percentage of students who were overweight or at-risk for overweight appears to have increased slightly over time
- Over time, students who were at-risk for overweight were more likely to become overweight than to attain a normal weight

Figure 1. Obesity Trends Among US Adults

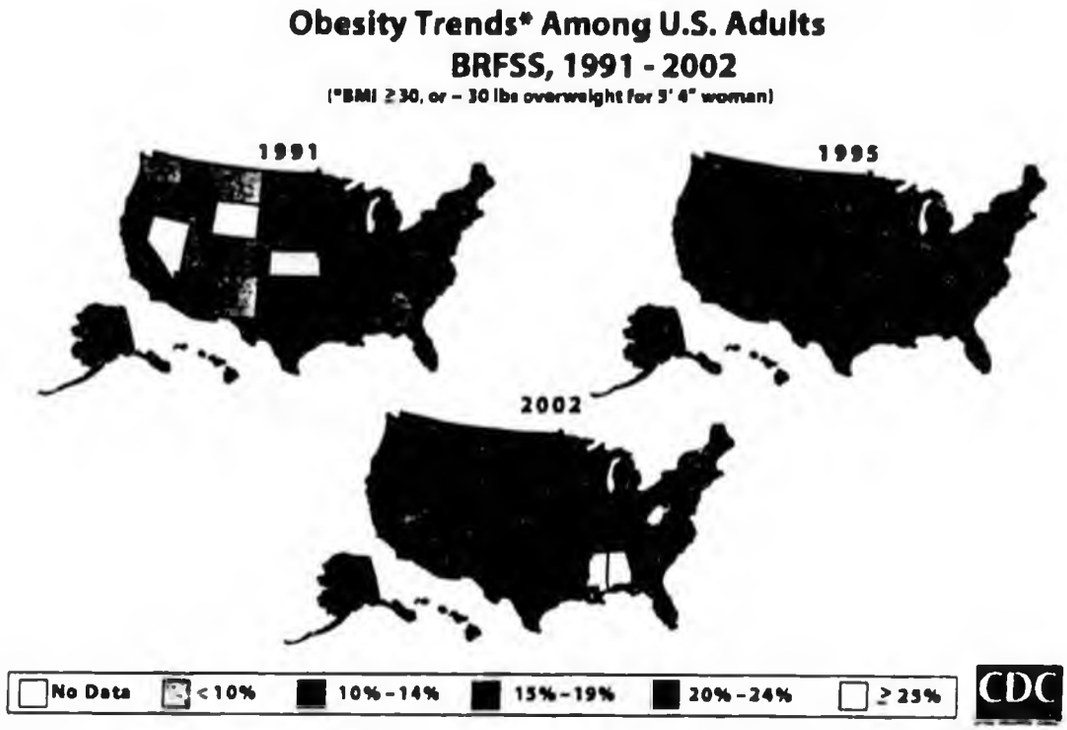


Figure 2. Trend in Percentage of Adults Who Are Overweight (BMI 25-29.9), Obese (BMI 30+) Alaska BRFSS, 1991-2003 (3-Year Moving Averages)

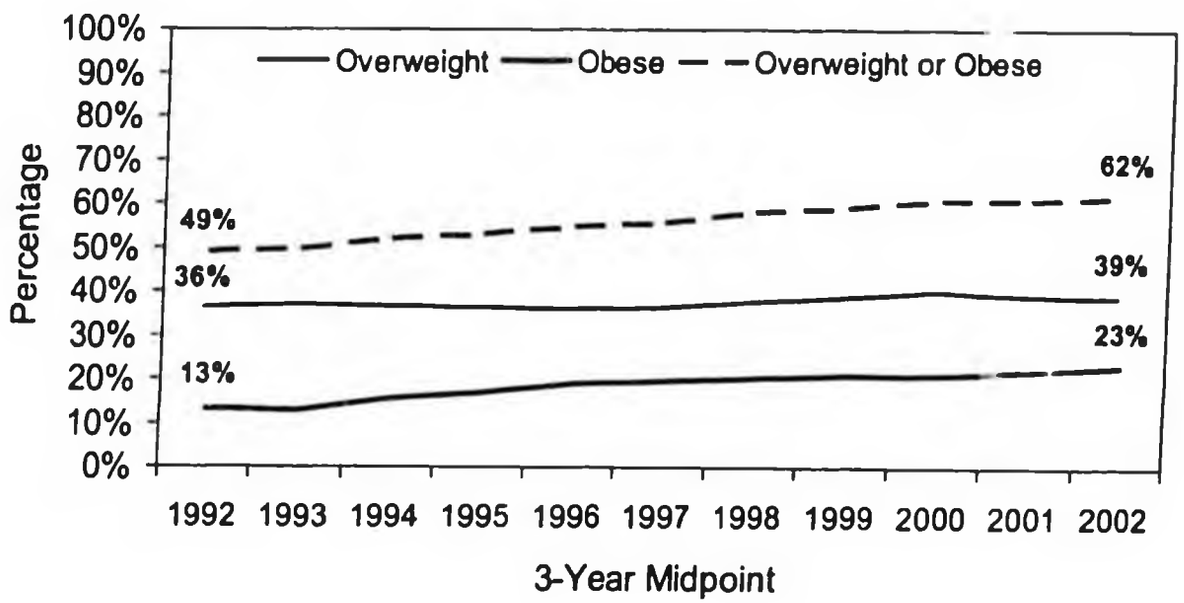


Figure 3. Alaskan High School Students Who Are Overweight or At-Risk for Becoming Overweight YRBS 2003

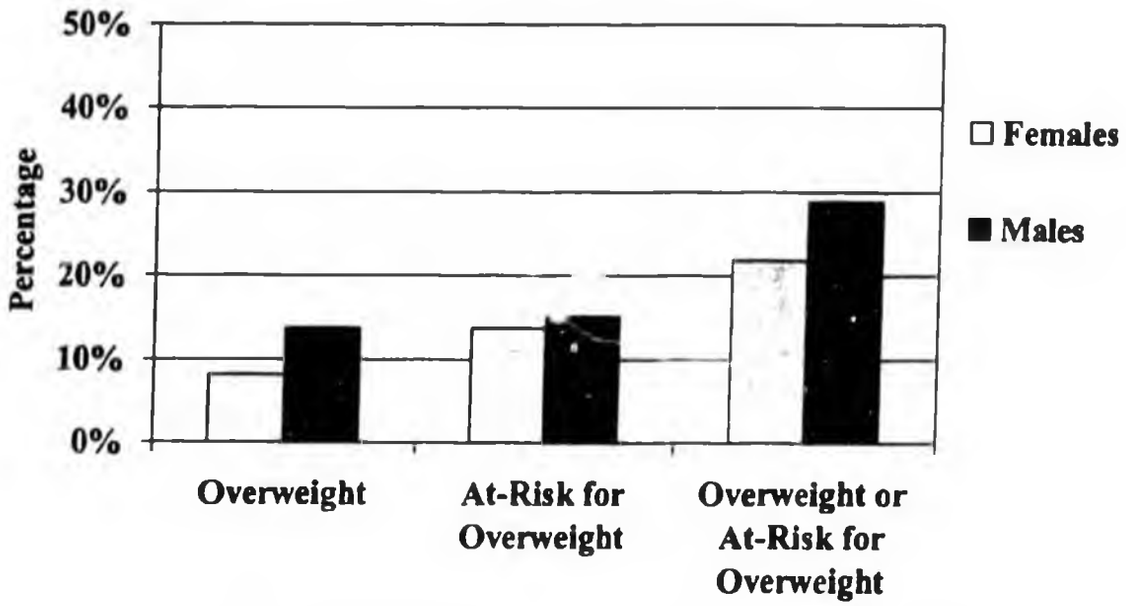


Figure 4. BMI Status for Anchorage School District Students, 1998-1999 – 2002-2003

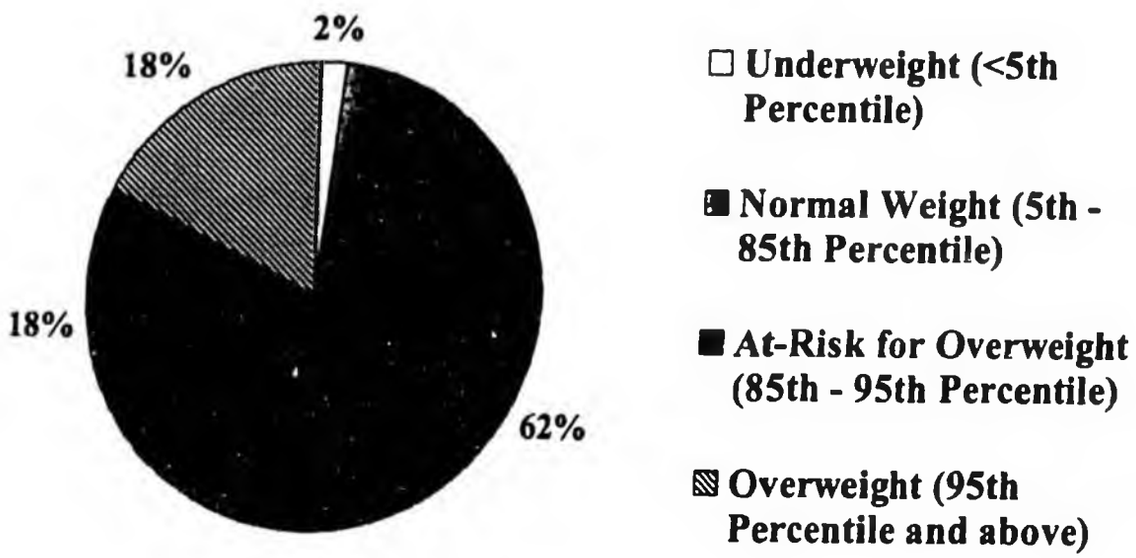


Figure 5. BMI Status for Female and Male Students, Anchorage School District 1998-2003

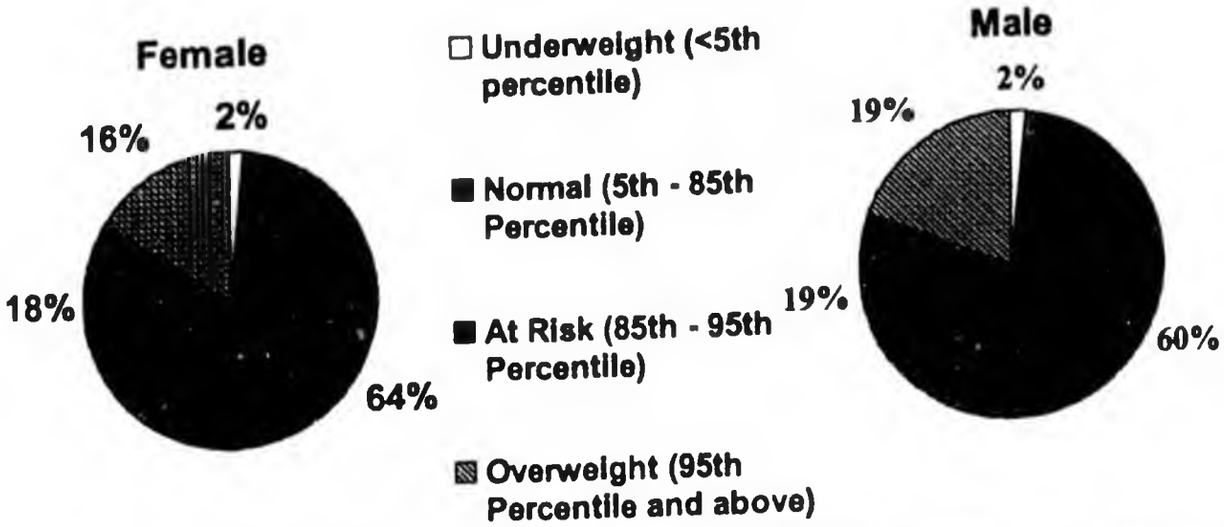


Figure 6. Percentage of Students Overweight/At-Risk of Overweight,
By Race/Ethnicity and Sex
Anchorage School District Students, 1998-2003

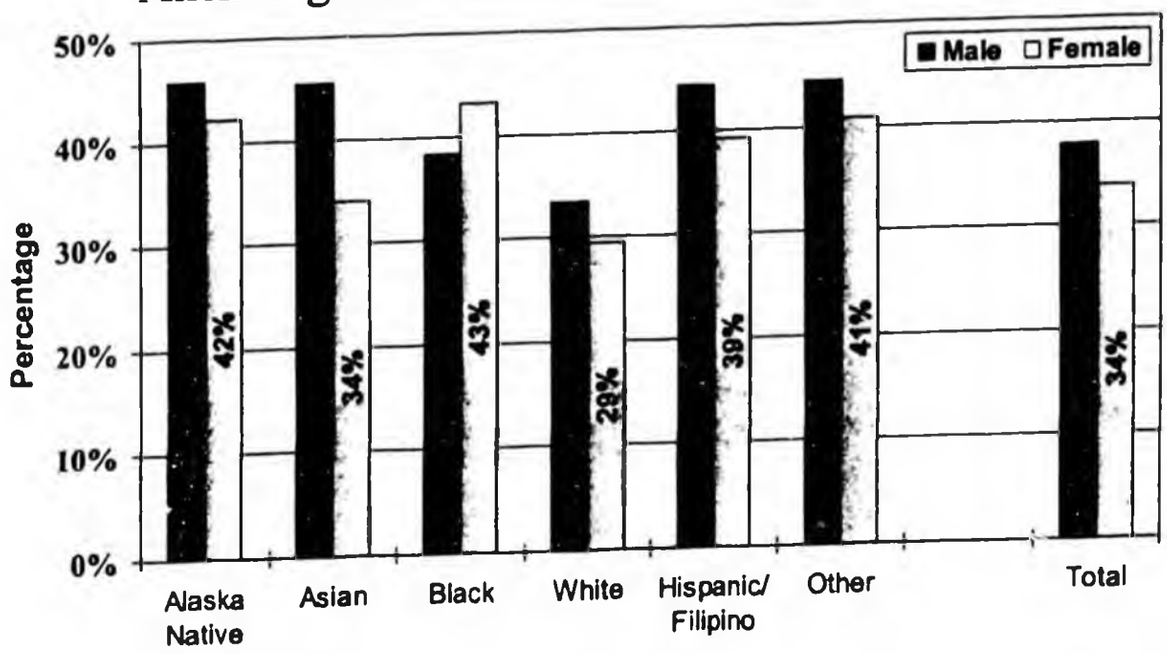


Figure 7. Anchorage School District Female Students At-Risk for Overweight and Overweight: 1998-2003

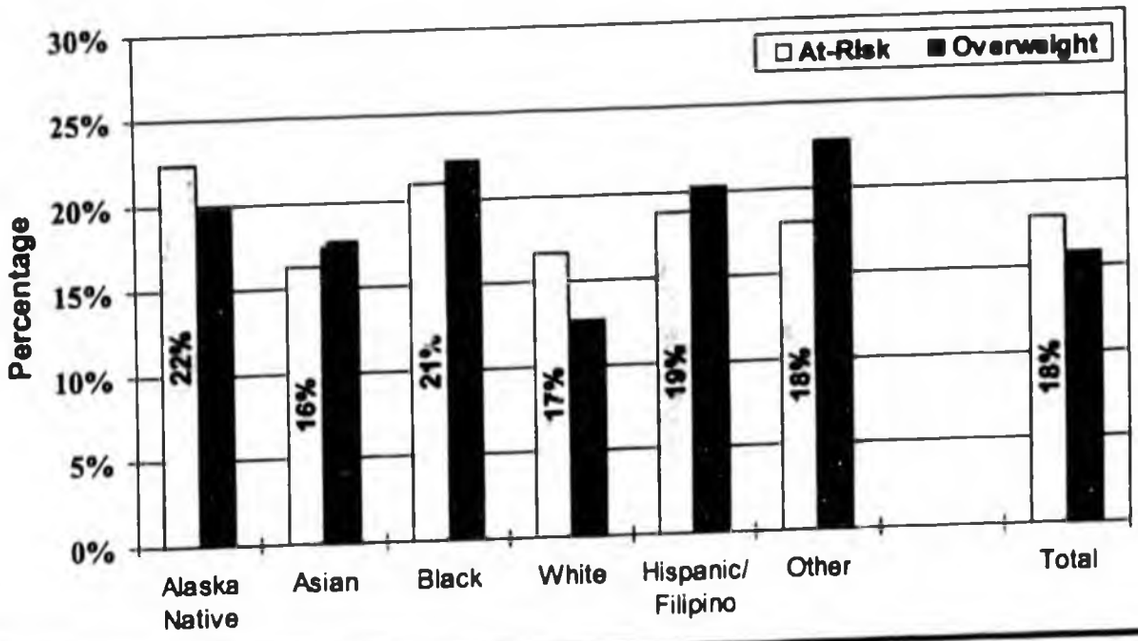


Figure 8. Anchorage School District Male Students At-Risk for Overweight and Overweight: 1998-2003

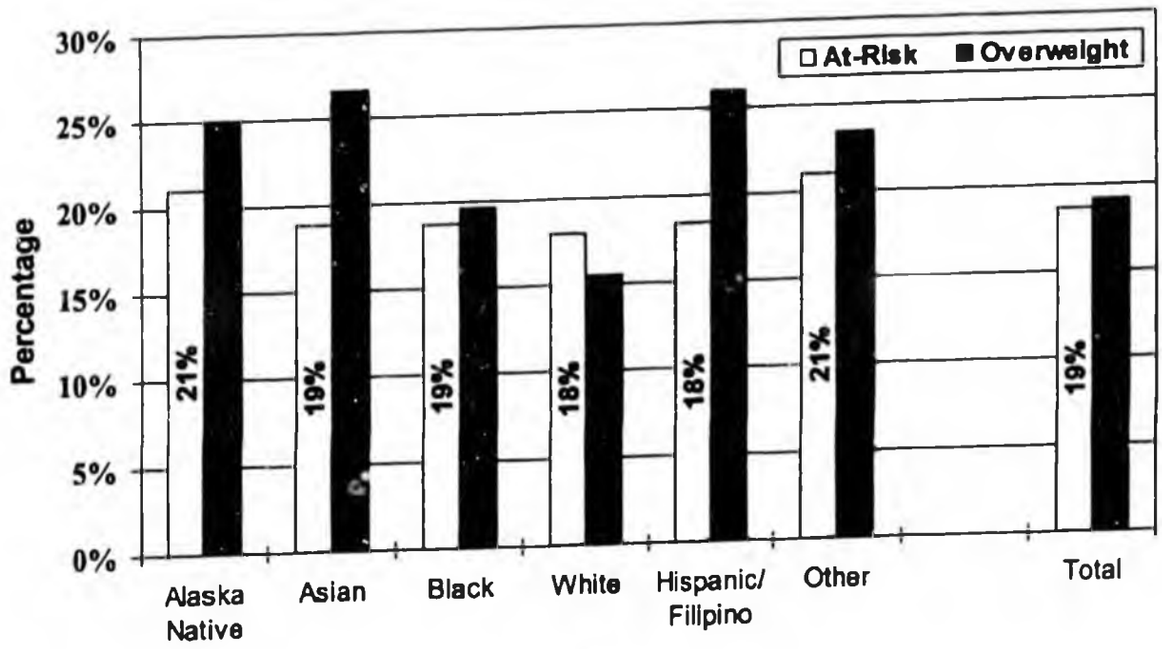


Figure 9. Percentage of Students Overweight/At-Risk of Overweight,
By Age and Sex
Anchorage School District Students, 1998-2003

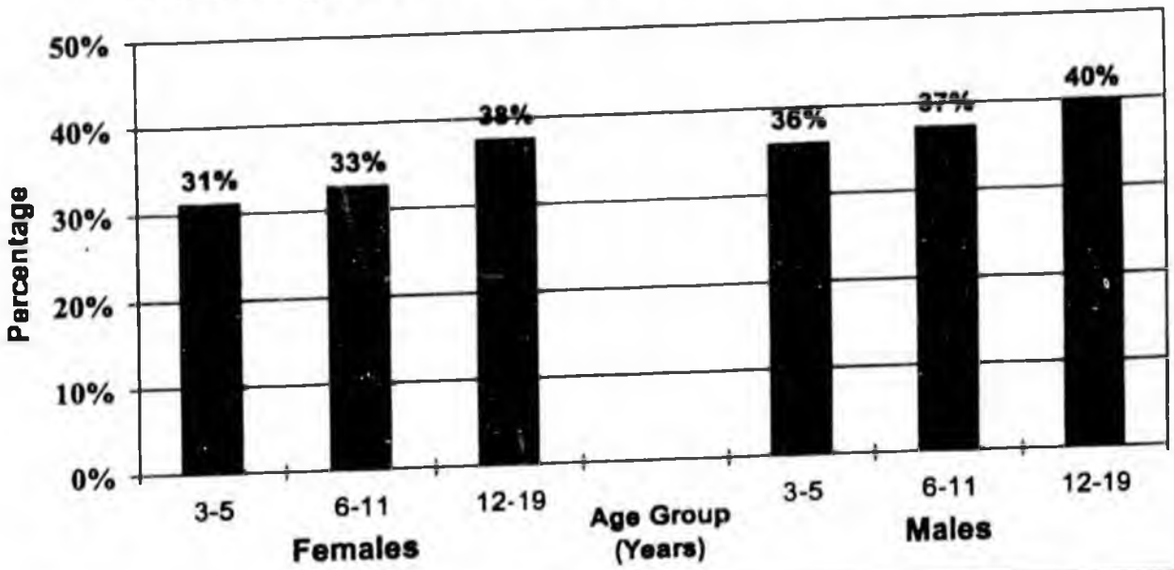


Figure 10. BMI Status By Age and Sex
Anchorage School District Students, 1998-2003

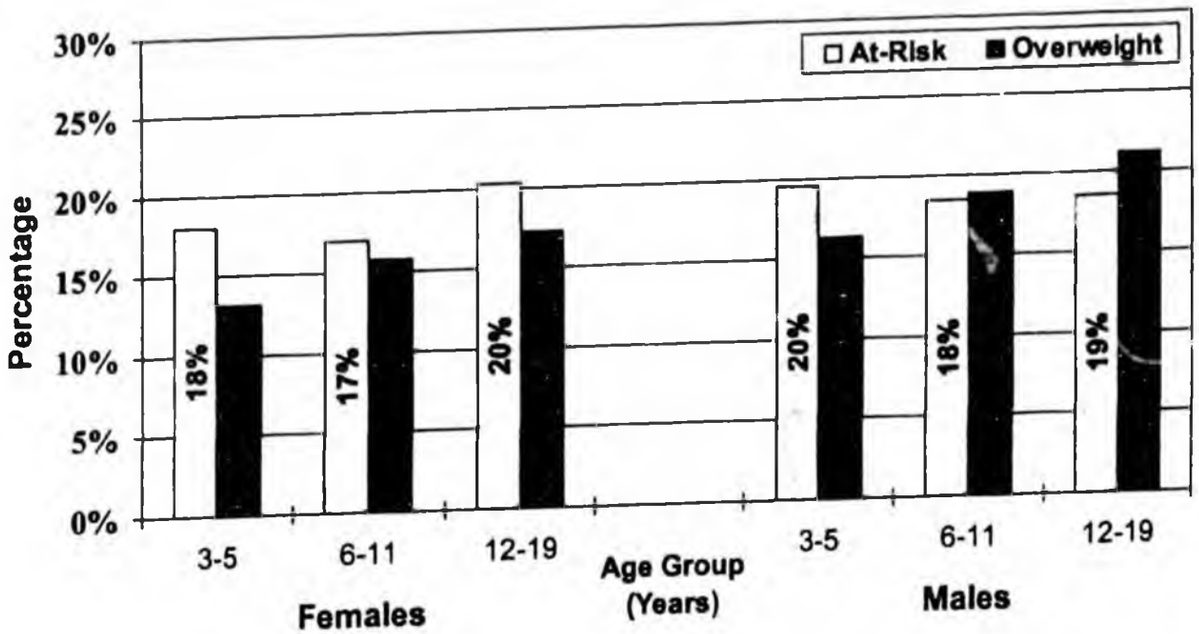


Figure 11. BMI Status of Kindergarten and First Grade Students: Anchorage School District 1998-2003

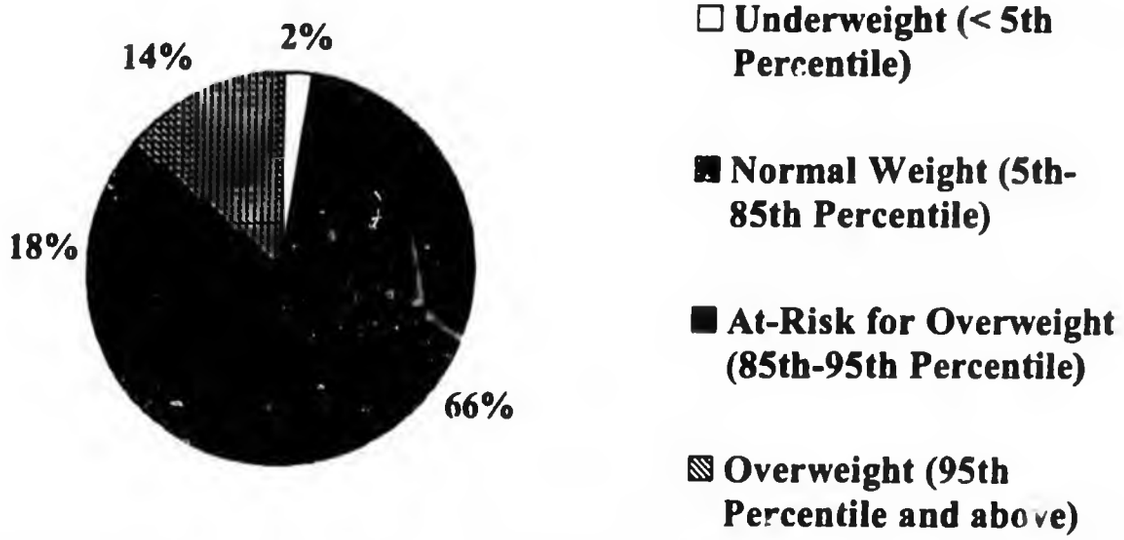


Figure 12. Mean BMI Percentile by Grade 1998/1999 – 2002/2003

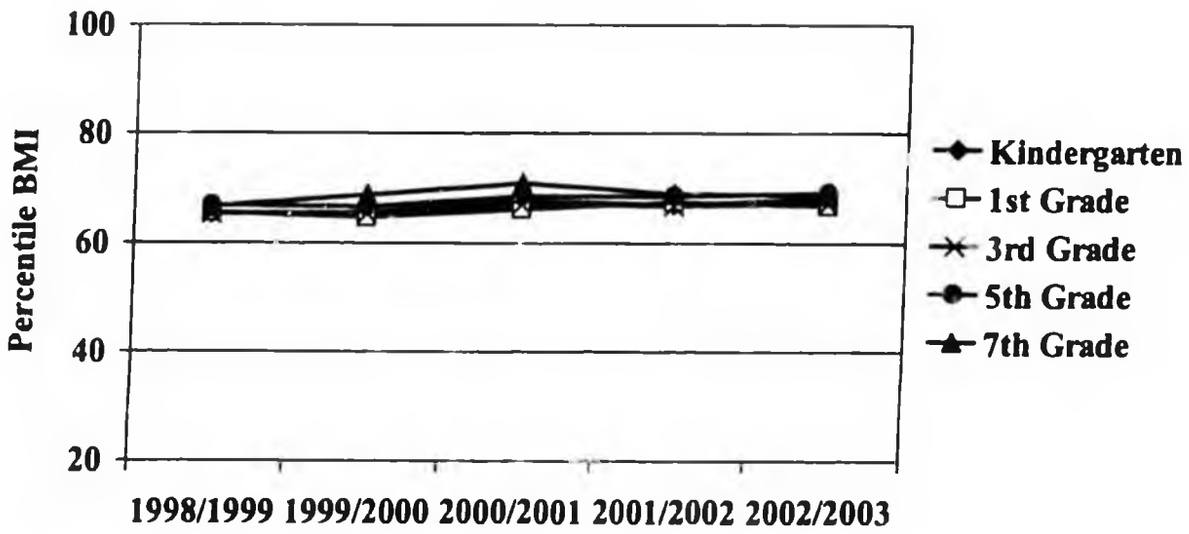


Figure 13. Mean BMI Percentile for 2 Grade Cohorts 1998-2003

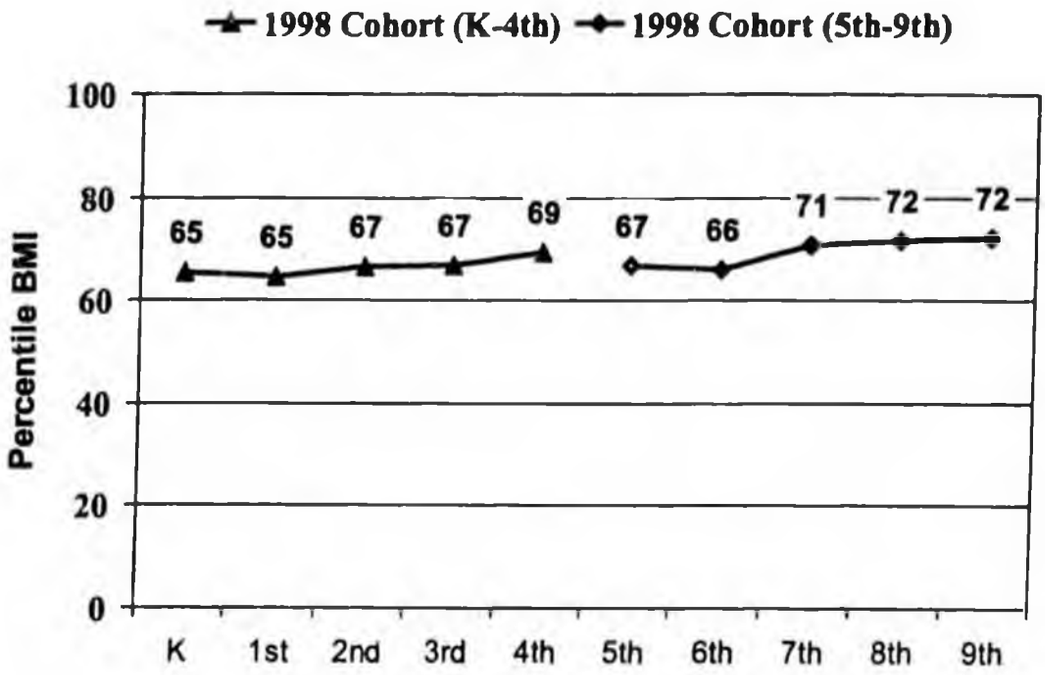


Figure 14. Change in Weight Status Among Normal Weight Students 1998-1999 – 2002-2003, Male and Female Students of All Ages

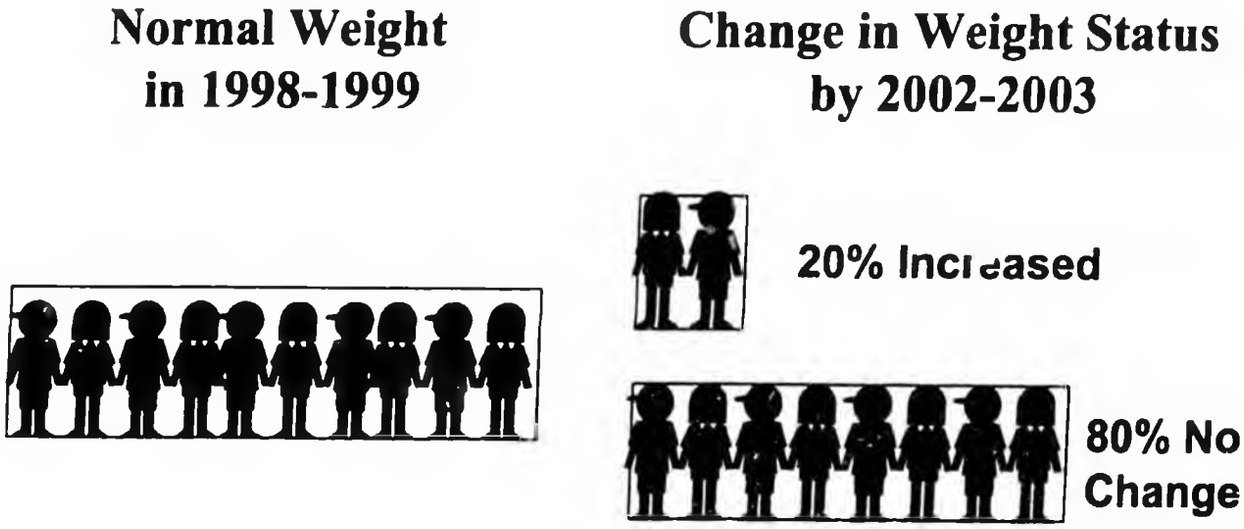


Figure 15. Change in Weight Status Among Overweight Students 1998-1999 – 2002-2003, Male and Female Students of All Ages

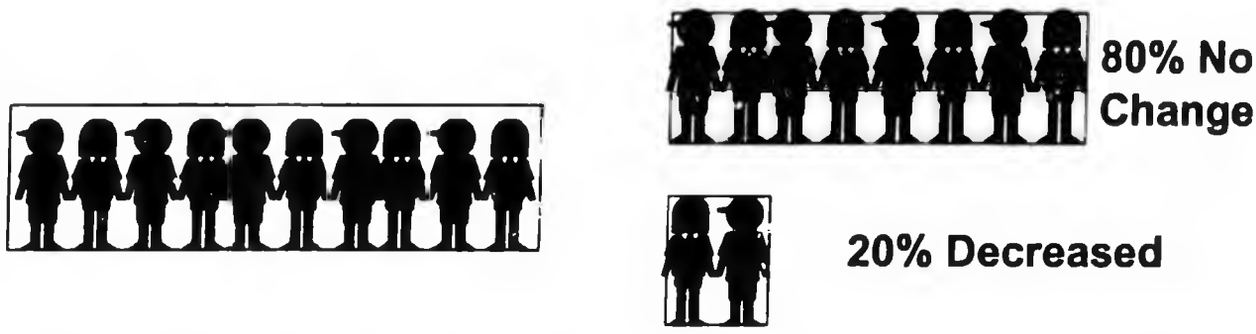
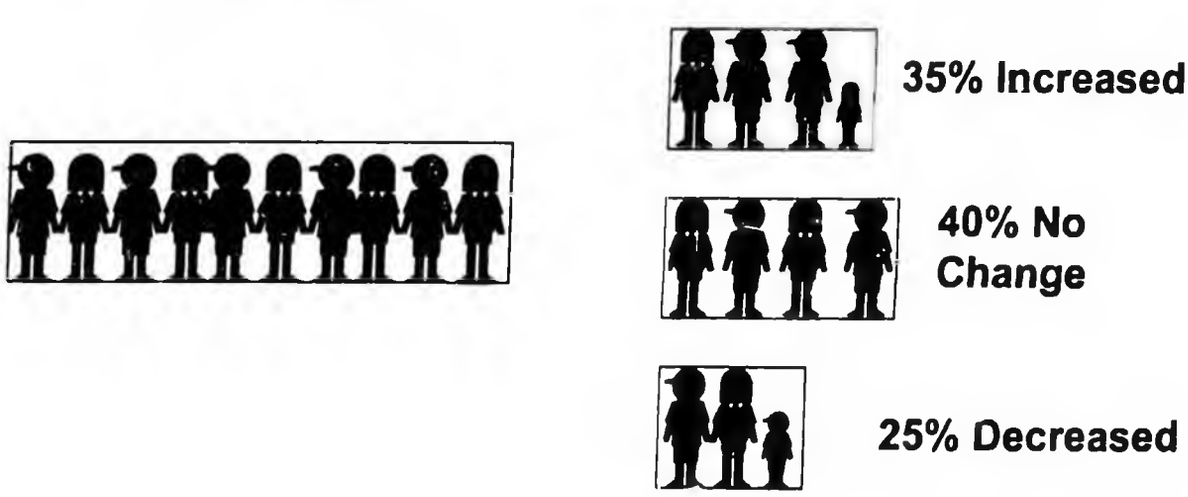


Figure 16. Change in Weight Status Among Students At-Risk for Overweight, 1998-1999 – 2002-2003, Male and Female Students of All Ages



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Physical education is "on the move" in many states

Many Americans believe our nation is sufficiently focused on fitness. But, behind the vivid images of robust runners, Olympic *Dream Teams*, and rugged mountain bikers is the troubling reality of a generation of young people that is, in large measure, inactive, physically unfit, and increasingly overweight.

The number of overweight and obese children in America has doubled in the last 20 years, to 1 in 3 children. Daily participation in physical education classes by high school students dropped from 42% in 1991 to 25% in 1995. Physical inactivity has contributed to an unprecedented epidemic of childhood obesity . These facts lead to an alarming conclusion – we are raising perhaps the most unhealthy and least active generation of Americans ever.

Legislators in statehouses across the country are hard at work addressing the problem by increasing the number of physical education classes in schools. In Oklahoma, Senate Bill 250 requires schools to provide 30 minutes of physical activity daily for grades one through five and 50 minutes of physical activity daily for grades six through eight. State policymakers in Maine want to establish the "Commission to Study Public Health," in order to study the causes of obesity and methods to decrease the cost of health care and increase the public health. The Commission would study physical education programs in the state and report back to the Legislature with policy recommendations.

The American Heart Association applauds the legislators for bringing proactive efforts to their states. For information on how to get involved in community efforts to increase physical education in our schools, please contact your local American Heart Association office. Click here for a state-by-state listing.

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NEW STUDY PROVES PHYSICALLY FIT KIDS PERFORM BETTER ACADEMICALLY

RESTON, VA, December 10, 2002 – Physically fit children do perform better academically! The National Association for Sport and Physical Education (NASPE) commends the California Department of Education (CDE) for its study released today that shows a distinct relationship between academic achievement and physical fitness of California's public school students.

"It makes great common sense to physical educators that active, physically fit children will perform better academically," said NASPE Executive Director Judith C. Young, Ph.D. "Now the California Department of Education has provided specific evidence. NASPE urges further research to examine relationships between physical activity and academic performance. In addition, information is needed which compares the students' physical education programs to their various levels of fitness."

The newly completed research study individually matched scores from the spring 2001 administration of the Stanford Achievement Test, Ninth Edition (SAT-9), given as part of California's Standardized Testing and Reporting Program, with results of the state-mandated physical fitness test, known as the Fitnessgram, given in 2001 to students in grades five, seven, and nine. The Fitnessgram, developed by the Cooper Institute for Aerobics Research, assesses six major health-related areas of physical fitness including aerobic capacity (cardiovascular

endurance), body composition (percentage of body fat), abdominal strength and endurance, trunk strength and flexibility, upper body strength and endurance, and overall flexibility. A score of 6 indicates that a student is in the healthy fitness zone in all six performance areas, and meets standards to be considered physically fit.

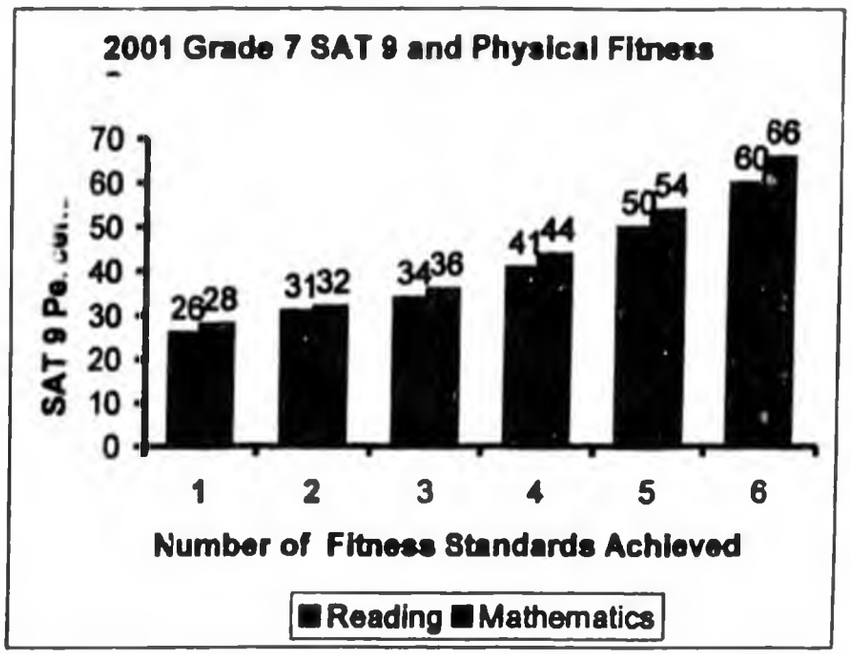
In the study, reading and mathematics scores were matched with fitness scores of 353,000 fifth graders, 322,000 seventh graders, and 279,000 ninth graders. The attached bar graphs for each grade level show a significant relationship between the two types of scores that were matched.

Key findings of the study are:

- Higher achievement was associated with higher levels of fitness at each of the three grade levels measured.
- The relationship between academic achievement and fitness was greater in mathematics than in reading, particularly at higher fitness levels.
- Students who met minimum fitness levels in three or more physical fitness areas showed the greatest gains in academic achievement at all three grade levels.
- Females demonstrated higher achievement than males, particularly at higher fitness levels.

According to State Superintendent of Public Instruction Delaine Eastin, "This statewide study provides compelling evidence that the physical well-being of students has a direct impact on their ability to achieve academically. We now have the proof we've been looking for: students achieve best when they are physically fit. Thousands of years ago, the Greeks understood the importance of improving spirit, mind, and body. The research presented here validates their philosophic approach with scientific validation."

Eastin pointed to physical education as a primary source for promoting physical fitness. "Every student in California should have quality physical education experiences from kindergarten through high school," Eastin said. "The goal of these programs should be to provide students with the knowledge, skills, and confidence to participate in health enhancing physical activity throughout their lives."



- The height of each bar shows the average (median) SAT-9 national percentile rank of those students with a particular fitness score.
- Higher academic achievement is associated with higher levels of fitness in grade 7.
- Students in grade 7 who meet minimum fitness levels in three or more physical fitness areas show the greatest gains in academic achievement.
- The relationship between academic achievement and fitness in grade 7 was greater in mathematics than in reading, particularly at high fitness levels.
- The test that was used, *Fitnessgram,* uses criterion-referenced standards to evaluate fitness. These standards represent a level of fitness that offers some degree of protection against diseases that result from sedentary living. Achievement of the fitness standards is based upon a test score falling in the Healthy Fitness Zone (HFZ). Each of the six tasks measures a different aspect of fitness, and the HFZ represent minimal levels of satisfactory achievement on the tasks.

The California Education Code mandates physical education for all students in grades one through nine, plus one additional year in high school. Students in grades one through six are required to have 200 minutes of physical education every 10 school days, and students in grades seven through twelve are required to have 400 minutes every 10 school days. Specific recommendations for teachers, students, and their families are available on the CDE Web site at: http://www.cde.ca.gov/cyfsbranch/lsp/health/pecommunications.htm.

Families are encouraged to plan activities that include opportunities for all family members to be physically active together. Health-related fitness assessment results can be used as a tool to help students understand, enjoy, improve, and maintain their physical health and well-being.

Information about the National Association for Sport and Physical Education (NASPE) can be found on the Internet at *www.aahperd.org*, the web site of the American Alliance for Health, Physical Education, Recreation & Dance (AAHPERD). NASPE is the largest of AAHPERD's six national associations. A nonprofit membership organization of over 18,000 professionals in the fitness and physical activity fields, NASPE is the only national association dedicated to strengthening basic knowledge about sport and physical education among professionals and the general public. Putting that knowledge into action in schools and communities across the nation is critical to improved academic performance, social reform and the health of individuals.

Pete Mjos

From: Stevens, Russ <Russ_Stevens@health.state.ak.us>
To: 'Pete Mjos' <torsk@alaska.net>
Sent: Monday, September 16, 2002 3:16 PM
Subject: Lower Direct Medical Costs Associated with Physical Activity.htm

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National Center for Chronic Disease Prevention and Health Promotion

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Lower Direct Medical Costs Associated with Physical Activity

The benefits of moderate physical activity are well known: lowered risk for heart attack and stroke, reducing weight, and improving mood. Researchers at the Centers for Disease Control and Prevention (CDC) recently documented another major advantage - improving the health of the Nation's health care expenditures. A study in the October issue of *The Physician and Sportsmedicine* found that physically active individuals had lower annual direct medical costs than did inactive people. The cost difference was $330 per person, based on 1987 dollars.

The potential savings if all inactive American adults became physically active could be $29.2 billion in 1987 dollars, or $76.6 billion in 2000 dollars.

This is the first study ever to examine direct medical costs associated with various levels of physical activity by reviewing actual medical expenditures. Previous studies in the field have used estimates to project the economic costs of physical inactivity. The CDC researchers analyzed the relationship between physical activity and medical expenditures from the 1987 National Medical Expenditures Survey (NMES), the most comprehensive healthcare information source available. They found that Americans 15 years and older who engaged in regular physical activity-at least 30 minutes of moderate or strenuous physical activity three or more times a week-had average annual direct medical costs of $1,019 versus costs of $1,349 for those who were inactive. Persons with health conditions that limited regular moderate physical activity were excluded from the study.

"This study has significant implications," said Jeffrey Koplan, M.D., M.P.H, Director of CDC. "It suggests that we can make a major impact on reducing health care costs by encouraging regular physical activity. The amount of physical activity

required to make a difference is reasonable and well within the reach of most Americans."

The level of physical activity measured in this study was even more modest than current Federal guidelines of 30 minutes or more of moderate physical activity five or more days a week, suggesting that following current recommendations could yield even greater cost savings.

The study found that physically active people had fewer hospital stays and physician visits and used less medication than physically inactive people. The cost savings were consistent for men and women, for those with and without physical limitations, and even for smokers and nonsmokers. The biggest difference in direct medical costs was among women 55 and older, supporting the widely held belief that the potential gain associated with physical activity is especially high for older women. The authors state that "a population-wide strategy might produce cost savings among most adult age groups."

"We must make it easier for people to be active," said Dr. Koplan. "We need to make a serious national effort to promote physical activity and support changes in the environment that get people moving again."

Changes that promote physical activity may be as simple as improving the location and appearance of stairwells to encourage walking at work or as complex as the redesign of communities. Some communities have existing infrastructure that supports physical activity, such as sidewalks and bicycle trails, and work-sites, schools, and shopping areas in close proximity to residential areas. In many other areas, such community amenities need to be developed to foster walking and cycling as a regular part of daily activity.

Contacts:
To obtain a copy of the article, please call the press contacts listed below.

- Tim Hensley at 770-488-5820
- CDC Media Relations at 404-639-3286

For more information about nutrition and physical activity,

- Call toll-free 1-888-CDC-4NRG
- Visit the CDC's nutrition and physical activity Web site at http://www.cdc.gov/nccdphp/dnpa/

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Save a heart; become a lady in red

COMPASS: Points of view from the community

By NANCY MURKOWSKI By STEVE CLEARY

(Published: February 1, 2005)

In recognition of February, American Heart Month, I'm calling on all women to take charge of their health and fight heart disease before it's too late.

According to the American Heart Association, cardiovascular disease, including heart disease and stroke, is the most dangerous threat to a woman's health. No other killer takes more lives, disables more people and ruins more careers in our state. This year alone several hundred of Alaska's mothers, daughters, sisters and wives will die from cardiovascular disease. Hundreds more will live with the debilitating effects of heart disease and stroke. And yet the American Heart Association found that less than one-fifth of women consider cardiovascular disease their greatest health risk.

It's time for us women to start taking care of ourselves and to "go red" by making our own health a priority. What does it mean to "go red for women?"

It means you should wear red Friday, which is National Wear Red Day. You may be aware that heart disease is the No. 1 killer of women, but too many women are still surprised by this fact. Put on a red dress, hat or sweater and tell other women the startling truth about heart disease. Men too can show support for the women in their lives by wearing a red tie or a red shirt.

More importantly, "going red" means looking at your own risk for cardiovascular disease, such as high blood pressure, high cholesterol, lack of exercise and being overweight. Talk to your doctor about your risk factors and take personal control over them. Make a commitment to heart health the same way you're adamant about fighting off cancer. If you get a mammogram regularly, give the same importance to knowing your cholesterol and blood pressure numbers. Start knowing your numbers while you're young and your risk is low. Mothers, set healthy examples for your families and feel good about the fact that a healthier lifestyle puts everyone in your family on track to living healthier, longer lives.

Finally, we must encourage our legislators to stay committed to improving the health of all Alaskans. Tobacco and obesity are the two most preventable causes of cardiovascular disease for both men and women. The Alaska Legislature wisely supported the governor and increased our state cigarette tax during last year's special session. It must now follow through to ensure that a percentage of the new tax revenue goes to tobacco prevention, education and cessation programs to help Alaskans who want to quit and to prevent children from picking up the deadly habit.

Although we've made important strides in working to reduce tobacco use in Alaska, we unfortunately have a long way to go to reduce Alaska's growing obesity problem. Did you know that Alaska has one of the highest obesity rates west of the Rockies and that more than half of Alaska children are overweight or obese? Learning to lead an active lifestyle is best taught at an early age. I hope you will join with me in supporting the American Heart Association's goal that all schoolchildren, grades K-12, should participate in daily, quality physical education -- a goal that is far from a reality in most of our schools. Daily, quality physical education helps combat childhood obesity and sets positive patterns for life. And it's never too late to start keeping in shape. By next year, I hope you will see "less" of me.

We can all do a lot to help reduce the burden of cardiovascular disease in Alaska. So this February, make it a point to "go red" and stay healthy for life!

First lady Nancy Murkowski is honorary chairwoman of the 2005 Go Red for Women Luncheon on Wednesday in Anchorage. For more information on women's heart health, visit americanheart.org or call 1-888-MY-HEART.

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Pete Mjos

From: Bob Laurie <Bob_Laurie@dot.state.ak.us>
To: Take Heart Listserve <takeheart@list.state.ak.us>
Sent: Monday, December 16, 2002 9:27 AM
Subject: Study Supports Physical Activity

The following press release from the California Department of Education was passed on to me. Although it does not mention Safe Routes To School, it might easily be used to support starting such programs.

STATE STUDY SUGGESTS PHYSICALLY FIT KIDS PERFORM BETTER ACADEMICALLY

SACRAMENTO--State Superintendent of Public Instruction Delaine Eastin today announced that the results of a recent study conducted by the California Department of Education (CDE) show a distinct relationship between academic achievement and the physical fitness of California's public school students.

"This statewide study provides compelling evidence that the physical well-being of students has a direct impact on their ability to achieve academically," said Eastin. "We now have the proof we've been looking for: students achieve best when they are physically fit. Thousands of years ago, the Greeks understood the importance of improving spirit, mind, and body. The research presented here validates their philosophic approach with scientific validation."

The newly completed research study individually matched scores from the spring 2001 administration of the Stanford Achievement Test, Ninth Edition (SAT-9), given as part of California's Standardized Testing and Reporting Program, with results of the state-mandated physical fitness test, known as the Fitnessgram, given in 2001 to students in grades five, seven, and nine.

In the study, reading and mathematics scores were matched with fitness scores of 353,000 fifth graders, 322,000 seventh graders, and 279,000 ninth graders. The attached bar graphs for each grade level show a significant relationship between the two types of scores that were matched.

Key findings of the study are:

a.. Higher achievement was associated with higher levels of fitness at each of the three grade levels measured.
b.. The relationship between academic achievement and fitness was greater in mathematics than in reading, particularly at higher fitness levels.

c.. Students who met minimum fitness levels in three or more physical fitness areas showed the greatest gains in academic achievement at all three grade levels.
d.. Females demonstrated higher achievement than males, particularly at higher fitness levels.

Eastin pointed to physical education as a primary source for promoting physical fitness. "Every student in California should have quality physical education experiences from kindergarten through high school," Eastin said. "The goal of these programs should be to provide students with the knowledge, skills, and confidence to participate in health enhancing physical activity throughout their lives."

The California Education Code mandates physical education for all students in grades one through nine, plus one additional year in high school. Students in grades one through six are required to have 200 minutes of physical education every 10 school days, and students in grades seven through twelve are required to have 400 minutes every 10 school days. Specific recommendations for teachers, students, and their families are available on the CDE Web site at: http://www.cde.ca.gov/cyfsbranch/lsp/health/pecommunications.htm

Families are encouraged to plan activities that include opportunities for all family members to be physically active together. Health-related fitness assessment results can be used as a tool to help students understand, enjoy, improve, and maintain their physical health and well-being.

In 2001, more than one million students participated in statewide physical performance testing mandated by Assembly Bill 265 in 1995. The law requires that school districts annually administer a physical fitness test designated by the State Board of Education to all fifth, seventh, and ninth graders.

The Fitnessgram, developed by the Cooper Institute for Aerobics Research, assesses six major health-related areas of physical fitness including aerobic capacity (cardiovascular endurance), body composition (percentage of body fat), abdominal strength and endurance, trunk strength and flexibility, upper body strength and endurance, and overall flexibility. A score of 6 indicates that a student is in the healthy fitness zone in all six performance areas, and meets standards to be considered physically fit.

Fitnessgram results from the 2001 administration indicated that 23 percent of California's fifth, seventh, and ninth graders tested could be considered physically fit. Detailed 2001 physical fitness results for schools, districts, countries, and the state are available on the CDE Web site: http://www.cde.ca.gov/statetests/pe/pe.html

For more information, please contact Debbie Vigil at 916/319-0341 or dvigil@cde.ca.gov, or Dianne Wilson-Graham at 916/319-0280 or dwilsong@cde.ca.gov.

Attachment *CONVINCING GRAPHS, BUT NO ATTACHMENT HERE*
Attachment includes 3 tables: (1) 2001 grade 5 SAT 9 and Physical Fitness; (2) 2001 Grade 7 SAT 9 and Physical Fitness; and (3) Grade 9 SAT 9 and Physical Fitness Scores