Weight of the Nation:
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Improving Health Outcomes: Integrating Obesity Prevention in Health Reform
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What I am going to try to do is talk about the Nemours' experience and use that as to give us some lessons learned in terms of health reform and what health reform should look like. And before I do that first, let me start off with a little information about Nemours. We are an operating foundation that focuses on children's health, and about five years ago we decided we haven't been focusing exclusively on pediatric care, and we decided to expand our mission to focus on prevention and community-based prevention. And the place we started from is that chronic diseases are contributing to poor health outcomes and increasing costs and is one of the major reasons for health systems reform. And so we started thinking about child health promotion and integrating population health and medical care to really get at the root causes of some of these problems.

So, what we did and some lessens to learn from thinking about health reform is we really thought about expanding the vision, the need to go from the traditional medical model to an expanded approach; from a biomedical view of health to a multifaceted/multi-sector view of health; from acute illnesses to prevention; from the focus on individuals to the focus on populations; from cure as the uncompromised goal to prevention as the primary goal; and from a focus on disease to a focus on health. We really started to re-imagine the delivery system, and we came up with a delivery system that really focuses on health and healthcare, and the range of things that we believe should be a part of any kind of systematic reform and health delivery system which includes on the way community and environmental changes and system changes. And then you have primary care and prevention. And you still have the need for weight management and in-patient services, other specialty services. So, this is what we believe the continuum of care should look like with respect to health reform. We also have really focused on the various sectors where children spend their time. So, schools, childcare centers, primary care, community, and childcare. And we believe that there should be 360 degrees of child health promotion. So, at every point in a child's life, they are exposed to healthy living and health -- in this case, healthy eating and physical activity. And so we have this concept of health promotion around the clock.

And so the two other things I wanted to mention is that we really think about cross-sectoral work, going to where the kids are in schools or in bringing health to child care, bringing health to all the environments where children live, learn and play. And the other huge part of this is the need for collaboration. And it's really all about working in the community. It's all about listening to the community or community partners in trying to develop programs that will really address their needs. So, in terms of implications for health reform, a couple of things I wanted to say there. The first is that we really started by focusing on health and quality outcomes. And so in Delaware, we are looking at reducing the prevalence of an unhealthy weight from 37 percent to 35 percent. And that focus on population health really changed the way we did our programs. It really had us starting to focus on policy change and how to reach the most children with high impact strategies in the least amount of resources. And so we really started focusing on policy change. And one of the policy changes is the prevention trust -- wellness and trust fund. We really believe that there needs to be a sustainable financing source for prevention. And we very much support the different House and Senate bills that have that kind of funding source, because let's face it, right now

market forces are not supporting the need for prevention. So, without a specific investment in prevention, it won't happen. And so that's why we have been supporting the need for financing and funding mechanism.

The other thing I wanted to say is, you could have the best policy in the world; but if you don't have practical tools and you are not supporting the state and local communities in doing prevention, you are not going to accomplish your goals. And so one of the things that we do is not just policy change, but practice change, trying to develop tools that are turnkey for the partners that we work with in the various sectors I mentioned. And as an example of that, I am going to talk to what we've been doing in childcare. How do you proposes to turn your good intentions into positive impact? And that's what we have done in the childcare field. We started out with some pilots working with individual childcare centers and kind of perfecting our model. And then we realized that it was going to take too long and too many resources to go individually to center to center. And so we decided let's look at policy change. And so we actually worked with our wonderful folks in Delaware government to actually implement regulations that for child care licensing that have healthy eating and physical activity standards: Encouraging water, using low fat milk, watching very limited amounts of TV and only for education, having at least 20 minutes of physical activity for every three hours in a child care center. So, these are the policies that we put in place, and they actually reached 54,000 children as opposed to just a hundred children in a childcare center. And then we didn't stop there because you can have the best policy in the world; but if you don't have tools for the child care centers and directors to really make the changes, then the changes won't happen. And so we've been working in a collaborative mode using the I. H. Ives method of collaboration and really developing learning communities that will help move the policy and help implement the policy at the center level. So, those are some of the things that we are doing at Nemours and some of the things that we think that are important to health reform.

Harvinder Sareen, PhD
Director of Clinical Programs
WellPoint Healthcare

I am here to share some of WellPoint's strategies to address childhood obesity and some of the implications that came about through that. WellPoint's mission is invested in, or embedded rather, in public health. Our mission is to improve the lives of the people we serve as well as improve the health of our communities. I think it was about five years ago that it was clear to us that in order to accomplish our mission, we would have to do something about the epidemic at hand and that was the epidemic of childhood obesity. Another thing that happened around that time was our regulatory agencies were very interested in health outcomes related to childhood obesity. We took a closer look. We tried to find evidence-based solutions of childhood obesity. And as you can imagine, there weren't too many answers at that time. So, given perhaps a paucity of any evidence-based answers, we employed a number of strategies to implement childhood obesity initiative. But what I will do is share perhaps six strategies with you which I think are pertinent to this discussion.

The first strategy was focusing on Medicaid. As you-all know, most of the Medicaid families are characterized by not only low-income families, but usually families that have low educational attainment. Many of them are ethnic minority families. Many of them are characterized by single-parent households and probably bear a disproportionate burden related to childhood obesity. So our priority was to focus on Medicaid families. We also looked around us and looked at our existing infrastructure and decided to build and reinforce the infrastructure. We have associations, relationships, with our physician groups. We also know that primary care represents a strategic venue for provision of well childcare and provision of obesity

prevention. What we wanted to do was go into provider offices, make sure that they have the training and resources needed to optimize obesity prevention and management. We also know, as everyone knows, that prevention is more cost effective than treatment. I think the conservative estimate is that for every dollar that is invested in prevention, there is a saving of up to $4 or more in future avoidable costs. And we also know that families usually bring in their children at least once a year, if not more, for well childcare -- childcare visits. Research and evaluation: Given that there was a paucity of evidence-based solutions, we were invested in the scientific evaluation of all of our interventions. We wanted to add to that sparse evidence base. And this was by, not only partnering with academic vendors, we also partnered with academic institutions, such as the Rand Corporation and also partnered with national entities such as the CDC to ensure that our messaging was consistent and that we were on the right path. Modifying environments: It was again very clear that obesity prevention could no longer be confined within, what I describe, as the four walls of primary care. In order for primary care and the provision of anticipatory guidance to be effective, we needed to make sure that those interventions were paralleled in schools and communities, the other environments where families and the young children spend a significant amount of time. And because of that, we perhaps went beyond the cross-accrual of the health benefits company and partnered with communities as well as schools. And leverage collaborations: We pursued public/private collaborations, perhaps a more significant being the Alliance for a Healthier Generation. I am sure many of you heard the keynote speaker in the morning. Our significant collaboration has been with the one championed by President Clinton in trying to see if we can reimburse nutritional counseling in primary care visits around obesity prevention and then to continuously and constantly innovate in our commitment to find innovative solutions to address childhood obesity. So, we use those strategies to implement a multipronged childhood obesity initiative. And we used core interventions around CME, physician CME, as well as a BMI program that was focused on clinical staff, knowing fully well that the benefits of the program would extend way beyond our membership. It would benefit thousands of additional children and their families. We focused on member resources, and this is in the form of educational materials, programs. We reached out to schools and communities and again the collaborative partnerships.

The rest of the deck just describes a little more detail on some of these interventions. This is the strategy that I described around Medicaid. This is new data. If you look at the top ten states with the highest level of childhood obesity and at those states that have the highest levels of poverty, you can just see what the level of overlap is. It is about 80 percent. It just brings about the importance of focusing on our low income, our socially disadvantaged families when it comes to addressing childhood obesity. Supporting primary care: We still get requests for childhood obesity training around CME, around physician tool kits. We just implemented distributed tool kits to all WellPoint physicians last month, and we have received requests for additional tool kits, and those tool kits requests have not stopped coming in. Buddy Mass Index training: We think that that's been a huge cornerstone, a successful effort, if you will. We started out at a time when there was no standard screening in place in primary care. Because of the training, about 2,500 different health professionals have been trained, that requests are still coming in. We're in the process of launching an online training component which we will have extended outreach.

Because of our efforts, we were invited to participate in a pilot with NCQA, and we are happy to announce that NCQA announced BMI as a HEDIS measure starting this year. And we think it's going to make a difference to the landscape of the provision of obesity-related care and primary care. Member resources: Again, to reinforce what the primary care physician is doing in the primary care office. Research and evaluation: Again, we were probably the first health plan to put BMI measures and our HEDIS data extraction tools to really see how many physicians are recording BMI. It's really clear that there's a long learning curve. So, NCQA announces a BMI measure as a HEDIS measure this year. When you look at the consumer awareness, it is still very low. So, even though there may be a policy for primary care physicians to document BMI, we also need to make sure that our individuals, our families, our communities also know

what BMI is, and also walk into a primary care physician's office and say, Doctor, I would like to know my child's and my BMI. Modify environments: We have partnered with the fruit and vegetable bar. We implemented the fruit and vegetable bars, partnered with UCLA, as well as LA unified school district under the leadership of individuals like Dr. Slusser. It was a multi-component intervention, nutrition curriculum, along with providing them with fruit and vegetable bars. And these were effective. It was a quasi-experimental study for those who are skeptical, controlled schools as well as intervention schools. And they were found to make a huge difference in children's intake of fruit and vegetables. We have partnered with the Governor's Council on Physical Fitness and Sports to reach out to after-school settings. Boys and Girls Clubs that are largely occupied or rather where our Medicaid families spend a significant amount of time.

And also collaborated with Rand to really delve deeper into Medicaid adolescence to try and understand what are some of the challenges associated with the utilization of care. Leverage and collaborations: We are very, very proud to be part of the Alliance for a Healthy Generation to really look at the feasibility and the effectiveness of additional reimbursement of primary care visits of nutritional counseling. We're on this journey with them on a three-year pilot, and we will be evaluated by external vendors. We are partnering with Merck to look at diabetes prevention. And this program is free. It's based out in the community. It's based through employer groups. We are also focused on partnering through the Healthy Hoosiers Alliance in Indiana. And innovate: you are more than welcome to apply and share your ideas with us. But this is just a little snapshot of our dedication to innovation. And then, just our implications as has been said over and over again, a commitment to prevention and wellness is important. We have heard people talk about it, but very often it just gets sidetracked. So, we do need to see that commitment, whether it is in the form of sustainable funding or it's in the form of strategies immediate as well as long term.

We know that health outcomes, in order to be successful, need to not only focus on the effective delivery of medical care, but also need to be paralleled through interventions in schools and communities. Public/private collaborations have huge potential. Disparities: Focus on disparities. Perhaps through reaching out to our Medicaid families and a little about multiple stakeholder accountabilities. Given that obesity has an etiology that's based on so many different stakeholders and so many different environments, it will take multiple stakeholder accountability to make a difference. And that stakeholder accountability could be through the primary care physician, it could be the health insurance, health benefits company. It is the community groups as well as the parent at home that has to work together to make a difference.

Loel Solomon, PhD
Kaiser Permanente

Kaiser Permanente is the nation's largest not-for-profit healthcare organization. We are here in the district and in nine other states. We grew up in the Kaiser shipyards as an industrial health organization. We were responsible for covering very large populations of people, and we are largely responsible for the mushrooming growth of cities like Oakland and Richmond during the war effort. And we had to attend to all of the public health issues as a citizen, as a civic member of those cities for the big increase in population. And so we have had physicians and health plan people that have been very involved in the challenges of large populations of folks. And it's really shaped our thinking about what prevention is and should be and needs to be. And when we think about the obesity epidemic, we are really addressing it in a multi-factorial way. And this very consistent message about what obesity prevention needs to be. We are not talking about whether we are focusing on individual behavior or environmental solutions, we are talking about how we really need to address it all and be pretty comprehensive. And Kaiser has taken that approach. But we have addressed obesity in a multi-factorial way because of our understanding about the multi-factorial

nature of the problem. There is no single silver bullet. And the other way that we have approached obesity prevention is informed by the fact that we, as an organization, have an unusual amount of assets. We have 15,000 physicians. We have 160,000 employees. We have medical office buildings on the ground in all these different cities. And that has created an incredible opportunity for Kaiser Permanente and our employees to become part of transportation commissions and building commissions and school wellness councils. And we have used that influence to effect policy change in a pretty significant way, and it's been a very exciting thing to see.

Our obesity prevention efforts are focused in three major places: First, because we are first and foremost a delivery system, we have implemented a phalanx of delivery system interventions focusing on doing really great documentation of BMI. We have a BMI as a vital sign program, and we've been measuring adherence to that for quite some time. And we are just now introducing, in some regions, physical activity as a vital sign trying to incorporate that into our clinical procedures. We have spent a lot of time working with our physicians and other caregivers to practice through the art of behavioral science when they are talking to their patients about weight, using brief negotiation techniques. We have done that with our staff and increasingly with community physicians and community health centers and other safety-net providers. And we have supported those kinds of conversations with office prompts, electronic medical records, and a whole suite of things to make the healthy conversation the easy conversation, so to speak. And I think those are table stakes. That's what a prevention-oriented delivery system has to do. We are very proud of our record there, but we quickly realized, and particularly our pediatricians, who were getting very frustrated about giving advice to their patients and having their patients walk out of their exam rooms and being completely unable to act on that advice because the environment conspired against those healthy choices. We've mounted a very significant environmental and policy change agenda with community-level interventions. We are now either funding or co-funding with the endowment in the Robert Wood Johnson Foundation and Kellogg and the CDC and others 40 place-based efforts that are built around community collaboratives that take that multi-sectoral approach and are implementing recommendations from the community guide and also doing a lot of innovation, because we know that the evidence isn't in the published literature. It's not in the peer-reviewed literature. So, we are also trying to create a fertile ground for a lot of innovation.

The other thing that we have done is focused a lot on straight-up grant making. We support organizations that are working with city leaders, promoters and others to focus around policy environmental change. And healthy eating, active living convergence partnership, we're working with other funders and the CDC as a technical adviser to really accelerate the movement for environmental and policy approaches to obesity prevention. And we are very excited about this surround sound that's starting to occur around that kind of approach. But a funny thing happened on the way to environmental and policy change. Because we have so many facilities, so many employees, so many cafeterias, we realized that we could not preach that gospel if we didn't reform ourselves. And so we have spent a lot of time changing our own food system, making our own vending machines healthier. We have 30 farmers markets now, in Kaiser Hospital lobbies and parking lots in multiple states. We are thinking about transportation-oriented design when we site and build new buildings. And just today, we are releasing a study of our own menu-labeling project where we are doing manual labeling in our cafeterias. We had a very rigorous pilot study with the Center for Weight and Health at U. C. Berkeley. We found that there's very significant changes in behavior that posting calories on the menu boards produces. And now we are rolling those menu boards out in all of the cafeterias that we operate. And so, we realize we have to lead from where we stand, and so that's what we are doing there.

As far as implications of our work for health reform, our experience on the ground shows that really good programs, really good activities, no matter how focused they are, no matter how much fidelity you get

to the model are just not enough. We really have to surround our people with healthy food and physical activity options. And so we are very excited to see in both versions, but the House and the Senate versions of reform very significant investment in community-based prevention. There is a natural tendency to default to clinical prevention. That's necessary. It's insufficient. So, we are very excited to see this community makeover style of grant making that is part of both the reform bill. Secondly, we know that it's a long-term proposition. We've been funding these collaboratives, some of them, as long as five years. And many of them are just now starting to hit their stride. Their relationships are solid. These multi-sectoral relationships are firm. And we are just now starting to hit pay dirt. And so we know that this funding needs to happen over the long-term and that's why stable funding, significant funding, outside of the annual budgetary process, as Senator Harkin said, is so vitally important. We need that dedicated funding for the health and wellness trust. And lastly, it's really important -- and you've heard this from a couple of speakers -- that we don't think of obesity prevention as something that public health alone is responsible for. We really need to take a "health in all places" kind of approach. This is a standard of practice in Europe. It's a standard of practice in many industrialized countries. And it needs to be here. There are some very positive signs in a number of versions of reform that require inner-agency collaboration, they required health impact assessment, that really alleviate the role of AG and transportation and HUD as critical producers of health. And so that is a very important thing that we see in the work.

Lastly, as I conclude, we really see that policy is an important driver for social norms. There's direct impacts the policy has on behavior. But there's also a really important signaling impact that policy has. That paints the picture of the kind of transformational change that we think we need to be about if we are going to win the battle against obesity. And it's the kind of change that is completely within our grasp, and I would just challenge all of us to hold the flame to realize the kind of change that we all know we need to bring about. Change and the world changes with you.

Christine Ferguson, JD
Executive Director
STOP Obesity Alliance

I want to preface my remarks with four things: I believe that whatever they pass this year in health reform, as long as it puts money on the table, will be great. My history is I spent 15 years in the United States Senate on the Finance Committee with John Chafee and was very involved in the last health reform right down to the bitter end. After that, I was secretary of Health and Human Services for seven years in Rhode Island and I did financing. So, I am a financing person, but then I was appointed as a public health commissioner in Massachusetts. So, I had that public health side too, so I am coming from both places. And in that process, I really have learned about the need for balance. And so seeing a thousand people in the room when I walked in, I was expecting, like, four or 500. It was like, oh, my God, it's all public health people. There are very few financing people in the audience, right? Any financing people? Like three? Okay. So, I don't want you to hit me on my way out because I know how that tension runs. But the balance between getting well and staying healthy, we need both. We need getting well, staying healthy, and preventing illness. We need all of those three things working really collaboratively, and we tend not to do that. So, I believe strongly in balance. And the final thing that I want to say in the preface is that I am appalled at what's happened to Dr. Benjamin. And I say this because I walked in her shoes. When I was appointed as the public health commissioner in Massachusetts, I weighed 120 pounds more than I weigh now. And when we had the press conference, I literally was standing there thinking to myself, which of us is stupider, me for agreeing to take this job, or the Governor for appointing me? And the reason is because there is this horrible stigma attached to this. Who better to deal with overweight and obesity issues than

somebody who is struggling with them themselves. And so I just really want to put out there that you guys have to be involved in this conversation because that is a core problem with how we address this issue overall. So, those are my sort of biases coming into this.

We have put together an alliance called the "STOP Obesity Alliance," and it has on its steering committee a broad spectrum of people. We have the 17th surgeon general as our health and wellness chair, Dr. Carmona, and we have the American Health Insurance Plans of America, AHIP, the Trust For America's Health, and the Service Employees International Union. I don't know how many of you know that that union, in particular, which has lower income wage workers has a rate of obesity and overweight that's, like, 70, 80 percent; Head Start workers -- a lot of people who work in the healthcare field. So, it's a broad spectrum of folks, and that represent a good cross-section of society and we have been focusing -- or policy makers we've been focusing on. We've been focusing on trying to agree on some principles. And I am raising these -- I am going to send you to our website, which is stopobesityalliance.org. And there are four things that we agreed on when we started this, which was two-and-a-half years ago. One was redefining success, and I think that we are talking predominantly about prevention and approaches to prevention here. But in addition to that, we need to talk about prevention of people going from one category to the other, from overweight to obese, which is growing at massive proportions at very high rates in this country. And looking at how we define success and looking at it from a health outcomes perspective and from an improvement of health perspective as opposed to a cosmetic or saying to everybody you have to achieve normal BMI when your BMI is already over 30. But I wonder how many of you have ever struggled with your weight. It's not an easy thing. And we do have great information from the National Heart, Lung and Blood Institute about what works and what doesn't work in the fact that a five-to-ten percent weight loss can really achieve significant health improvements. So, while we are also talking about how we are going to bend this curve and get to the Kaiser vision of what the population looks like, we have to deal also with the population that we have and where they are at because those are the parents of the kids that we are trying to bend the curve with.

And then encouraging innovation and best practices, addressing and reducing stigma. Honestly, you know, if you really think about why we haven't addressed this issue until we have 60 percent of the population in this condition to approach this in any way other than solely personal responsibility and the idea of shunning. And I will tell you I don't think that shunning worked. And anybody who is fat or overweight or obese knows that, from the moment they become that way, they are, in fact, shunned in so many ways. And it doesn't necessarily lead to activity that changes your behavior. And so we really need to think about whether or not that's a successful strategy and broadening the research agenda. And this cross-section of groups decided that having a definition of success that really focused on health addressing stigma, really working on encouraging best practices, and broadening our research agenda as a nation were key components. And we put together a document called the GPS, which is a guide. There are a series of questions that we are recommending that you ask when you are putting a policy together. And as a former state official, I can tell you that oftentimes when we have legislative direction or when we were talking about the budget, we didn't ever have the answer to this question: How will we define success? If you give me a grant, a line item in my public health budget for $2 million to decrease obesity and overweight in Massachusetts or to get to normal BMI in Massachusetts with a six-million-person population, they never said that. They never told us what the definition of success was. So, when we came back in to get more money, they would say: Well, there are still people who are obese and overweight, so you haven't succeeded. We have to be clear about what our definition of success is from a large community perspective as well as from an individual perspective. From an individual perspective, we think we should be talking about five to 10 percent weight loss and maintenance of that long-term, that that's a good starting point for success. From a community perspective, we have to be clear about what we mean, when we invest money, what success will be. And so there are a series of questions and the data that backs it up.

The next is: How will the policy program encourage innovation or multi-factorial intervention in obesity prevention and treatment? How is this actually going to achieve the goal, the definition of success? And, again, I am recommending you go to the website. How will the policy or program reduce stigma and create positive attitudes and approaches when treating or discussing obesity? I am a public health official. I am in the state. I am in front of the legislature. We have had to cut our budget. You put up a picture of an overweight kid, an overweight adult, a child with cancer, a child in a wheelchair, an adult in a prison, an adult with HIV AIDS, and you decide who is going to get money and who is not going to get money in that scenario. And as a general rule, the people who come in last are the people who are overweight or obese. And we have to be willing to take that on and address it. And then, lastly, the question is: How will the policy or program focus and coordinate our research efforts? And as Kaiser and our other panels have talked about, how are we making sure that, when we do interventions, we are actually doing the research that is necessary to get out the results because we don't do such a great job of that. So, when we talk about health reform this year, Janelle and Senator Harkin have done a phenomenal job of getting into the health reform proposals that are out there so far these questions of investment, actual money on the table, and focus on prevention. In addition to that, we need to be specific in the language, as specific as we possibly can get, to really talk about the get-well piece as well as the prevention piece; because if you are obese or overweight in this country, as a general rule, the get-well piece has been pretty hard to get help with. So, if you think about what is excluded, oftentimes in policies and how we approach this issue collectively as a nation, we tend not to fund support for losing weight and maintaining weight. We tend not to do that because we have thought about it as cosmetic. So, in health reform, I think it's important that we focus very specifically on the relationship between overweight and obesity and chronic disease. And funding the improvement and the maintenance and the loss of weight as well as the prevention from the get-go. That's the balance piece. That's putting it all together. It's not one or the other, it's both. And so in the final bill, what we hope to see is something that addresses obesity and overweight in particular when it focuses on chronic disease and broader, if at all possible, when we talk about the benefits package; that we use comparative effectiveness to improve what's covered and what's not covered; that our employee wellness programs are focused on incentive-based programs as opposed to negative incentives. And that we really look at not excluding this whole category of service from both prevention services and coverage services. So, at the end of the day, we need money on the table for prevention and treatment, and we need teeth on the table. And we need to understand that regardless of what happens this year, how many of you think you will be able to go home after that? We will be doing health reform for the rest of our lives. I've been doing it for 30 years.

You will be doing it for another 30 years, and your children will be doing it for 30 years. This is never going to end. The implementation and the process of reforming our system to adjust to us is absolutely an ongoing process. So, we need to understand that, once the bill is passed, the implementation process becomes just as critically important, and it's the balance at the end of the day. We want people to get well, stay well, and prevent illness to begin with and prevent obesity to begin with. And those -- all three of those things need to be covered in the bill in order to have the balance that is necessary to really bend this curve and straighten it out and get to the Kaiser vision.

Jenelle Krishnamoorthy
Professional Staff
Senator Tom Harkin

I do want to say we are in the midst on health reform and prevention, and public health seems to be all the buzz. And I am so happy that's it's become kind of the sexy topic. But I must say we still have quite a fight on our hands because many times people love to talk about it. But when we get down to money,

that's when it gets tough and that's when, you know, Senator Harkin and folks say: Show me the money. How are we going to do that paradigm shift? And as the Senator talked about -- we right now looked in our health reform bill at what we can do in the clinical level, what we can do on the federal level. And folks have talked about the investment fund and health in every policy. Then also, you know, in the community really thinking about the CDC and the community preventive services task force, which has just done wonderful work. We need to embolden them and keep working with them so we can look at keeping people healthy before they have to use the medical system. Some of the things in the community prevention programs, we have encouraged physical activity, good nutrition, reduction of tobacco use, and also looking at mental and behavioral health issues, which is really important not to forget. We also have some programs in there that target folks that are aged 55 to 65 and individuals with disabilities and other sub-populations. But just an example so you all know the feel out there and you may have seen this, but one of the press releases that came out with someone that says they're for prevention in public health said, quote, "The health committee bill will pave sidewalks, build jungle gyms and open grocery stores, but it won't bring down healthcare costs or make quality coverage more affordable. In a time of record debt and deficits, how can we justify such wasteful spending? We need to root out the waste, fraud and abuse that is driving up healthcare costs, not create a whole slew of new wasteful programs. This health committee bill will establish the community makeover program to spend billions to beautify streets and up to $10 per person in selected communities, funded federal government program to build sidewalks and bike paths and put up street lights, finance knew grocery stores and farmers markets, deal with menu labeling, and subsidized community projects like building jungle gyms and parks. Some of these programs may have value, but this is the wrong bill at the wrong time. At with our nation's health and economy at stake, this bill must not turn into a Christmas tree of every partisan interest group in Washington." That's where things still can be. And as, you know, you heard Senator Harkin talking about this investment fund and investing our money so that we can deal with prevention and public health, right now it starts with ramping it up each year -- two, four, six, eight, ten. I think it will be very important to watch where that investment fund goes over the next several months. Again, this is going to be a fight to ensure, especially the community prevention, that it sticks and stays a centerpiece in this health reform bill. Because, again, you've probably heard someone called the Congressional Budget Office, CBO. Now, you've probably heard earlier this week where they said, you know, in this health committee bill it's not going to bend the cost curve, it's just spending money.

Well, it's spending money on items like this. So, that's all going to be considered a cost. Again, that means that folks are going to have to say: This is a good investment. We want to spend money even though we know Trust for America's Health and other folks you-all have shown that there's a good return on investment in these cost-effective-proven prevention interventions. Please do see your elected official and tell them this is important. This is going to save money down the way and that it's good, effective programs to fight for in health reform.