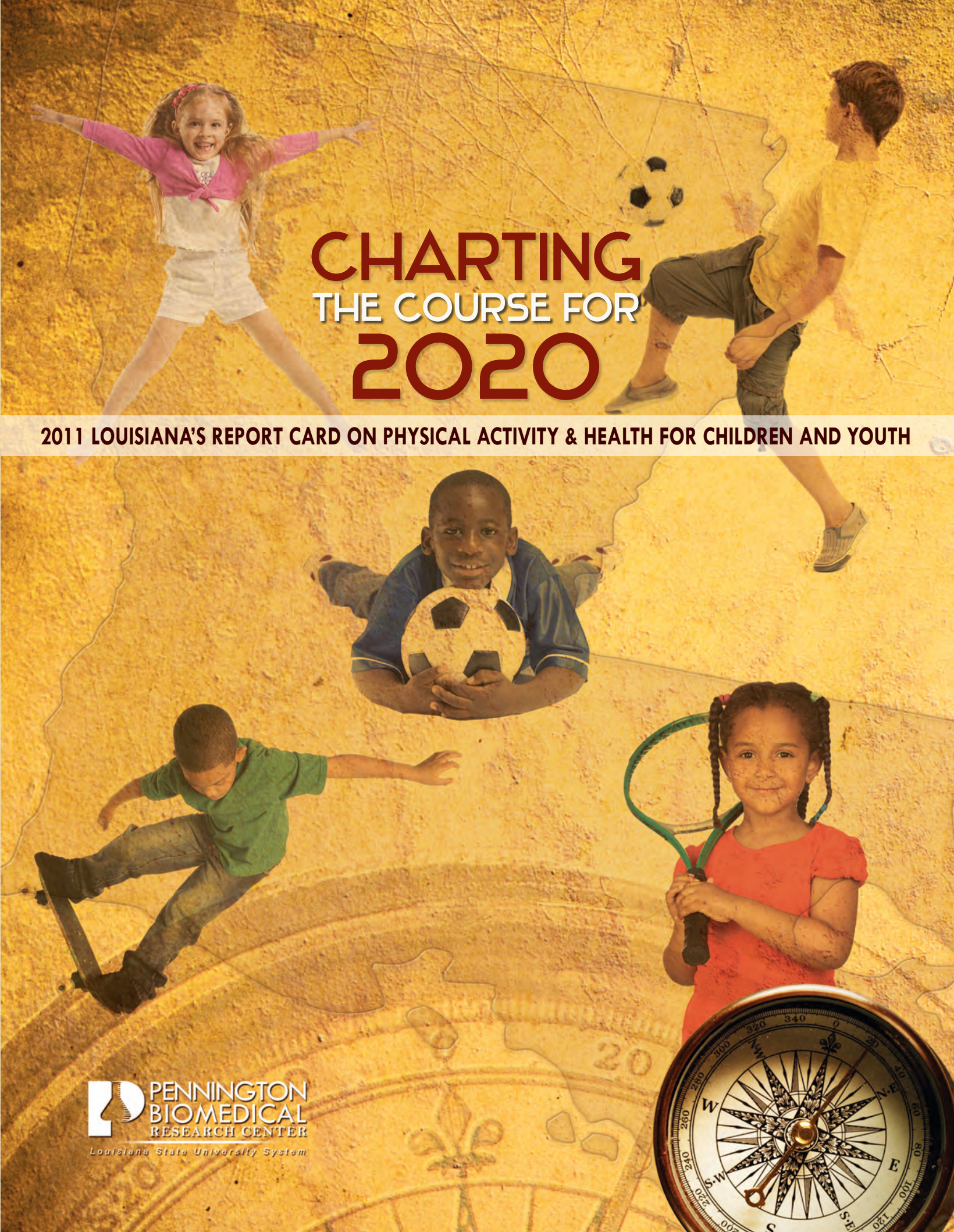

CHARTING THE COURSE FOR 2020

2011 LOUISIANA'S REPORT CARD ON PHYSICAL ACTIVITY & HEALTH FOR CHILDREN AND YOUTH

PENNINGTON BIOMEDICAL RESEARCH CENTER
Louisiana State University System

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Louisiana State University System

Our *mission* is to discover the triggers of chronic diseases through innovative research that improves human health across the lifespan. We are helping people live **Well** Beyond the Expected.

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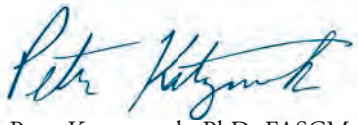
FOREWORD

It is my pleasure to introduce the 2011 installment of *Louisiana's Report Card on Physical Activity and Health for Children and Youth*. This is the fourth annual edition of the Report Card, which is guided by a Research Advisory Committee composed of members from across the state. You will notice that the Report Card takes a different tack this year, as we opt not to present specific grades for each indicator. Rather, we focus on setting goals and developing strategies to achieve those goals.

National public health objectives were developed under the auspices of Healthy People 2020 (*www.healthypeople.gov*). The overarching goals of Healthy People 2020 are to encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of prevention activities. We embraced these goals in developing this year's Report Card; however, the targets we established for Louisiana are more aggressive than the Healthy People 2020 targets. On June 16, 2011, the National Prevention Strategy was released, which will guide and coordinate efforts to improve the health of the population. It is within this framework that the strategies outlined in this year's Report Card were developed.

The indicators reported in this document represent significant health concerns for children in our state. Tackling these health issues will take a concerted effort from all concerned citizens. We need to take an aggressive stance in improving the health of our children, but we must also exercise a degree of patience as we begin to deploy public health strategies and monitor their effectiveness. The reduction in the use of tobacco in the United States is viewed by many experts as a public health success story. Since the release of the first *Surgeon General's Report on Smoking and Health* in 1964, the prevalence of smoking has decreased from 42% to 21%. This change has taken 45 years to achieve, and I anticipate turning the tide on physical inactivity and obesity is an equally if not more challenging proposition.

I encourage those who have a role to play in improving the health of children and youth to be proactive in developing prevention strategies that will have a long-term, sustained impact. It will be great to look back 45 years from now and consider our efforts as an important factor in another public health success story.



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GOAL OF THE REPORT CARD

The primary goal of the Report Card is to assess the level of physical activity and sedentary behaviors in Louisiana's children and youth, the level of facilitators and barriers for physical activity, and their related health outcomes. The Report Card is an authoritative, evidence-based document that provides a comprehensive evaluation of the physical activity levels and the indicators that influence physical activity among children and youth in Louisiana. The Report Card takes an "ecological approach" to the problem of physical inactivity among Louisiana's children and youth, recognizing that many influences in which our kids live such as their family, school, community, and policy environments can affect their physical activity and other health behaviors. The categories and indicators in the Report Card correspond to these environmental influences on physical activity behaviors. Through this effort, we are able to track these behaviors and their influences over time and show progress, deficiencies, and inequities for each indicator.

The Report Card is a resource for health statistics on children and youth in Louisiana, but most importantly, it is an advocacy tool that provides a level of accountability and call-to-action for adult decision makers on how we, as parents, teachers, medical professionals, and community leaders, can help implement new initiatives, programs, and policies that support healthy environments to improve the physical activity levels and health of our children. The annual Report Card findings galvanize researchers and the community across Louisiana to improve our children's physical activity opportunities and health.

2011 REPORT CARD STRATEGY

2011 REPORT CARD STRATEGY

The 2011 edition of *Louisiana's Report Card on Physical Activity & Health for Children and Youth* marks the fourth annual publication. With each successive year, the development of the Report Card has cultivated new strategies and directions while still keeping its overall goal. This year, the Report Card foregoes grade assignments in order to establish baseline data to set goals, objectives, and specific targets for each of the indicators to reach by the year 2020. This year's Report Card is modeled on the goals, objectives and methodology for setting targets based on Healthy People 2020.[1] However, the data and targets in this Report Card are specific to the population of children and youth in Louisiana. We have taken a more aggressive approach to setting public health targets and have established goals that are higher than those of Healthy People 2020. The majority of the Healthy People 2020 goals are based on 10% improvement over baseline levels – given the poor ranking of the children and youth of Louisiana, we have adopted higher goals as the Research Advisory Committee decided that anything less would not result in meaningful improvements in health. Thus, we are striving for 20% improvement in physical traits such as obesity and physical fitness, and 40% improvement in modifiable behaviors such as physical activity and nutrition.

A draft of this year's Report Card was released in August 2011 so that public comments on the goals, objectives, and targets could be solicited in two ways: 1) the draft of the Report Card was posted on the internet (*www.louisianareportcard.org*) so that individuals and organizations from the community could submit their comments, and 2) there was an open forum at the Fourth Annual Childhood Obesity and Public Health Conference held at the Pennington Biomedical Research Center on September 14, 2011, to solicit feedback. These opportunities allowed the community and organizations to have a voice and to incorporate their opinions about the goals and targets before the Report Card was published in final form.

The 2020 targets that were established for Louisiana are practical and achievable and can be reached if we help implement initiatives, strategies, and policies that support healthy behaviors and environments to improve the physical activity levels and health of our children. The 2020 targets represent reasonable public health goals, but do not necessarily correspond to achieving an "A" grade on the Report Card. It is possible that reaching the 2020 target for an indicator will mean there are still insufficient appropriate physical activity opportunities. Setting feasible, achievable targets will help us to slowly achieve optimal health beyond 2020. Within each of the indicators presented in the Report Card, the baseline data will be presented along with the 2020 targets. Each indicator will also have information on guidelines and action strategies (if available) to help us meet the 2020 targets for Louisiana. Given the instability of estimates from year to year in the state survey data due to the general lack of data on indicators influencing obesity and physical activity among Louisiana's children and youth, the Research Advisory Committee will seek a sustained change in the indicators across two or more survey years as an indication that real and sustainable change has been observed.

SUMMARY OF REPORT CARD GOALS, OBJECTIVES AND 2020 TARGETS

SUMMARY OF REPORT CARD GOALS, OBJECTIVES AND 2020 TARGETS

Categories/Goals and Indicators	Objectives	Topics or Sub-groups	Data Source	Baseline Year	Louisiana Baseline	Target-Setting Method	2020 Target
PHYSICAL ACTIVITY/INACTIVITY: Goal = Improve health, fitness and quality of life through daily physical activity.							
Physical Activity Levels	Increase the proportion of adolescents who meet current federal physical activity guidelines for aerobic physical activity, vigorous physical activity and for muscle-strengthening activity.	Aerobic Physical Activity in grades 9-12	LA YRBS	2009	23.0%	40%↑	32.2%
		Vigorous Physical Activity in children 6-17 years	NSCH	2007	34.0%	40%↑	47.6%
		Muscle-Strengthening Activity in grades 9-12	LA YRBS	2009	44.5%	40%↑	62.3%
Screen Time	Decrease the proportion of adolescents who exceed recommended limits for screen time.	TV/videos/video games in grades 9-12	LA YRBS	2009	40.3%	40% ↓	24.2%
		Computer/computer games in grades 9-12	LA YRBS	2009	24.4%	40% ↓	14.6%
Sports Participation	Increase the proportion of children and adolescents who participate in after-school sports or sports teams.	Children and adolescents aged 6-17 years	NSCH	2007	51.6%	40%↑	72.2%
		Adolescents in grades 9-12	LA YRBS	2009	50.6%	40%↑	70.8%
HEALTH & HEALTH BEHAVIORS: Goal = Promote health and well-being of children and adolescents and reduce chronic disease risk by increasing physical activity and other healthful behaviors.							
Overweight and Obesity	Reduce the proportion of children and adolescents who are obese.	Children aged 2 to 5 years	PedNSS	2007	13.8%	20% ↓	11.0%
		Children aged 10 to 17 years	NSCH	2007	20.7%	20% ↓	16.6%
		Adolescents in grades 9-12	LA YRBS	2009	14.7%	20% ↓	11.8%
		Children and adolescents 2 to 19 years	LA SBHCs	2008-2009	29.0%	20% ↓	23.2%
Aerobic Fitness	Increase the proportion of children and adolescents who perform within a Minimum Fitness Standard (MFS) on the PACER sub-test of aerobic fitness.	Adolescents aged 10-18 years	HRPFA	2009-2010	39.0%	20% ↑	46.8%

SUMMARY OF REPORT CARD GOALS, OBJECTIVES AND 2020 TARGETS -- CONTINUED

Categories/Goals and Indicators	Objectives	Topics or Sub-groups	Data Source	Baseline Year	Louisiana Baseline	Target-Setting Method	2020 Target
Overall Physical and Emotional Well-Being	Reduce the proportion of adolescents who have attempted suicide.	Adolescents in grades 9-12	LA YRBS	2009	10.9%	40% ↓	6.5%
Fruit and Vegetable Consumption	Increase the intake of fruits and vegetables in the diets of adolescents.	Fruits ≥ 4 times per day in grades 9-12	LA YRBS	2009	3.5%	40% ↑	4.9%
		Vegetables ≥ 3 times per day in grades 9-12	LA YRBS	2009	9.7%	40% ↑	13.6%
Tobacco Use	Reduce tobacco use by adolescents.	Tobacco products in grades 9-12	LYTS	2009	30.9%	40% ↓	18.5%
		Cigarettes in grades 9-12	LYTS	2009	15.9%	40% ↓	9.5%
		Smokeless tobacco products in grades 9-12	LYTS	2009	9.2%	40% ↓	5.5%
		Cigars in grades 9-12	LYTS	2009	10.9%	40% ↓	6.5%
FAMILY: Goal = Increase the awareness of the benefits of physical activity for all individuals, and improve family support for achieving adequate levels of physical activity.							
Family Perceptions and Roles Regarding Physical Activity	Increase the proportion of parents who attend events and activities in which their children and adolescents participate.	Children and adolescents aged 6-17 years	NSCH	2007	85.8%	16.6% ↑	100%
SCHOOL AND COMMUNITY: Goal = Promote school and neighborhood environments that provide and increase opportunities for physical activity throughout the day inclusive of all children.							
Physical Activity Programming at School	Increase the proportion of adolescents who participate in daily school physical education.	Adolescents in grades 9-12	LA YRBS	2009	36.4%	20% ↑	43.7%
Built Environment and Community Design	Increase the proportion of children and adolescents who have favorable neighborhood amenities that promote physical activity opportunities.	Sidewalks or walking paths for 0-17 year olds	NSCH	2007	62.0%	20% ↑	74.4%
		Parks or playgrounds for 0-17 year olds	NSCH	2007	65.6%	20% ↑	78.7%
POLICY AND INVESTMENTS: Goal = Increase the number of policies and investments made to improve the health of children and youth.							

PHYSICAL ACTIVITY/INACTIVITY

GOAL

Improve health, fitness and quality of life through daily physical activity.

INDICATOR: **PHYSICAL ACTIVITY LEVELS**

Objective 1:

Increase the proportion of adolescents who meet current federal physical activity guidelines for aerobic physical activity, vigorous physical activity and for muscle-strengthening activity.

INDICATOR: **SCREEN TIME**

Objective 2:

Decrease the proportion of adolescents who exceed recommended limits for screen time.

INDICATOR: **SPORTS PARTICIPATION**

Objective 3:

Increase the proportion of children and adolescents who participate in after-school sports or sports teams

INDICATOR: PHYSICAL ACTIVITY LEVELS

BACKGROUND: The 2008 Physical Activity Guidelines for Americans[2] recommends 60 minutes of physical activity every day for children and youth. Of the 60 or more minutes of daily physical activity, most should be moderate-to-vigorous intensity and should include at least 20 minutes per day of vigorous physical activity as well as muscle-strengthening and bone-strengthening activities on at least three days of the week.[2]

OBJECTIVE: Increase the proportion of adolescents who meet current federal physical activity guidelines for aerobic physical activity (at least 60 minutes every day), vigorous physical activity and for muscle-strengthening activity (at least 3 days a week).

DATA SOURCE/TRACKING: The Louisiana Youth Risk Behavior Survey (YRBS) will be used to monitor the percentage of children who meet recommendations for aerobic physical activity and muscle-strengthening activity. The YRBS asks students how many days they are physically active for a total of at least 60 minutes per day during the past 7 days. Response categories range from 0 days to 7 days. The YRBS also asks students on how many of the past 7 days did they do exercises to strengthen or tone their muscles, such as push-ups, sit-ups, or weight lifting. Response categories for this question also range from 0 days to 7 days. Since the YRBS includes data for high school aged adolescents, the National Survey of Children's Health (NSCH) will be used to monitor vigorous physical activity percentages among children and adolescents ages 6-17 years. The NSCH asks a parent or guardian how many days during the past week the child exercised, played a sport, or participated in physical activity for at least 20 minutes that made him/her sweat and breathe hard.

BASELINE: Twenty-three percent of high school students in Louisiana met recommendations for aerobic physical activity and 44.5% met recommendations for muscle-strengthening activity, according to results from the 2009 LA YRBS.[3] Thirty-four percent of children and adolescents ages 6-17 years participated in at least 20 minutes of vigorous physical activity each day, according to results from the 2007 NSCH.[18]

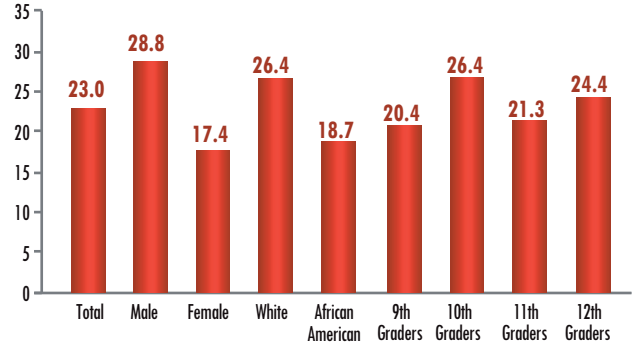
Objective 1: Increase the proportion of adolescents who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Aerobic Physical Activity	23.0%	2009	LA YRBS	40% ↑	32.2%
Vigorous Physical Activity	34.0%	2007	NSCH	40% ↑	47.6%
Muscle-Strengthening Activity	44.5%	2009	LA YRBS	40% ↑	62.3%

LA 2020 TARGET: To increase physical activity levels by 40% among children and adolescents, the 2020 targets for aerobic physical activity, vigorous physical activity and muscle-strengthening activity are 32.2%, 47.6% and 62.3%, respectively.

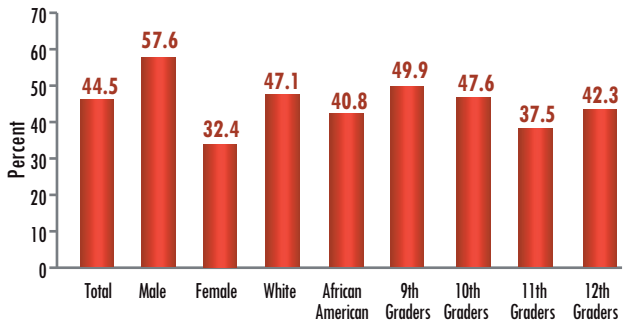
DATA TRENDS & DISPARITIES: Data from the 2009 LA YRBS showed that 77% of high school students did not achieve recommendations for aerobic physical activity (Figure 1).[3] Only 17.4% of females and 28.8% of males met recommendations.[3] A lower percentage of African American students were physically active every day compared to White students (Figure 1).[3] A higher percentage of 10th

Figure 1: Percentage of High School Students who Met Physical Activity Recommendations (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

Figure 2: Percentage of High School Students in Louisiana who Met Recommendations for Muscle-Strengthening Activities (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

graders achieved physical activity recommendations compared to other students (Figure 1).[3]

Results from the 2009 LA YRBS showed that 44.5% of high school students met recommendations for muscle-strengthening activities (Figure 2).[3] However, females were less likely than males to meet recommendations, and there were a lower percentage of African American students who met recommendations compared to White students (Figure 2).[3] Ninth and 10th grade students were more likely to achieve recommendations for muscle-strengthening activities (Figure 2).[3]

ACTION STRATEGIES

PARENTS

- Engage in at least 150 minutes of moderate-intensity activity each week for adults, or at least one hour of activity each day for children (National Prevention Strategy).[4]
- Parents should ask childcare providers about their approach to promoting healthy lifestyles for children, and parents should also visit the child care setting to see how providers model and teach physical activity, good nutrition, and healthy sleep practices (Surgeon General).[5]
- Active transport should be encouraged between homes, schools, and community destinations for afterschool activities, including to and from parks, libraries, transit, bus stops, and recreation centers (White House Task Force).[6]

TEACHERS AND SCHOOL ADMINISTRATORS

- Develop partnerships with other sectors for the purpose of linking youth with physical activity opportunities in schools and communities. (National Physical Activity Plan).[7]
- Ensure that early childhood education settings for children ages 0 to 5 years promote and facilitate physical activity (National Physical Activity Plan).[7]
- Provide access to and opportunities for high-quality, comprehensive physical activity programs, anchored by physical education, in Pre-kindergarten through grade 12. Ensure that the programs are physically active, inclusive, safe, and developmentally and culturally appropriate (National Physical Activity Plan).[7]
- Schools should have a planned and sequential health education curriculum for Pre-K through grade 12 based on national standards and address a clear set of behavioral outcomes that empower students to make healthy dietary choices and meet physical activity recommendations (Surgeon General).[5]
- Provide access to and opportunities for physical activity before and after school (National Physical Activity Plan).[7]
- Develop joint-use agreements to allow school facilities to be accessible for physical activity when schools are closed (White House Task Force, Robert Wood Johnson Foundation Leadership for Healthy Communities, Institute of Medicine, Surgeon General).[5-6, 8-9]

POLICY MAKERS

- Encourage physical activity in schools, child care, and early childhood settings through physical education programs, recess, and support for active transportation initiatives (e.g., walk-to-school programs) (2010 Dietary Guidelines).[10]
- Child care regulatory agencies should require child care providers and early childhood educators to provide infants, toddlers, and preschool children with opportunities to be physically active throughout the day, and limit use of equipment that restricts infants' movement and by implementing appropriate strategies to ensure the amount of time they spend sitting or standing still is limited (Institute of Medicine).[11]
- Develop and implement state and school district policies requiring school accountability for the quality and quantity of physical education and physical activity programs (National Physical Activity Plan).[7]
- Make 30 minutes of daily physical activity a requirement for all students in all grades (Robert Wood Johnson Foundation Leadership for Healthy Communities).[8]

- Research funding is required to support observational cohort studies of predictors of change in physical activity in children in order to delineate the determinants of physical activity that are amenable to intervention (International Conference on Physical Activity and Obesity in Children).[12]
- Advocate for the development of both direct and indirect legislation that allows for the promotion of physical activity (International Conference on Physical Activity and Obesity in Children).[12]

PHYSICIANS AND HEALTH CARE PROVIDERS

- Advocate at the local, state, and institutional levels for policies and programs that promote physical activity (National Physical Activity Plan).[7]
- Conduct physical activity assessments, provide counseling, and refer patients to allied health care or health and fitness professionals (National Prevention Strategy).[4]
- Record patient's physical activity levels and discuss the importance of consistent exercise and daily physical activity (National Physical Activity Plan, Surgeon General).[5, 7]
- Establish physical inactivity as a treatable and preventable condition with profound health implications (National Physical Activity Plan).[7]
- The promotion of physical activity is an essential public health promotion strategy, and should be advocated to individuals of all ages (13th World Sport for All Congress).[13]

RESEARCHERS

- Create, maintain, and leverage cross-sector partnerships and coalitions that implement effective strategies to promote physical activity. Partnerships should include representatives from public health; health care; education; parks; recreation, sports; transportation, urban design, and community planning; business and industry; volunteer and non-profit organizations; faith communities; mass media; and organizations serving historically underserved and understudied populations (National Physical Activity Plan).[7]
- Disseminate tools and resources important to promoting physical activity, including resources that address the burden of disease due to inactivity, the implementation of evidence-based interventions, and funding opportunities for initiatives (National Physical Activity Plan).[7]
- To better characterize physical activity levels, studies should begin to incorporate multiple methodologies such as accelerometry and questionnaires to obtain a better picture of the amount of physical activity and the context in which it is performed (International Conference on Physical Activity and Obesity in Children).[12]
- More research is required on the determinants of physical activity in children at different ages. The knowledge base needs to include documented causal relationships, and models that account for a substantial proportion of the variance in order to inform the development of effective, age-appropriate interventions (International Conference on Physical Activity and Obesity in Children).[12]
- Public health practitioners should partner with local researchers to ensure that their physical activity interventions are properly documented and evaluated (International Conference on Physical Activity and Obesity in Children).[12]
- More research is required to determine the optimal multi-component physical activity intervention strategy that will bring about large scale population shifts in physical activity in the most cost-effective manner (13th World Sport for All Congress).[14]

INDICATOR: SCREEN TIME

BACKGROUND: The American Academy of Pediatrics (AAP) has issued the following recommendations for television and screen time:

- Children's television and video time should be limited to 2 hours of quality programming per day.[15]
- Television sets should be removed from children's bedrooms.[16]
- Children younger than 2 years of age should be discouraged from watching television.[16]

OBJECTIVE: Decrease the proportion of adolescents who exceed recommended limits for screen time.

DATA SOURCE/TRACKING: Due to the limited number of data sources for Louisiana that examine screen time among children or youth and survey item responses, the Louisiana YRBS is the only data source that has response categories that allows the examination of those who exceed recommended limits for screen time, and thus, will be used to track this indicator. The Louisiana YRBS asks high schools students how many hours they watch TV on an average school day and also asks students how many hours they play video or computer games or use a computer for something that is not school work on an average school day. For both questions, item responses range from none to 5 or more hours per day.

BASELINE: According to data from the 2009 LA YRBS,[3] 40.3% of high school students exceeded 2 hours a day for TV, videos, or video games, and 24.4% of high school students exceeded 2 hours a day for computer or computer game usage.

Objective 2: Decrease the proportion of adolescents who exceed recommended limits for screen time.

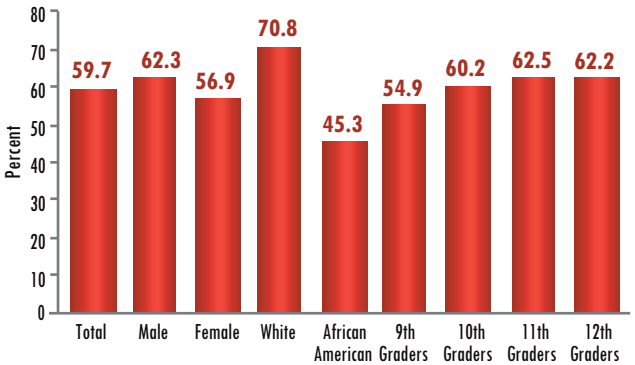
	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
TV/videos/video games	40.3%	2009	LA YRBS	40% ↓	24.2%
Computer/computer games	24.4%	2009	LA YRBS	40% ↓	14.6%

LA 2020 TARGET: Decrease the proportion of adolescents who exceed recommended limits for sedentary screen time (more than 2 hours a day) to 24.2% for TV, video and video game usage, and 14.6% for computer and computer game usage.

DATA TRENDS & DISPARITIES: According to the 2009 LA YRBS,[3] 40.3% of high school students in Louisiana exceeded recommendations for TV, videos, or video game usage, while 59.7% met recommended limits of no more than 2 hours a day (Figure 3). A higher percentage of males and White students met recommended limits for TV, videos, and video games compared to their respective counterparts (Figure 3).[3] A lower percentage of 9th graders met recommended limits for TV, videos, or video game usage compared to high school students in other grade levels (Figure 3).[3]

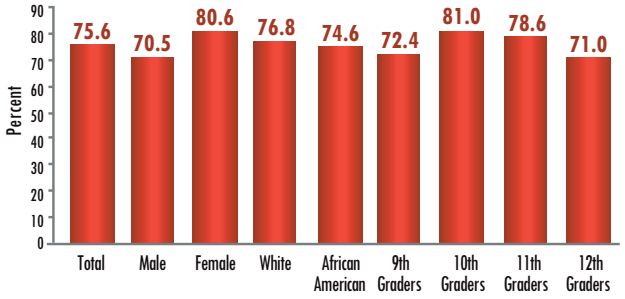
DATA TRENDS & DISPARITIES: According to the 2009 LA YRBS,[3] 40.3% of high school students in Louisiana exceeded recommendations for TV, videos, or video game usage, while 59.7% met recommended limits of no more than 2 hours a day (Figure 3). A higher percentage of males

Figure 3: Percentage of High School Students in Louisiana who Did Not Exceed Recommended Limits for TV/Video, and Video Games (NO MORE THAN 2 HOURS A DAY) (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

Figure 4: Percentage of High School Students in Louisiana who Did Not Exceed Recommended Limits for Computer/Computer Games (NO MORE THAN 2 HOURS A DAY) 2009



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

and White students met recommended limits for TV, videos, and video games compared to their respective counterparts (Figure 3).[3] A lower percentage of 9th graders met recommended limits for TV, videos, or video game usage compared to high school students in other grade levels (Figure 3).[3]

Data from the 2009 LA YRBS[3] also showed that 24.4% of high school students in Louisiana exceeded 2 hours a day for computer and computer game usage, while 75.6% did not exceed recommended limits (Figure 4). A higher percentage of females than males and a higher percentage of White students than African American students met recommended limits for computer and computer game usage (Figure 4).[3]

ACTION STRATEGIES

PARENTS

- Limit television viewing of children to a maximum of two hours per day of quality programming (American Academy of Pediatrics).[15]
- Consider following the American Academy of Pediatrics recommendations for limiting TV time among children (National Prevention Strategy).[4]
- Reduce children's screen (television and computer) time (2010 Dietary Guidelines for Americans).[10]

TEACHERS & SCHOOL ADMINISTRATORS

- The American Academy of Pediatrics guidelines on screen time should be made more available in early childhood settings (White House Task Force).[6]
- Adults working with children should limit screen time, including television, cell phone, or digital media, to less than two hours per day for children aged two – five (Institute of Medicine).[11]
- The school environment should be a primary target for efforts to educate parents concerning the reduction of sedentary behaviors at home such as TV and computer games (Louisiana Department of Health and Hospitals).[17]
- Limit passive screen time (National Prevention Strategy).[4]

POLICY MAKERS

- States should be encouraged to strengthen licensing standards and Quality Rating and Improvement Systems to support good program practices regarding nutrition, physical activity, and screen time in early education and child care settings (White House Task Force).[6]
- Promote policies that reduce sedentary screen time, such as adopting regulatory policies limiting screen time in preschool and after-school programs (Institute of Medicine).[9]

PHYSICIANS & HEALTH CARE PROVIDERS

- Recommend limitation of television and video time to a maximum of 2 hours per day (American Academy of Pediatrics).[15]
- The American Academy of Pediatrics guidelines on screen time should be made more available to parents, and young children should be encouraged to spend less time using digital media and more time being physically active (White House Task Force).[6]
- Healthcare providers should counsel parents and children's caregivers not to permit televisions, computers, or other digital media devices in children's bedrooms or other sleeping areas (Institute of Medicine).[11]

RESEARCHERS

- More research is needed on the dose-response relationship between screen time and health outcomes in children (International Conference on Physical Activity and Obesity in Children).[12]

INDICATOR: SPORTS PARTICIPATION

OBJECTIVE: Increase the proportion of children and adolescents who participate in after-school sports or sports teams.

DATA SOURCE/TRACKING: The National Survey of Children's Health (NSCH) and the Louisiana Youth Risk Behavior Survey (YRBS) will both be used to monitor sports participation among children and youth in Louisiana since each has a different survey population. The NSCH is a proxy report (administered to the parent) of children and adolescents aged 6-17 years old, and the LA YRBS is administered to high school students. The NSCH asks parents if their child was on a sports team or took sports lessons after school or on weekends during the previous 12 months. Categorical responses indicate participation or no participation. The LA YRBS asks students how many sports teams they played on (including any teams run by their school or community groups) during the past 12 months. Response categories range from 0 teams to 3 or more teams.

BASELINE: According to the 2007 NSCH,[18] 51.6% of 6-17 year olds participated in at least one after-school sports team or lesson. Data from the 2009 Louisiana YRBS[3] showed that 50.6% of high school students played on at least one sports teams.

Objective 3: Increase the proportion of children and adolescents who participate in after-school sports or sports teams.

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Children and adolescents aged 6-17	51.6%	2007	NSCH	40% ↑	72.2%
High school students grades 9-12	50.6%	2009	LA YRBS	40% ↑	70.8%

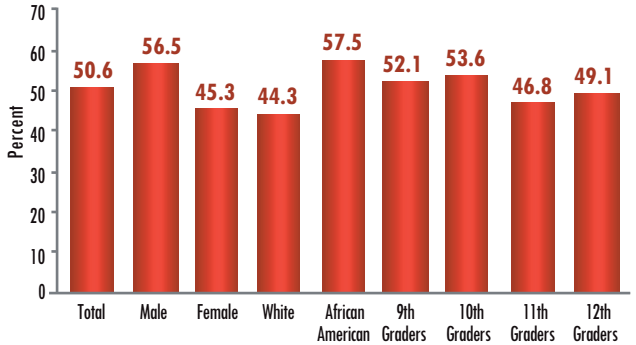
LA 2020 TARGETS: The 2020 targets for sports participation are 72.2% for children and adolescents aged 6-17 years (NSCH) and 70.8% for high school students (LA YRBS).

DATA TRENDS & DISPARITIES: According to the 2009 Louisiana YRBS, 50.6% of high school students in Louisiana played on at least one sports team (Figure 5).[3] Sports participation was higher among males than females, and was also higher among African American students compared to White students (Figure 5).[3] Sports participation was higher among 9th and 10th graders (Figure 5).[3]

Data from the 2007 NSCH[18] also showed that slightly over half (51.6%) of 6-17 year olds participated in after-school sports teams or lessons (Figure 6). Sports participation was lower among females compared to males. African Americans had the lowest rate of sports participation when looking at the 2007 NSCH[18] results by race/ethnicity (Figure 6). Children and youth from lower-income families had lower rates of participation in sports. (Figure 6).[18]

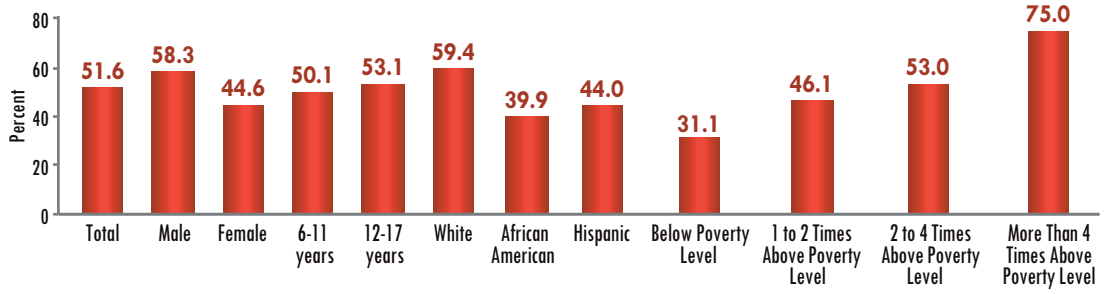
To meet the 2020 targets for sports participation, efforts will be needed to increase sports participation among females and reduce racial and economic disparities in sports participation. It will also be important to understand underlying causes/differences for the shifting racial disparities between surveys and age groups (6-17 year olds vs. high school students).

Figure 5: Percentage of High School Students in Louisiana who Played on at Least One School or Community Sports Teams (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

Figure 6: Percentage of Children and Youth (6-17 yrs) in Louisiana that Participated in at Least One-After-School Sports Teams or Lessons in the Past 12 Months 2007



Source: Child and Adolescent Health Measurement Initiative, Maternal and Child Health Bureau. 2007 National Survey of Children's Health. Retrieved from www.nschdata.org

ACTION STRATEGIES

PARENTS

- Use existing athletics and sports infrastructures and programs to enhance physical activity opportunities in communities (National Physical Activity Plan).[7]
- Provide access to and opportunities for physical activity before and after school (National Physical Activity Plan).[7]

TEACHERS & SCHOOL ADMINISTRATORS

- Support interscholastic sports and help decrease prohibitive costs of sports (White House Task Force).[6]
- Offer opportunities for students to participate in intramural physical activity programs during after-school hours (Surgeon General).[5]
- Federal, state, and local educational agencies, in partnership with communities and businesses, should work to support programs to extend the school day, including after-school programs, which offer and enhance physical activity opportunities in their programs (White House Task Force).[6]
- Establish joint use agreements with local government agencies to allow use of school facilities for physical activity programs offered by the school or community-based organizations outside of school hours (Surgeon General).[5]

POLICY MAKERS

- Local governments should be encouraged to enter into joint use agreements to increase children's access to community sites for indoor and outdoor recreation (White House Task Force).[6]
- Enhance the existing parks, recreation, fitness, and sports infrastructure to build capacity to disseminate policy and environmental interventions that promote physical activity (National Physical Activity Plan).[7]
- Communities should increase opportunities for extracurricular physical activity (Centers for Disease Control and Prevention).[19]

PHYSICIANS & HEALTH CARE PROVIDERS

- Professionals in the health sector can contribute to new understanding and practice of healthy behavior by working with the Sport for All Movement – physical activities which are available for everyone (13th World Sport for All Congress).[20]

RESEARCHERS

- Given that there are few studies of the health benefits associated with individual sports, more research is required on discipline-specific efforts of different sports (13th World Sport for All Congress).[21]
- More research is needed to study the cost-effectiveness of sport as a means to increasing physical activity and improving health (13th World Sport for All Congress).[14]

HEALTH AND HEALTH BEVAVIORS

GOAL

Promote health and well-being of children and adolescents and reduce chronic disease risk by increasing physical activity and other healthful behaviors.

INDICATOR: **OVERWEIGHT AND OBESITY**

Objective 4:

Reduce the proportion of children and adolescents who are obese.

INDICATOR: **AEROBIC FITNESS**

Objective 5:

Increase the proportion of adolescents who perform within the Minimum Fitness Standard (MFS) on the PACER sub-test of aerobic fitness.

INDICATOR: **OVERALL PHYSICAL AND EMOTIONAL WELL-BELING**

Objective 6:

Reduce the proportion of adolescents who have attempted suicide.

INDICATOR: **FRUIT AND VEGETABLE CONSUMPTION**

Objective 7:

Increase the intake of fruits and vegetables in the diets of adolescents.

INDICATOR: **TOBACCO USE**

Objective 8:

Reduce tobacco use by adolescents.

INDICATOR: OVERWEIGHT AND OBESITY

BACKGROUND: The Body Mass Index (BMI) is a measurement of overweight and obesity and is calculated as weight (kg) divided by height (m^2).[22] Gender and age specific BMI percentiles for children and youth can be determined by using growth charts developed by the Centers for Disease Control and Prevention (CDC).[23] According to the American Academy of Pediatrics (AAP),[22] children and adolescents whose gender-specific BMI-for-age is ≥ 85th percentile but < 95th percentile should be classified as overweight, and those with a BMI ≥ 95th percentile should be considered obese. The rates of obesity that are presented in this Report Card are based on calculations of children's BMI and are classified according to the AAP recommendations (≥ 95th percentile).

OBJECTIVE: Reduce the proportion of children and adolescents who are obese.

DATA SOURCE/TRACKING: A number of different data sources, each with a different survey population, are available to track and monitor obesity rates among children and youth in Louisiana: the Pediatric Nutrition Surveillance System (PedNSS)[24] will be used to monitor obesity rates among young children aged 2 to 5 who are in low-income households who attend federally-funded maternal and child health nutrition programs, the National Survey of Children's Health (NSCH)[18] will be used to assess the obesity rates of children and youth aged 10-17 yrs, the Louisiana Youth Risk Behavior Survey (YRBS)[3] will be used to assess obesity among high school students, and data from the Louisiana School-Based Health Centers (SBHCs) will also be used to monitor obesity rates among children and adolescent ages 2 to 19 years who attended those health centers.[25]

BASELINE: According to the 2007 PedNSS,[24] 13.8% of children aged 2 to 5 years who attended federally-funded maternal and child health nutrition programs were obese. The 2007 NSCH[18] showed that 20.7% of children aged 10 to 17 years were obese, while the 2009 Louisiana YRBS[3] showed that the obesity rate for high school students was 14.7%, and 2008-2009 data from the Louisiana SBHCs[25] showed that 29.0% of its attendees (children and adolescents 2 to 19 years of age) were obese.

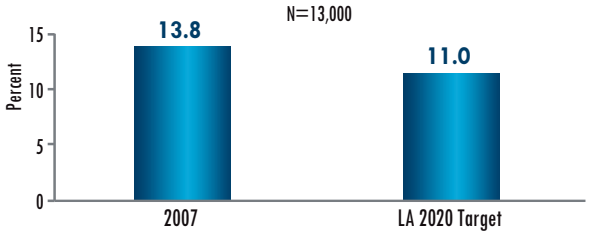
Objective 4: Reduce the proportion of children and adolescents who are obese.

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Children aged 2 to 5	13.8%	2007	PedNSS	20% ↓	**11.0%**
Children aged 10 to 17	20.7%	2007	NSCH	20% ↓	**16.6%**
Adolescents in grades 9-12	14.7%	2009	LA YRBS	20% ↓	**11.8%**
Children & adolescents age 2 to 19	29.0%	2008-2009	LA SBHCs	20% ↓	**23.2%**

LA 2020 TARGETS: To reduce the proportion of children and adolescents who are obese, the 2020 targets are: 11.0% for children aged 2 to 5 years (PedNSS), 16.6% for children aged 10-17 years (NSCH), 11.8% for high school students in grades 9-12 (LA YRBS), and 23.2% for children aged 2-19 years (SBHCs).

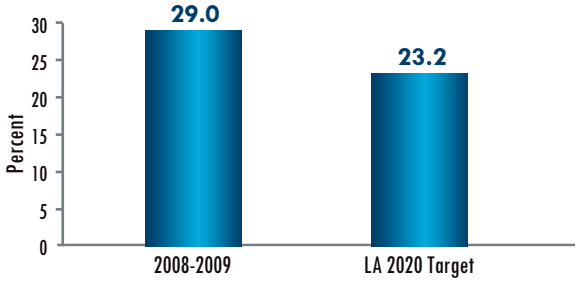
DATA TRENDS & DISPARITIES: Results from the 2007 PedNSS[24] showed that 13.8% of children aged 2-5 years in Louisiana who attended federally-funded maternal and child health nutrition programs were obese (Figure 7).

Figure 7: Percentage of Obese Children Aged < 5 Years, PedNSS (Low-income Children in Federally Funded Maternal and Child Health Programs)



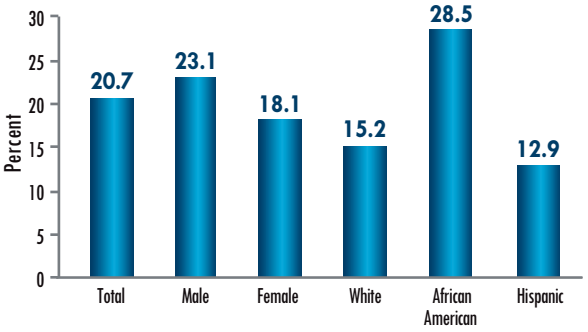
Source: Polhamus B, Dalenius K, Borland E, Mackintosh H, Smith B, Grummer-Strawn L. Pediatric Nutrition Surveillance 2007 Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009. Retrieved from http://www.cdc.gov/pednss/pdfs/PedNSS_2007.pdf

Figure 8: Percentage of Obese Children and Adolescents (ages 2-19) in Louisiana who Were Seen in School Based Health Centers



Source: Romero P, Louisiana Council on Obesity Prevention and Management. Obesity Data from the Louisiana Department of Health and Hospitals Adolescent School Health Program - Louisiana School Based Health Centers 2010.

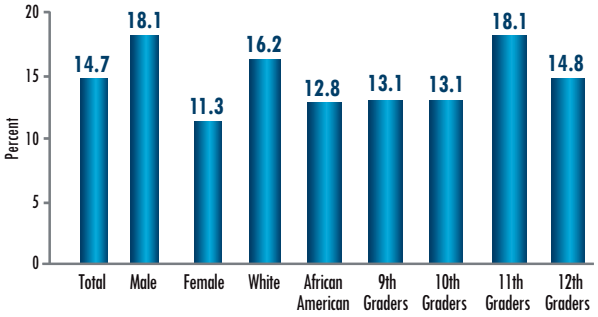
Figure 9: Percentage of Children and Youth (ages 10-17) in Louisiana who Were Obese 2007



Source: Child and Adolescent Health Measurement Initiative, Maternal and Child Health Bureau. 2007 National Survey of Children's Health. Retrieved from www.nschdata.org

Twenty-nine percent of children and adolescents aged 2-19 years who attended Louisiana School-Based Health Centers were obese, according to 2008-2009 data (Figure 8).[25] The 2007 NSCH[18] showed that obesity rates among children and youth aged 10-17 years reached 20.7% (Figure 9). Results also showed gender and racial disparities, with higher rates of obesity among males and African Americans compared to their respective counterparts (Figure 9).[18] Data from the 2009 Louisiana YRBS[3] showed that the rate of obesity among high school students was 14.7% (Figure 10). There were higher obesity rates among males than females and among White students compared to African American students (Figure 10). Obesity rates were highest among 11th graders (Figure 10).[3]

Figure 10: Percentage of High School Students in Louisiana that Were Obese (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

ACTION STRATEGIES

PARENTS

- Pregnant women and women planning a pregnancy should be informed of the importance of conceiving at a healthy weight and having a healthy weight gain during pregnancy, based on the relevant recommendations of the Institute of Medicine (White House Task Force).[6]
- Prepare healthier meals that replace high-calorie foods with more fruits and vegetables, and help children meet physical activity recommendations (2010 Dietary Guidelines).[10]

TEACHERS & SCHOOL ADMINISTRATORS

- The school environment should be a primary target for efforts to educate parents concerning obesity prevention since children spend 50% of their waking hours in school-related activities (Louisiana Department of Health and Hospitals).[17]
- Child care providers should identify and use resources that recommend effective approaches to promoting physical activity, good nutrition, and healthy sleep in early childhood settings (Surgeon General).[5]

POLICY MAKERS

- More national, state and local funds are needed for programs that work simultaneously to conduct research and provide ongoing interventions to prevent and treat overweight/obesity among children (Louisiana Department of Health and Hospitals).[17]
- Participate in community coalitions or partnerships to address obesity (Centers for Disease Control and Prevention).[19]
- Recognize health disparities among subpopulations and ensure equitable access to safe and affordable healthy foods and opportunities for physical activity for all people (2010 Dietary Guidelines).[10]

- Develop legislation, policies, and systems in key sectors such as public health, health care, retail, school food service, recreation/fitness, transportation, and nonprofit/volunteer to prevent and reduce obesity (2010 Dietary Guidelines).[10]
- Support future research that will further examine the individual, community, and system factors that contribute to the adoption of healthy eating and physical activity behaviors; identify best practices and facilitate adoption of those practices (2010 Dietary Guidelines).[10]
- Identify approaches for assessing and tracking children's body mass index (or other valid measures) for use by health professionals to identify overweight and obesity and implement appropriate interventions (2010 Dietary Guidelines).[10]

PHYSICIANS & HEALTH CARE PROVIDERS

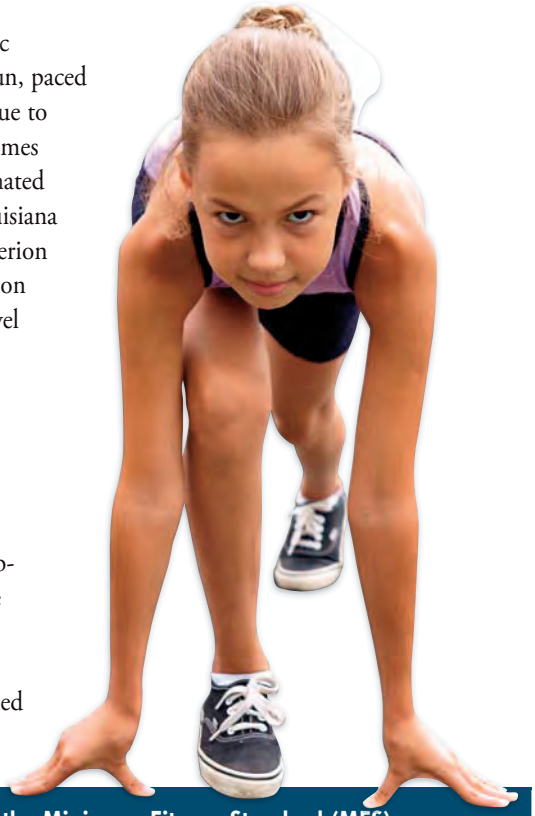
- Educational interventions that target the parents of children at risk for obesity should be an integral part of standard pediatric and family medical care (Louisiana Department of Health and Hospitals).[17]
- Medical and other health professional schools, health professional associations, and health care systems should ensure that health care providers have the necessary training and education to effectively prevent, diagnose, and treat obese and overweight children (White House Task Force).[6]
- Promote effective prenatal counseling about maternal weight gain, breast-feeding, the relationship between obesity and diabetes, and the need to avoid alcohol, tobacco, and drug use during pregnancy (Surgeon General).[5]
- Measure/calculate children's BMI, deliver appropriate care, and provide information to parents about how to help their children achieve a healthy weight and that obesity increases the risk for disease and disability (White House Task Force, National Prevention Strategy, Surgeon General, American Academy of Pediatrics).[4-6, 26]
- Healthcare providers should measure weight and length/height and plot on growth charts as part of every well-child visit (Institute of Medicine).[11]
- Ensure that patients are referred to resources (both internal and external) that will help them meet their psychological, nutritional, and physical activity needs (Surgeon General).[5]
- Federally-funded and private insurance plans should cover services necessary to prevent, assess, and provide care to overweight and obese children (White House Task Force).[6]
- Recognize and monitor changes in obesity-associated risk factors for adult chronic disease, such as hypertension, dyslipidemia, hyperinsulinemia, impaired glucose tolerance, and symptoms of obstructive sleep apnea syndrome (American Academy of Pediatrics).[15]

RESEARCHERS

- Educational interventions that provide early parent education concerning the risk factors for obesity, appropriate nutrition and physical activity for developing children are needed (Louisiana Department of Health and Hospitals).[17]
- Determine the types and amounts of physical activity that are needed to prevent the development of excessive adiposity during childhood and adolescence (Physical Activity Guidelines Advisory Committee Report).[27]
- Given the importance of energy balance in the development of obesity, more research is required to understand the efforts of the total volume of energy expenditure (i.e. area under the curve) rather than moderate-to-vigorous physical activity per se on the development of obesity (International Conference on Physical Activity and Obesity in Children).[12]
- There is a need for ongoing work on the definitions of overweight and obesity in children and youth, particularly studies that investigate the influence of ethnicity on the utility of BMI-for-age cut-points for identifying obesity-related health risks (International Conference on Physical Activity and Obesity in Children).[12]

INDICATOR: AEROBIC FITNESS

BACKGROUND: Aerobic fitness can be measured using the Progressive Aerobic Cardiovascular Endurance Run (PACER).[28] The PACER is a 20-meter shuttle run, paced to music which progressively increases in speed after each run.[28] Students continue to complete each trial until they can no longer complete the run before the music times out.[28] The PACER is one sub-test of Health-Related Fitness Assessments coordinated by the Cecil J. Picard Center for Child Development and Lifelong Learning, Louisiana universities and school districts collaborate with the center to administer this criterion reference measurement tool that uses age- and sex-specific cutoff values, or criterion referenced health standards to determine if a child has achieved the minimum level of fitness performance needed for good health and reduced risk of a poor health outcome.[28]



OBJECTIVE: Increase the proportion of adolescents who perform within a Minimum Fitness Standard (MFS) on the PACER sub-test of aerobic fitness.

DATA SOURCE/TRACKING: Statewide results collected from the PACER sub-test of Health-Related Physical Fitness Assessments [29] will be used to monitor the proportion of adolescents who have a performed within the MFS.

BASELINE: Thirty-nine percent of adolescents aged 10-18 years of age performed within the MFS on the PACER, according to 2009-2010 Fitness Assessments.[29]

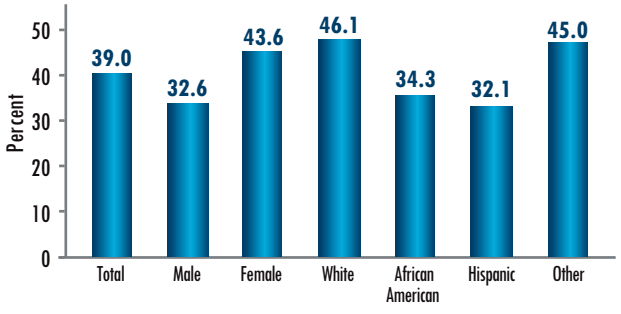
Objective 5: Increase the proportion of adolescents who perform within the Minimum Fitness Standard (MFS) on the PACER sub-test of aerobic fitness.

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Adolescents aged 10-18	39.0%	2009-2010	Health-Related Physical Fitness Assessments	20% ↑	46.8%

LA 2020 TARGET: Increase the proportion of children performing within the MFS on the PACER to 46.8%.

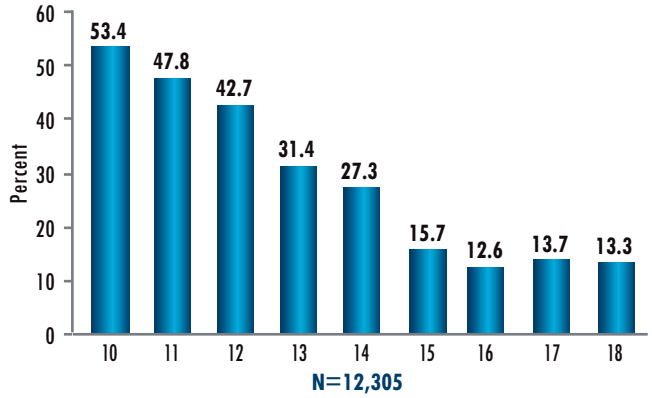
DATA TRENDS & DISPARITIES: Thirty-nine percent of students who participated in 2009-2010 Fitness Assessments performed within the MFS on the PACER Sub-Test (Figure 11).[29] A higher proportion of female students performed within the MFS on the PACER compared to male students, and a higher proportion of White students performed within the MFS compared to children of other racial/ethnic backgrounds (Figure 11).[29]

Figure 11: Percentage of Children and Youth (ages 10-18) that Performed within the MFS on the PACER 2009-2010



Source: Cecil J. Picard Center for Child Development and Lifelong Learning. 2009-2010 Health-Related Physical Fitness Assessments.

Figure 12: Percentage of Children and Youth (ages 10-18) that Performed within the MFS on the PACER by Age



Source: Cecil J. Picard Center for Child Development and Lifelong Learning. 2009-2010 Health-Related Physical Fitness Assessments.

Rates of MFS achievement decreased with increasing age (Figure 12).[29] While 53.4% of 10 year olds achieved a MFS on the PACER, only 13.3% of 18 year olds performed within the MFS (Figure 12).[29] In order to achieve the 2020 target, efforts will need to be made to eliminate racial disparities in aerobic fitness and also increase aerobic fitness among older children.

ACTION STRATEGIES

Action strategies specifically in the area of promoting aerobic fitness are currently lacking. However, the Physical Activity Guidelines Advisory Committee Report[27] concluded that physical activity is associated with aerobic fitness. Many studies have shown this positive relationship[27-32], and aerobic fitness can be improved with physical activity.[27, 30-33] Thus, by promoting and increasing physical activity for children and youth using the action strategies provided for physical activity (see page 18), there is the potential to also benefit children's aerobic fitness levels.

INDICATOR: OVERALL PHYSICAL AND EMOTIONAL WELL-BEING

BACKGROUND: See the 2010 Report Card for a more detailed explanation of the link between emotional health and physical activity.

OBJECTIVE: Reduce the proportion of adolescents who have attempted suicide.

DATA SOURCE/TRACKING: The Louisiana Youth Risk Behavior Survey (YRBS) will be used to monitor overall physical and emotional well-being among adolescents in grades 9-12. One indicator of emotional well-being at the population level is the proportion of adolescents who have attempted suicide. The LA YRBS asks students how many times they actually attempted suicide during the past 12 months. Response categories range from 0 times to 6 or more times.

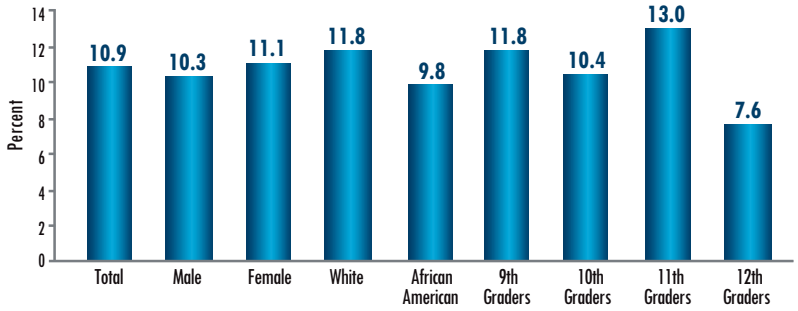
BASELINE: According to the 2009 Louisiana YRBS,[3] 10.9% of adolescents had attempted suicide during the 12 months preceding the survey.

Objective 6: Reduce the proportion of adolescents who have attempted suicide					
	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Adolescents in grades 9-12	10.9%	2009	LA YRBS	40% ↓	6.5%

LA 2020 TARGET: To reduce the proportion of adolescents who have attempted suicide from 10.9% to 6.5%.

DATA TRENDS & DISPARITIES:
According to the data from the 2009 LA YRBS, 10.9% of high school students in Louisiana attempted suicide during the 12 months preceding the survey (Figure 13).[3] Rates of attempted suicide were nearly equal between males and females and was higher among White students and 11th graders (Figure 13).[3]

Figure 13: Percentage of High School Students in Louisiana who Attempted Suicide One or More Times During the Past 12 Months (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

ACTION STRATEGIES

PARENTS

- Build strong, positive relationships with family and friends (National Prevention Strategy).[4]
- Become more involved in the community (e.g., mentor or tutor youth, join a faith or spiritual community)(National Prevention Strategy).[4]
- Encourage children and adolescents to participate in extracurricular and out-of-school activities (National Prevention Strategy).[4]
- Work to make sure children feel comfortable talking about problems such as bullying and seek appropriate assistance as needed (National Prevention Strategy).[4]

TEACHERS & SCHOOL ADMINISTRATORS

- Schools should have comprehensive wellness plans that include an active school health council to guide health-related policy decisions (Surgeon General).[5]
- School districts should be encouraged to create, post, and implement a strong local school wellness policy (White House Task Force).[6]
- Schools should have a school and school workplace wellness policy that includes teachers and other school employees to model healthy behaviors (Surgeon General).[5]

- Ensure students have access to comprehensive health services, including mental health and counseling services (National Prevention Strategy).[4]
- Implement programs and policies to prevent abuse, bullying, violence, and social exclusion, build social connectedness, and promote positive mental and emotional health (National Prevention Strategy).[4]
- Implement programs to identify risks and early indicators of mental, emotional, and behavioral problems among youth and ensure that youth with such problems are referred to appropriate services (National Prevention Strategy).[4]

POLICY MAKERS

- Enhance data collection systems to better identify and address mental and emotional health needs (National Prevention Strategy).[4]
- Include safe shared spaces for people to interact (e.g., parks, community centers) in community development plans which can foster healthy relationships and positive mental health among community residents (National Prevention Strategy).[4]
- Ensure that those in need, especially potentially vulnerable groups, are identified and referred to mental health services (National Prevention Strategy).[4]
- Pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas, such as rural communities (National Prevention Strategy).[4]
- Develop state and local systems involving partnerships among families, schools, courts, health care providers, and local programs to create coordinated approaches that support healthy development (Institute of Medicine).[34]
- Invest in prevention and promotion, including setting aside resources for evidence-based prevention in mental health service programs and investment in proven prevention approaches by school systems (Institute of Medicine).[34]

PHYSICIANS AND HEALTH CARE PROVIDERS

- Educate parents on normal child development and conduct early childhood interventions to enhance mental and emotional well-being (National Prevention Strategy).[4]
- Screen for mental health needs among children and adults, especially those with disabilities and chronic conditions, and refer people to treatment and community resources as needed (National Prevention Strategy).[4]
- Develop integrated care programs to address mental health, substance abuse, and other needs within primary care settings (National Prevention Strategy).[4]
- Enhance communication and data sharing (with patient consent) with social services networks to identify and treat those in need of mental health services (National Prevention Strategy).[4]

RESEARCHERS

- Focus on interventions that occur before the onset of mental, emotional, or behavior and that include the promotion of mental, emotional, and behavioral health (Institute of Medicine).[35]
- Broaden the range of outcomes included in evaluation of prevention programs and policies related to mental, emotional, and behavior disorders (Institute of Medicine).[35]
- Include analysis of the costs and cost-effectiveness of interventions focused on mental, emotional, and behavioral disorders/health (Institute of Medicine).[35]
- Form partnerships with community organizations to develop evaluations of: 1) adaptation of existing interventions in response to community-specific cultural characteristics; 2) preventive interventions designed based on research principles in response to community concerns; and 3) preventive interventions that have been developed in the community, have demonstrated feasibility of implementation and acceptability in that community, but lack experimental evidence of effectiveness (Institute of Medicine).[35]

INDICATOR: FRUIT AND VEGETABLE CONSUMPTION

BACKGROUND: The 2010 Dietary Guidelines for Americans[10] recommends that children and adults (aged 2 and up) should increase their consumption of fruits and vegetables to achieve: health benefits, a healthy eating pattern, and appropriate nutrients while staying within their caloric needs. The caloric needs of children and youth depends on their age, gender and level of physical activity (see Table 2 & Table 3 below).[10, 36] Based on a 2,000 calorie diet, children should consume 2 cups (4 servings) of fruit and 2 ½ cups (5 servings) of vegetables; however, these amounts should be adjusted to daily caloric needs.[10, 36]

Table 2:
Calorie Needs Per Day by Age, Gender, and Physical Activity Level

Age	Male			Female		
	Sedentary	Moderately Active	Active	Sedentary	Moderately Active	Active
2	1,000	1,000	1,000	1,000	1,000	1,000
3	1,200	1,400	1,400	1,000	1,200	1,400
4	1,200	1,400	1,600	1,200	1,400	1,400
5	1,200	1,400	1,600	1,200	1,400	1,600
6	1,400	1,600	1,800	1,200	1,400	1,600
7	1,400	1,600	1,800	1,200	1,600	1,800
8	1,400	1,600	2,000	1,400	1,600	1,800
9	1,600	1,800	2,000	1,400	1,600	1,800
10	1,600	1,800	2,200	1,400	1,800	2,000
11	1,800	2,000	2,200	1,600	1,800	2,000
12	1,800	2,200	2,400	1,600	2,000	2,200
13	2,000	2,200	2,600	1,600	2,000	2,200
14	2,000	2,400	2,800	1,800	2,000	2,400
15	2,200	2,600	3,000	1,800	2,000	2,400
16	2,400	2,800	3,200	1,800	2,000	2,400
17	2,400	2,800	3,200	1,800	2,000	2,400
18	2,400	2,800	3,200	1,800	2,000	2,400

Sources: Britten P, Marcoe K, Yamini S, Davis C. Development of food intake patterns for the MyPyramid Food Guidance System. J Nutr Educ Behav 2006;38(6 Suppl):S78-S92.

U.S. Department of Agriculture, U.S. Department of Health and Human Services. Dietary Guidelines for Americans, 2010. 7th Edition. Washington, DC: U.S. Government Printing Office; December 2010. Available at: *http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/PolicyDoc.pdf*.

Table 3: USDA Recommendations for Fruits and Vegetables Per Day (cups, c) by Daily Caloric Needs

Caloric Needs	Fruits	Vegetables
1,000	1 c	1 c
1,200	1 c	1 ½ c
1,400	1 ½ c	1 ½ c
1,600	1 ½ c	2 c
1,800	1 ½ c	2 ½ c
2,000	2 c	2 ½ c
2,200	2 c	3 c
2,400	2 c	3 c
2,600	2 c	3 ½ c
2,800	2 ½ c	3 ½ c
3,000	2 ½ c	4 c
3,200	2 ½ c	4 c

Sources: Britten P, Marcoe K, Yamini S, Davis C. Development of food intake patterns for the MyPyramid Food Guidance System. J Nutr Educ Behav 2006;38(6 Suppl):S78-S92.

U.S. Department of Agriculture, U.S. Department of Health and Human Services. Dietary Guidelines for Americans, 2010. 7th Edition. Washington, DC: U.S. Government Printing Office; December 2010. Available at: *http://www.cnpp.usda.gov/Publications/Dietaryguidelines/2010/PolicyDoc/PolicyDoc.pdf*

OBJECTIVE: Increase the intake of fruits and vegetables in the diets of adolescents.

DATA SOURCE/TRACKING: The Louisiana Youth Risk Behavior Survey (YRBS) will be used to monitor fruit and vegetable consumption among adolescents in grades 9-12. The LA YRBS asks students how many times they ate fruit during the past 7 days. Response categories are: none, 1-3 times during the past 7 days, 4-6 times during the past 7 days, 1 time per day, 2 times per day, 3 times per day, and 4 or more times per day. To ascertain students' total vegetable consumption, the YRBS asks students four separate

questions about how many times during the past 7 days that they ate: 1) green salad; 2) potatoes, excluding french fries, fried potatoes, or potato chips; 3) carrots; or 4) other vegetables. For each of these questions, response categories are: none, 1 to 3 times during the past 7 days, 4 to 6 times during the past 7 days, 1 time per day, 2 times per day, 3 times per day, and 4 or more times per day.

BASELINE: 3.5% of high school students ate fruit for ≥ 4 times per day, and 9.7% ate vegetables ≥ 3 times per day, according to 2009 LA YRBS data.[3]

Objective 7: Increase the intake of fruits and vegetables in the diets of adolescents in grades 9-12.					
	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Fruits	3.5% ate fruit ≥ 4 times per day	2009	LA YRBS	40% ↑	4.9%
Vegetables	9.7% ate vegetables ≥ 3 times per day	2009	LA YRBS	40% ↑	13.6%

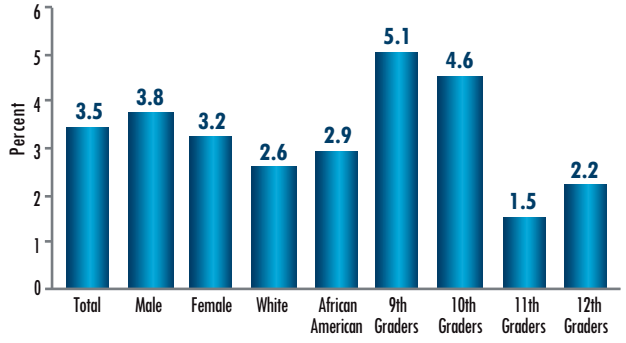
LA 2020 TARGET: Increase the proportion of children consuming fruit ≥ 4 times per day and vegetables ≥ 3 times per day to 4.9% and 13.6%, respectively.

DATA TRENDS & DISPARITIES: Only 3.5% of high school students ate fruit four or more times per day according to results from the 2009 YRBS data (Figure 14).[3] Fruit consumption (4 or more times per day) was higher among males and among African American students (Figure 14).[3] Fruit consumption was also higher among students in grades 9 and 10 (Figure 14).[3]

The 2009 LA YRBS showed that 9.7% of high school students reported that they ate vegetables (excluding French fries, fried potatoes, or potato chips) three or more times per day.[3] Vegetable consumption was higher among males and among White students (Figure 15).[3] Vegetable consumption varied between grade levels (Figure 15).[3]

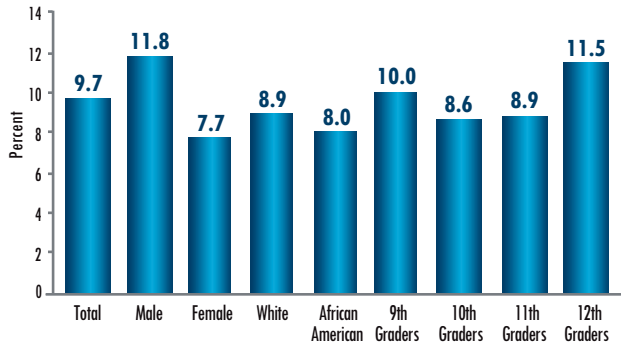
The data selected to track progress in fruit and vegetable consumption are from the YRBS, a survey of high school students. Unfortunately, there are little or no data available on the dietary patterns of younger children in Louisiana. This is a serious limitation of the current health surveillance system for children in Louisiana.

Figure 14: Percentage of High School Students in Louisiana who Ate Fruit Four or More Times Per Day (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

Figure 15: Percentage of High School Students in Louisiana who Ate Vegetables Three or More Times Per Day (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

ACTION STRATEGIES

PARENTS

- Eat less by avoiding oversized portions, make half of the plate fruits and vegetables, make at least half of the grains whole grains, switch to fat-free or low-fat (1%) milk, choose foods with less sodium, and drink water instead of sugary drinks (National Prevention Strategy).[4]
- Reduce portions, especially of high-calorie foods and replace with lower calorie foods such as vegetables and fruits (2010 Dietary Guidelines).[10]
- Increase fruit and vegetable intake – eat recommended amounts. Include fruits and vegetables in meals and snacks, when eating out, and increase availability of fruits and vegetables in your home (2010 Dietary Guidelines).[10]
- Plan ahead to make better food choices by preparing and packing healthy meals at home for children to eat at school and having healthy snacks available at home and available for on-the-go (2010 Dietary Guidelines).[10]
- Cook and eat more meals at home, instead of eating out and prepare meals to include vegetables, fruits, whole grains, fat-free or low-fat dairy products, and protein foods that provide fewer calories and more nutrients (2010 Dietary Guidelines).[10]
- Think about choosing healthy options when eating out by checking calorie counts online and by choosing dishes that include vegetables, fruits, and/or whole grains (2010 Dietary Guidelines).[10]

TEACHERS & SCHOOL ADMINISTRATORS

- Ensure that all meals and snacks sold and served in schools and childcare and early childhood settings are consistent with the Dietary Guidelines (2010 Dietary Guidelines).[10]
- Child care regulatory agencies should require that all meals, snacks, and beverages served by early childhood programs are consistent with the Child and Adult Care Food Program meal patterns and safe drinking water be available and accessible to the children (Institute of Medicine).[11]
- Increase the alignment of foods sold at school, including in the a la carte lines and vending machines, with the Dietary Guidelines (White House Task Force).[6]
- Implement and enforce policies that increase the availability of healthy foods, including in a la carte lines, school stores, vending machines, and fundraisers (National Prevention Strategy).[4]
- Schools should ensure availability of appealing, healthy food options that enable students to comply with recommendations in the U.S. Dietary Guidelines for Americans, including fresh fruits and vegetables, whole grains, and lean proteins (Surgeon General).[5]
- Ensure that child care and after-school program licensing agencies encourage utilization of the nutrition assistance programs and increase nutrition enrollment (CACFP, Afterschool Snack Program, and the Summer Food Service Program) (Institute of Medicine).[9]

- Develop policies and programs that support farm-to-school programs and target schools that serve a large number of children who are eligible to receive free or reduced-price meals (Robert Wood Johnson Foundation Leadership for Healthy Communities).[8]
- School environments that offer healthy food choices and increased opportunities for physical activity should be promoted. This may include initiatives to remove vending machines that offer large-portion, unhealthy snacks and the discouragement of providing unhealthy food (pizza party, donut day, etc.) as rewards for good behavior or academic accomplishment (Louisiana Department of Health and Hospitals).[17]
- Update cafeteria equipment (e.g., remove deep fryers, add salad bars) to support provision of healthier foods (National Prevention Strategy, White House Task Force).[4, 6]

POLICY MAKERS

- Establish nutrition requirements in child care by using national recommendations such as the Dietary Guidelines for Americans (Surgeon General).[5]
- Strengthen licensing standards for early learning centers to include nutritional requirements for foods and beverages sold (National Prevention Strategy).[4]
- Encourage publicly and privately-managed facilities that serve children, such as hospitals, afterschool programs, recreation centers, and parks (including national parks) to implement policies and practices, consistent with the Dietary Guidelines, to promote healthy foods and beverages and reduce or eliminate the availability of calorie-dense, nutrient-poor foods (White House Task Force).[6]

- Ensure that foods served or sold in government facilities and government-funded programs and institutions such as schools and juvenile correctional facilities meet nutrition standards consistent with the Dietary Guidelines for Americans (National Prevention Strategy).[4]
- Mandate and implement strong nutrition standards for foods and beverages available in government-run or regulated after-school programs, recreation centers, parks, and childcare facilities, including limiting access to unhealthy foods and beverages (Institute of Medicine).[9]
- Government agencies should promote access to affordable healthy foods for infants and young children from birth to age five in all neighborhoods, including those in low-income areas, by maximizing participation in federal nutrition assistance programs and increasing access to healthy foods at the community levels. For children that qualify, maximize participation in federal nutrition assistance programs (Special Supplemental Nutrition Program for Women, Infants, and Children, the Child and Adult Care Food Program, and the Supplemental Nutrition Assistance Program)(Institute of Medicine).[11]
- Increase participation rates in USDA nutrition assistance programs through creative outreach and improved customer service, state adoption of improved policy options and technology systems, and effective practices to ensure ready access to nutrition assistance program benefits, especially for children (White House Task Force).[6]
- Put policies in place that require government-run and-regulated agencies responsible for administering nutrition assistance programs to collaborate across agencies and programs to increase enrollment and participation in these programs (i.e., WIC agencies should ensure that those who are eligible are also participating in SNAP, etc.) (Institute of Medicine).[9]
- Incentive programs should be created to encourage grocery stores to locate in underserved neighborhoods and offer healthier food and beverage choices (White House Task Force, Robert Wood Johnson Foundation Leadership for Healthy Communities, Institute of Medicine, Centers for Disease Control and Prevention, National Prevention Strategy).[4, 6, 8-9, 19]
- Expand access to grocery stores, farmers markets, and other outlets for healthy foods (2010 Dietary Guidelines).[10]
- Encourage communities to promote efforts to provide fruits and vegetables in a variety of settings and encourage the establishment and use of direct-to-consumer marketing outlets such as farmers' markets and community supported agriculture subscriptions (White House Task Force).[6]
- Improve the nutritional quality of foods and beverages served and sold in schools and as part of school-related activities (Institute of Medicine).[9]
- Communities should improve availability of affordable healthier food and beverage choices in public service venues (Centers for Disease Control and Prevention).[19]

PHYSICIANS & HEALTH CARE PROVIDERS

- Encourage parents and caregivers to promote healthy eating patterns by offering nutritious snacks, such as vegetables and fruits, low-fat dairy foods, and whole grains; encouraging children's autonomy in self-regulation of food intake and setting appropriate limits on choices; and modeling healthy food choices (American Academy of Pediatrics).[15]
- Health and education professionals providing guidance to parents of young children and those working with young children should be trained, educated, and have the right tools to increase children's healthy eating and counsel parents about their children's diet (Institute of Medicine).[11]
- Assess and record information on the dietary patterns of pediatric patients (Surgeon General, American Academy of Pediatrics).[5, 26]
- Assess dietary patterns (both quality and quantity of food consumed), provide nutrition education and counseling, and refer people to community resources (e.g., Women, Infants, and Children – WIC, Head Start, County Extension Services, and nutrition programs for older Americans (National Prevention Strategy).[4]

RESEARCHERS

- Demonstrate and evaluate the effect of targeted subsidies on purchases of healthy food through nutrition assistance programs (White House Task Force).[6]
- Analyze the effect of state and local sales taxes on less healthy, energy-dense foods (White House Task Force).[6]

INDICATOR: TOBACCO USE

BACKGROUND: See the 2009/2010 Report Cards for a more detailed explanation of the link between tobacco use, physical activity and other health behaviors.

OBJECTIVE: Reduce tobacco use by adolescents.

DATA SOURCE/TRACKING: The Louisiana Youth Tobacco Survey (LYTS) will be used to monitor tobacco use (total tobacco, cigarette, smokeless tobacco, and cigar use) among adolescents in grades 6-12.

BASELINE: Results from the 2009 LYTS[37] showed that the prevalence of tobacco use reached 30.9% among students in grades 6-12, 15.9% for cigarettes, 9.2% for smokeless tobacco products, and 10.9% for cigar use.

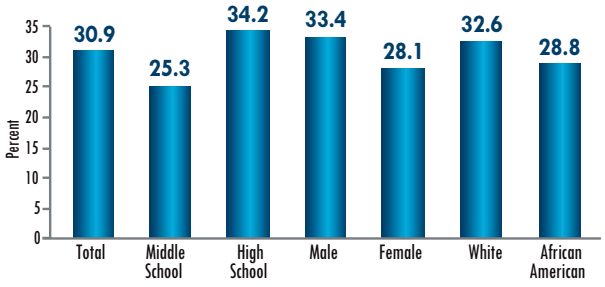
Objective 8: Reduce tobacco use by adolescents in grades 6-12.

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Tobacco products	30.9%	2009	LYTS	40% ↓	18.5%
Cigarettes	15.9%	2009	LYTS	40% ↓	9.5%
Smokeless tobacco products	9.2%	2009	LYTS	40% ↓	5.5%
Cigars	10.9%	2009	LYTS	40% ↓	6.5%

LA 2020 TARGET: Reduce tobacco use by adolescents in grades 6-12 to: 18.5% for tobacco products (overall), 9.5% for cigarettes, 5.5% for smokeless tobacco products, and 6.5% for cigar use.

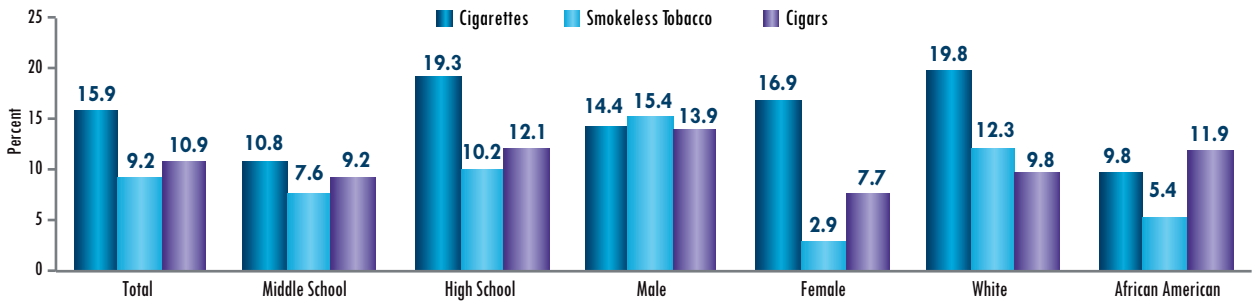
DATA TRENDS & DISPARITIES: The prevalence of tobacco use among students in grades 6-12 reached 30.9%, according to data from the 2009 LYTS (Figure 16).[37] Males were more likely to use tobacco products (overall), smokeless tobacco products, and cigars than females; however, females were more likely to use cigarettes.[37] White students had higher rates of tobacco use (overall), cigarettes, and smokeless tobacco products compared to African American students (Figures 16 & 17).[37] However, African American students had a higher rate of cigar use (Figure 17).[37] Results from the 2009 LYTS[37] show the increased prevalence of tobacco use (overall and by individual types) from middle school students to high school students.

Figure 16: Percentage of High School Students that Used Some Form of Tobacco - Current Users (2009)



Source: Centers for Disease Control and Prevention, Louisiana Department of Health and Hospitals, Chronic Disease Prevention & Control Unit, Louisiana Tobacco Control Program. 2009 Louisiana Youth Tobacco Survey (LYTS). www.latobaccocontrol.com.

Figure 17: Percentage of Students that Indicated Tobacco Use by Type (2009)



Source: Centers for Disease Control and Prevention, Louisiana Department of Health and Hospitals, Chronic Disease Prevention & Control Unit, Louisiana Tobacco Control Program. 2009 Louisiana Youth Tobacco Survey (LYTS). www.latobaccocontrol.com.

ACTION STRATEGIES

PARENTS

- Teach children about the health risks of smoking (National Prevention Strategy).[4]
- Make homes smoke free to protect themselves and family members from secondhand smoke (National Prevention Strategy).[4]
- Quit using tobacco products and ask health care providers for cessation support (National Prevention Strategy).[4]

TEACHERS & SCHOOL ADMINISTRATORS

- Support and develop a 100% Tobacco-Free School policy: prohibit tobacco use at all school facilities and events, year-round; encourage and help students and staff to quit using tobacco; provide instruction that addresses social and psychological causes of tobacco use; be a part of a school wellness program to deliver consistent messages about tobacco use; counter tobacco industry influences on young people, foster community-wide efforts to prevent tobacco use and addiction (Louisiana Tobacco Control Program).[38]
- Promote tobacco free environments (National Prevention Strategy).[4]
- Restrict the marketing and promotion of tobacco products to children and youth (National Prevention Strategy).[4]

POLICY MAKERS

- Implement and sustain comprehensive tobacco prevention and control programs, including comprehensive tobacco free and smoke free policies and paid media advertising (National Prevention Strategy).[4]
- Work with the FDA to enforce the provisions set forth in the Tobacco Control Act (National Prevention Strategy).[4]
- Implement and enforce policies and programs to reduce youth access to tobacco products (National Prevention Strategy).[4]
- Balance traditional beliefs and ceremonial use of tobacco with the need to protect people from secondhand smoke exposure (National Prevention Strategy).[4]
- Enact and enforce laws that mandate the provision of smoke-free environments in all public places (American Academy of Pediatrics).[39]
- Promote programs that contribute to the prevention and decrease of tobacco use by youth, including programs that discourage tobacco use, support anti-tobacco advertising, and teach skills to resist peer and advertising influences (American Academy of Pediatrics).[39]
- Control access to tobacco products by: prohibiting the sale of tobacco products to youth; supporting that all tobacco products should be labeled with warning and health hazards of tobacco use; banning advertising of all tobacco products from all media, events, and venues; banning the sales of products that imitate tobacco products such as candy cigarettes; using tax policies to deter purchase and use of tobacco products (American Academy of Pediatrics).[39]

PHYSICIANS AND HEALTH CARE PROVIDERS

- Know the harms of tobacco use and second-hand smoke exposure and educate patients and their families about those harms. Discussion and anticipatory guidance about tobacco use should ideally begin by 5 years of age and emphasize resisting the influence of advertising and rehearsal of peer-refusal skills (American Academy of Pediatrics).[39]
- Encourage and counsel all parents, including those who smoke, to deliver anti-tobacco messages with their children early in their life and continue to do so throughout childhood and adolescence (American Academy of Pediatrics).[39]
- Implement evidence-based recommendations for tobacco use treatment and provide information to their patients on the health effects of tobacco use and secondhand smoke exposure (National Prevention Strategy).[4]
- Support comprehensive tobacco control and prevention, education, and cessation programs and policies in schools and your community. Educate, participate, promote, and advocate for tobacco control (American Academy of Pediatrics).[39]
- Support clean-air and smoke-free environment ordinances and legislation in your community and state, particularly for environments in which children learn, live, and play, such as schools, multiunit housing, public parks, child care settings, public beaches, sidewalks, restaurants, and sporting arenas (American Academy of Pediatrics).[39]
- Be familiar with tobacco-use-cessation services in your community and provide referrals to these programs for your patients and their families (American Academy of Pediatrics).[39]

RESEARCHERS

- Use media to educate and encourage people to live tobacco free (National Prevention Strategy).[4]
- Develop evidence-based curricula to educate pediatric clinicians on the health effects of second-hand smoke exposure, nicotine addiction and effective treatments (American Academy of Pediatrics).[39]

FAMILY

GOAL

Increase the awareness of the benefits of physical activity for all individuals, and improve family support for achieving adequate levels of physical activity.

INDICATOR: **FAMILY PERCEPTIONS AND ROLES REGARDING PHYSICAL ACTIVITY**

Objective 9:

Increase the proportion of parents who attend events and activities in which their children and adolescents participate.

INDICATOR: FAMILY PERCEPTIONS AND ROLES REGARDING PHYSICAL ACTIVITY

OBJECTIVE: Increase the proportion of parents who attend events and activities in which their children and adolescents participate.

DATA SOURCE/TRACKING: The National Survey of Children's Health (NSCH)[18] will be used to monitor family perceptions and roles regarding physical activity. The NSCH asks parents how often they attend events or activities that their child participated in. Response categories are: never attend, sometimes attend, usually attend, or always attend. The percentage of parents who respond that they usually attend or always attend will be combined for this measure. This question is only asked to parents who indicate that their child participates in sports teams or lessons, clubs or organizations, or any other organized events or activities.

BASELINE: Data from the 2007 NSCH showed that 85.8% of parents usually or always attended their child's activities or events during the 12 months preceding the survey.[18]

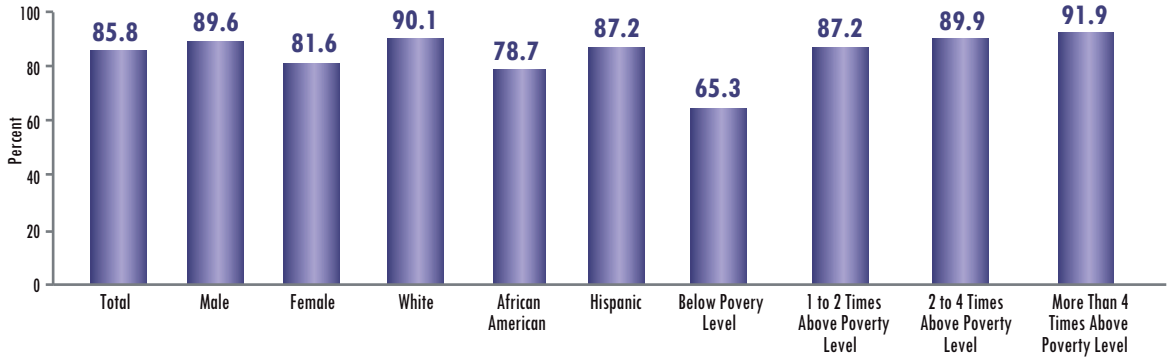
Objective 9: Increase the proportion of parents who attend events and activities in which their children and adolescents participate (during the past 12 months).

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Children and adolescents aged 6-17	85.8%	2007	NSCH	16.6% ↑	100%

LA 2020 TARGET: To increase the proportion of parents who usually or always attend the events and activities of their children from 85.8% to 100%.

DATA TRENDS & DISPARITIES: According to the 2007 NSCH,[18] 85.8% of parents who indicated that their child (ages 6-17 yrs) participated in sports teams or lessons indicated that they usually or always attended those events (Figure 18). Parents of males were more likely to attend events and activities than parents of females (Figure 18).[18] Parental attendance was lower among African Americans than Whites (Figure 18).[18] There were also clear economic disparities in rates of parental attendance at sporting events. When looking at the data by income level, parental attendance at sporting activities or events was lowest among families below poverty level and increased with higher income levels (Figure 18).[18] It is important to note that parental attendance was only asked if they indicated that their child participated in sports teams or lessons, clubs or organization, or any other organized events or activities, thus, eliminating any bias from children's actual participation.

Figure 18: Percentage of Louisiana Parents Who Usually or Always Attended Events and Activities in Which Their Children (6-17 yrs) Participated (2007)



Source: Child and Adolescent Health Measurement Initiative, Maternal and Child Health Bureau. 2007 National Survey of Children's Health. Retrieved from www.nschdata.org

ACTION STRATEGIES

PARENTS

- There is promising evidence for the role of parents and specifically, certain types of parenting behavior, in encouraging physical activity behavior in children. These innovative strategies should be evaluated and adopted (International Conference on Physical Activity and Obesity in Children).[12]
- Increase physical activity by picking activities that are fun and developmentally appropriate for children (2010 Dietary Guidelines).[10]
- Be active with family and friends. Having a support network can help you stay active (2010 Dietary Guidelines).[10]
- Keep track of your physical activity to meet the recommendations in the Physical Activity Guidelines for Americans (2010 Dietary Guidelines).[10]
- Provide time for both structured and unstructured physical activity during school and outside of school (recess, physical activity breaks, physical education classes, after-school programs, and active time with family and friends – youth can learn about physical activity and spend time doing it (2008 Physical Activity Guidelines).[2]
- Provide children and adolescents with positive feedback and good role models. Model and encourage an active lifestyle for children (2008 Physical Activity Guidelines).[2]

TEACHERS & SCHOOL ADMINISTRATORS

- Develop joint-use agreements to increase community and children's and access to school-owned recreation facilities when schools are closed (Robert Wood Johnson Foundation Leadership for healthy communities, White House Task Force, Institute of Medicine, Surgeon General).[5-6, 8-9]
- Teachers should also model and encourage an active lifestyle for children (2008 Physical Activity Guidelines).[2]

POLICY MAKERS

- Promote policies that build physical activity into daily routines at both school and work settings (Institute of Medicine).[9]
- Raise awareness of the importance of increasing physical activity by developing a social marketing program that emphasizes the multiple benefits for children and families of sustained physical activity (Institute of Medicine).[9]
- Promote recreational physical activity by improving access to public and private recreational facilities in communities with limited recreational options through reduced costs, increased operating hours, and development of culturally appropriate activities (Institute of Medicine).[9]

PHYSICIANS & HEALTH CARE PROVIDERS

- Clinicians should advise their patients and their families to adopt and maintain healthy eating and physical activity behaviors consistent with national guidelines and limiting sedentary behaviors such as screen time (American Academy of Pediatrics).[26]
- Encourage parents to model healthy diets and portion sizes, physical activity, and limited television time (American Academy of Pediatrics).[26]
- Encourage an authoritative parenting style in support of increased physical activity and reduced sedentary behavior which provides tangible and motivational support for children (American Academy of Pediatrics).[26]

RESEARCHERS

- More research is required on the effectiveness of family-based physical activity interventions and the role of parenting style on the development of obesity (International Conference on Physical Activity and Obesity in Children).[12]
- More research is necessary in the areas of gender and ethnic differences in parenting and its influence on physical activity to develop culturally appropriate interventions (International Conference on Physical Activity and Obesity in Children).[12]
- There is a need to develop research models to better understand parent mediating variables, and on changing parenting behaviors might affect physical activity and obesity in children (International Conference on Physical Activity and Obesity in Children).[12]
- More research is needed to understand the parent and child decisional factors as they pertain to active play and active commuting. Such information can lead to targeting specific barriers in family interventions to increase physical activity and decrease screen time (International Conference on Physical Activity and Obesity in Children).[12]

SCHOOL AND COMMUNITY

GOAL

Promote school and neighborhood environments that provide and increase opportunities for physical activity throughout the day inclusive of all children.

INDICATOR: PHYSICAL ACTIVITY PROGRAMMING AT SCHOOL

Objective 10:

Increase the proportion of adolescents who participate in daily school physical education.

INDICATOR: TRAINING OF SCHOOL PERSONNEL IN PHYSICAL ACTIVITY

Objective 11:

Establish a database to track and monitor educational certifications for all physical education teachers at the elementary, middle, and high school levels.

INDICATOR: BUILT ENVIRONMENT AND COMMUNITY DESIGN

Objective 12:

Increase the proportion of children and adolescents who have favorable neighborhood amenities that promote physical activity opportunities.

INDICATOR: PHYSICAL ACTIVITY AND PROGRAMMING AT SCHOOL

BACKGROUND: All public elementary and middle schools are required by the Louisiana Department of Education (DOE) to provide a minimum of 150 minutes of physical education (PE) per week for students in grades 1-8.[40] The DOE also requires all public high school students to take at least one and one-half units of PE and another one-half unit of health instruction to fulfill graduation requirements.[40] Students who attend non-public high schools are required to take two units of physical education with at least 30 minutes of health instruction taught in each of the physical education classes.[41] It is recommended that the physical education classes in both public and non-public high schools are taught during the ninth and tenth grade years.[40-41]

OBJECTIVE: Increase the proportion of adolescents who participate in daily school physical education.

DATA SOURCE/TRACKING: The Louisiana Youth Risk Behavior Survey (YRBS) will be used to monitor physical activity programming at school by examining daily physical education participation among adolescents in grades 9-12.[3] The YRBS asks students how many days they go to physical education (PE) classes in an average week when they are in school. Response categories range from 0 days to 5 days.

BASELINE: The proportion of students in Louisiana who attended daily physical education classes in an average school week was 36.4%, according to results from 2009 LA YRBS.[3]

Objective 10: Increase the proportion of adolescents who participate in daily school physical education.

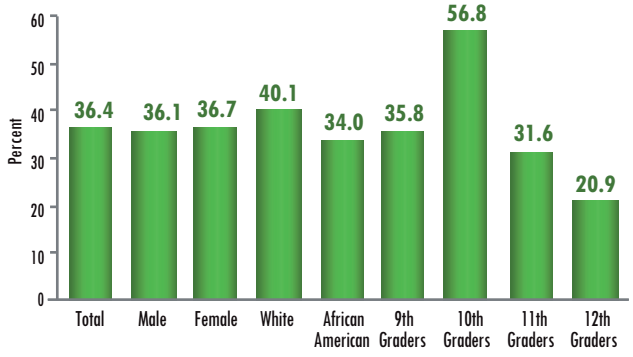
	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
Adolescents in grades 9-12	36.4%	2009	LA YRBS	20% ↑	43.7%

LA 2020 TARGET: Increase the proportion of adolescents in grades 9-12 who participate in daily school physical education to 43.7%.

DATA TRENDS & DISPARITIES: Results from the 2009 LA YRBS showed that the percentage of high school students in Louisiana who attended daily physical education (PE) classes in an average school week was 36.4% (Figure 19).[3] Daily PE attendance was similar between females and males (Figure 19).[3] Daily PE attendance was higher among White students compared to African American students, and among 10th graders.[3]

It is important to note that changes in school policies and scheduling conflicts or recommendations can influence PE attendance and whether students would be more likely to take physical education in certain grades. Thus, while students may take PE during a certain grade, the YRBS asks this question to all students in grades 9-12, which may present some bias in the distribution of the data and the prevalence of participation.

Figure 19: Percentage of High School Students in Louisiana who Attended Physical Education (PE) Classes Daily in an Average School Week (2009)



Source: Centers for Disease Control and Prevention (CDC), Louisiana Department of Education, Division of Student and School Learning Support, Health and Wellness Services Section. 2009 Youth Risk Behavior Survey (YRBS).

ACTION STRATEGIES

PARENTS

- Parents should ask childcare providers about their approach to promoting healthy lifestyles for children, and parents should also visit the child care setting to see how providers model and teach physical activity, good nutrition, and healthy sleep practices (Surgeon General).[5]
- Form partnerships with parent-teacher organizations, families, and community members to support healthy eating and physical activity policies and programs (Surgeon General).[5]

TEACHERS AND SCHOOL ADMINISTRATORS

- Develop and implement state and school district policies requiring school accountability for the quality and quantity of physical education and physical activity programs (National Physical Activity Plan).[7]
- Require and implement a planned and sequential physical education curriculum for pre-kindergarten through grade 12 that is based on national standards (Surgeon General).[5]
- State and local educational agencies should be encouraged to increase the quality and frequency of sequential, age-and developmentally-appropriate physical education for all students, taught by certified physical education teachers (White House Task Force).[6]
- Require daily physical education for students in pre-kindergarten through grade 12, allowing 150 minutes per week for elementary schools and 225 minutes per week for secondary schools (Surgeon General).[5]
- Provide daily physical education and recess that focuses on maximizing time physically active (National Prevention Strategy).[4]
- Create a comprehensive school physical activity program that integrates physical activity into educational settings to encourage sustainable, healthy behaviors (Robert Wood Johnson Foundation Leadership for Healthy Communities).[8]
- Communities should require physical education in schools, increase the amount of physical activity in physical education programs in schools, and increase opportunities for extracurricular physical activity (Centers for Disease Control and Prevention).[19]
- Ensure that early childhood education settings for children ages 0-5 years promote and facilitate physical activity (National Physical Activity Plan).[7]
- State and local educational agencies should be encouraged to promote recess for elementary students and physical activity breaks for older students, and provide support to schools to implement recess in a healthy way that promotes physical activity and social skill development (White House Task Force).[6]
- State and local educational agencies should be encouraged to provide opportunities in and outside of school for students at increased risk for physical activity, including children with disabilities, children with asthma and other chronic diseases, and girls (White House Task Force).[6]

Implement and promote walk-and bike-to-school programs (Surgeon General).[5]

POLICY MAKERS

- Include high-quality physical education as a core requirement in school curricula and set time standards (for example, at least 150 minutes per week)(Robert Wood Johnson Foundation Leadership for Healthy Communities).[8]
- Make 30 minutes of quality daily physical activity a requirement for all students in all grade levels (Robert Wood Johnson Foundation Leadership for Healthy Communities).[8]
- Institute regulatory policies mandating minimum play space, physical equipment, and duration of play in preschool, afterschool, and childcare programs (Institute of Medicine).[9]
- Support walking school buses and Safe Routes to School programs (Robert Wood Johnson Foundation Leadership for Healthy Communities, White House Task Force).[6, 8]

PHYSICIANS AND HEALTH CARE PROVIDERS

Advocate for increasing physical activity at school through intervention programs from grade 1 through the end of high school and college and through the creation of school environments that support physical activity in general (American Academy of Pediatrics).[26]

- Promote physical activity at school and in child care settings (including after-school programs) by asking children and parents about activity in these settings during routine office visits (American Academy of Pediatrics).[26]

RESEARCHERS

- More research is required as to whether physical activity effects classroom behavior and academic achievement in children and adolescents (Physical Activity Guidelines Advising Committee Report).[27]

INDICATOR: TRAINING OF SCHOOL PERSONNEL IN SCHOOL ACTIVITY

BACKGROUND: All newly hired middle and high school physical education teachers in Louisiana are required by the DOE to have either undergraduate or graduate training in physical education or a related field, according to the 2006 School Health Policies and Programs Study (SHPPS).[42] The DOE also requires newly hired middle and high school physical education teachers to be certified, licensed, or endorsed by the state.[42] It is important to note that these are requirements only at the middle and high school levels.[42]

OBJECTIVE: Establish a database to track and monitor the educational certifications for all physical education teachers at the elementary, middle, and high school levels.

ACTION STRATEGIES

Action strategies for this indicator (training of school personnel in physical activity) focus on teacher/school administrators and policy makers, however, they can be related to all sectors of society to promote, advocate, and become involved.

TEACHERS AND SCHOOL ADMINISTRATORS

- Schools should have a comprehensive professional development and credentialing program for staff that addresses health education, physical education, food service, and health services (Surgeon General).[5]
- Encourage post-secondary institutions to incorporate population-focused physical activity promotion training in a range of disciplinary degree and certificate programs (National Physical Activity Plan).[7]

POLICY MAKERS

- State and local educational agencies should be encouraged to increase the quality and frequency of sequential, age-and developmentally-appropriate physical education for all students, taught by certified physical education teachers (White House Task Force).[6]
- Adopt high-quality PE certification standards so teachers are adequately prepared and that require teachers to be adequately trained to teach health education classes (Robert Wood Johnson Leadership for Healthy Communities).[8]
- Increase funding to school districts to provide high-quality physical education classes and teachers (Robert Wood Johnson Leadership for Healthy Communities).[8]

INDICATOR: BUILT ENVIRONMENT AND COMMUNITY DESIGN

OBJECTIVE: Increase the proportion of children and adolescents who have favorable neighborhood amenities that promote physical activity opportunities.

DATA SOURCE/TRACKING: The National Survey of Children's Health (NSCH)[18] will be used to assess the built environment and community design. The NSCH asks parents if sidewalks or walking paths exist in their neighborhood and also whether there are parks or playgrounds in their neighborhood. Item responses are dichotomized into either having these amenities or not having these amenities.

BASELINE: Sixty-two percent of children and youth (ages 0-17 years) had sidewalks or walking paths in their neighborhoods and 65.6% had parks or playgrounds, according to results from the 2007 NSCH.[18]

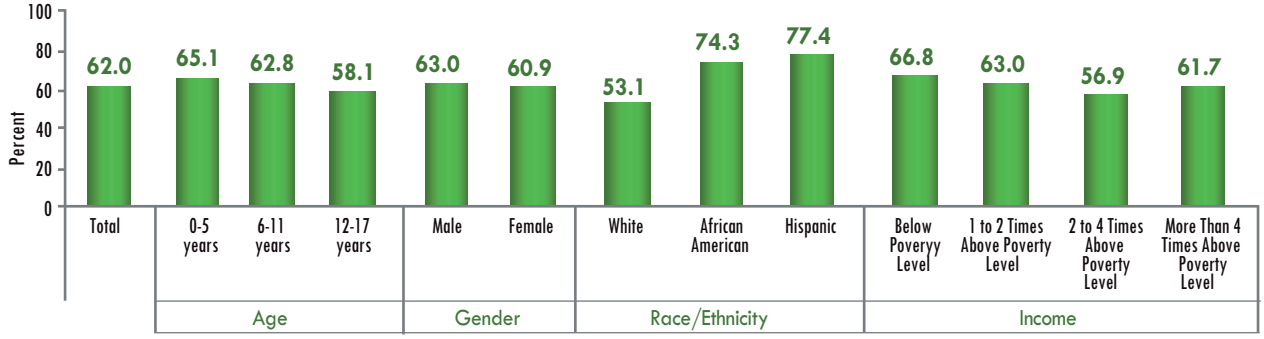
Objective 11: Increase the proportion of children and adolescents (ages 0-17 years) who have favorable neighborhood amenities that promote physical activity opportunities.

	Louisiana Baseline	Baseline Year	Data Source	Target-Setting Method	2020 Target
With sidewalks or walking paths	62.0%	2007	NSCH	20% ↑	74.4%
With parks or playgrounds	65.6%	2007	NSCH	20% ↑	78.7%

LA 2020 TARGETS: Increase the proportion of children and adolescents who have sidewalks or walking paths in their neighborhoods to 74.4%, and those who have parks or playgrounds to 78.7%.

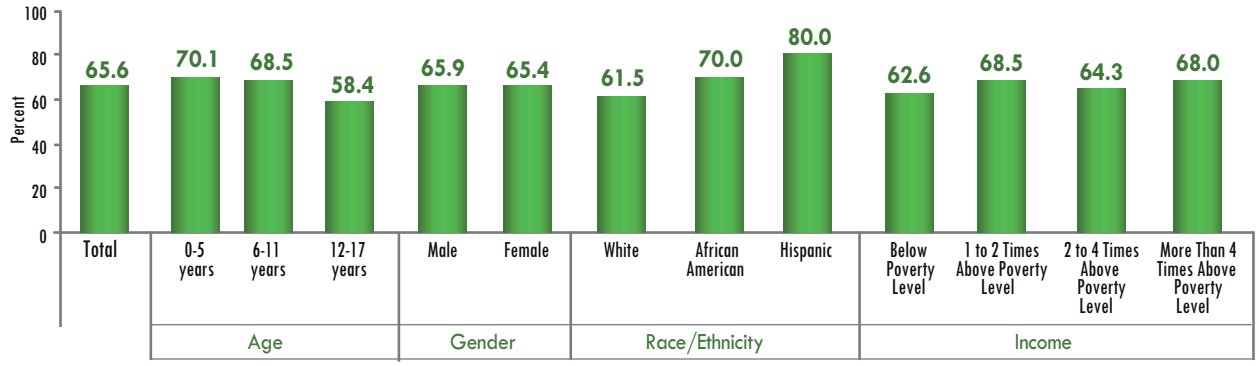
DATA TRENDS & DISPARITIES: Sixty-two percent of children and youth in Louisiana between the ages of 0-17 years lived in neighborhoods with sidewalks or walking paths, according to the 2007 NSCH.[18] Children of younger ages, males, and children of Hispanic origin were more likely to have sidewalks or walking paths than their respective counterparts (Figure 20). These same disparities/trends are also observed when looking at the proportion of children with parks or playgrounds in their neighborhoods (Figure 21). It is important to understand; however, how the built environment, or neighborhood amenities may affect physical activity behavior, and also how the social environment may influence the need for neighborhood amenities. For example, neighborhoods with busy traffic may be more likely to need sidewalks than secluded neighborhoods. Also, families of higher income levels may be more likely to live in neighborhoods that are safer or may be more likely to have access to recreational facilities which may influence the need for amenities such as sidewalks and playgrounds. Also, economic racial disparities may also affect the distribution of certain peoples within these neighborhoods with different needs.

Figure 20: Percentage of Children and Youth (ages 0-17) That Lived in Neighborhoods with Sidewalks or Walking Paths 2007



Source: Child and Adolescent Health Measurement Initiative, Maternal and Child Health Bureau. 2007 National Survey of Children's Health. Retrieved from www.nschdata.org

Figure 21: Percentage of Children and Youth (ages 0-17) That Lived in Neighborhoods with Parks or Playgronds 2007



Source: Child and Adolescent Health Measurement Initiative, Maternal and Child Health Bureau. 2007 National Survey of Children's Health. Retrieved from www.nschdata.org

ACTION STRATEGIES

PARENTS

- "Active transport" should be encouraged between homes, schools, and community destinations for afterschool activities, including to and from parks, libraries, transit, bus stops, and recreation centers (White House Task Force).[6]

TEACHERS AND SCHOOL ADMINISTRATORS

- Develop joint-use agreements to increase community and children's access to school-owned recreation facilities when schools are closed (Robert Wood Johnson Foundation Leadership for Healthy Communities, White House Task Force, Institute of Medicine, Surgeon General).[5-6, 8-9]
- Make physical activity facilities available to the local community (National Prevention Strategy).[4]
- Support walk and bike to school programs (e.g., Safe Routes to School) and work with local governments to make decisions about selecting school sites that can promote physical activity (National Prevention Strategy).[4]

POLICY MAKERS

- The community and its built environment should promote physical activity for children from birth to age five such as ensuring that indoor and outdoor recreation areas encourage all children, including infants, to be physically active; allowing public access to indoor and outdoor recreation areas located in public education facilities; and ensuring that indoor and outdoor recreation areas provide opportunities for physical activity that meet current standards for accessible design under the Americans with Disabilities Act (Institute of Medicine).[11]
- Local government should be encouraged to enter into joint-use agreements to increase children's access to community sites for indoor and outdoor recreation (White House Task Force).[6]
- Prioritize resources and provide incentives to increase active transportation and other physical activity through community design, infrastructure projects, systems, policies, and initiatives (National Physical Activity Plan).[7]
- Design safe neighborhoods that encourage physical activity (e.g., include sidewalks, bike lanes, adequate lighting, multi-use trails, walkways, and parks)(National Prevention Strategy).[4]

- Ensure funding for the construction and maintenance of gymnasiums, playgrounds, and fields, and increase funding for recreation facilities in areas of high need (National Physical Activity Plan, Robert Wood Johnson Leadership for Healthy Communities).[7-8]
- Continue to work with and collaborate with Safe Routes to Schools programs in communities to increase the number of children safely walking and bicycling to school (White House Task Force, Institute of Medicine).[6, 9]
- Implement "complete streets' in neighborhoods to improve safe walking and biking options in communities. Complete street measures include- but are not limited to-bicycle lanes, pedestrian signals, and tactics that promote moderate traffic speeds (Robert Wood Johnson Leadership for Healthy Communities).[8]
- Communities should improve access to outdoor recreational facilities and enhance infrastructure supporting bicycling, walking, and access to public transportation (Centers for Disease Control and Prevention).[19]
- Plan, build, and maintain a network of sidewalks and street crossings that connect schools, parks, and other destinations (Institute of Medicine).[9]
- Work with planners to develop dense, mixed-use neighborhoods with schools, businesses, recreation facilities, parks, libraries and other facilities within walking distance of residential areas or near public transportation and major roads and consider health impacts when making transportation or land use decisions (Robert Wood Johnson Foundation Leadership for Healthy Communities, National Prevention Strategy).[4, 8]
- Improve security, personal and traffic safety of areas where persons are or could be physically active, such as in parks and in higher crime neighborhoods (Institute of Medicine, Centers for Disease Control and Prevention).[9, 19]

PHYSICIANS AND HEALTH CARE PROVIDERS

- Support efforts to preserve and to enhance parks as areas for physical activity, inform local development initiatives regarding the inclusion of walking and bicycle paths, and promote families' use of local physical activity options by making information and suggestions about physical activity alternatives available in doctors' offices (American Academy of Pediatrics).[26]

RESEARCHERS

- More research is required on the effects of the components of the built environment as a determinant of childhood physical activity and obesity. More research is required to determine the effects of the home, school and community environment on physical activity levels (International Conference on Physical Activity and Obesity in Children).[12]
- Given the evidence that simply changing the built environment may not be effective in changing physical activity behavior in children and youth, more research on the effectiveness of combinations of social and built environment interventions is required (International Conference on Physical Activity and Obesity in Children).[12]

POLICIES AND INVESTMENTS

GOAL

Increase the number of policies and investments made to improve the health of children and youth.

INDICATOR: PROGRESS ON GOVERNMENT STRATEGIES AND POLICIES

Objective 13:

Establish a database to track implementation and progress on government strategies and policies related to physical activity or the prevention of obesity among children and youth.

INDICATOR: GOVERNMENT INVESTMENTS

Objective 14:

Establish a database to track, monitor, and assess fiscal investments and whether policies related to physical activity or the prevention of obesity among children and youth require any state funding and of those, which have actually received state funding when anticipated by the act.

INDICATOR: INDUSTRY AND PHILANTHROPIC INVESTMENTS

Objective 15:

Establish a database to track, monitor, and assess industry and philanthropic investments that specifically support physical activity and obesity initiatives for children and youth in Louisiana in a centralized and transparent manner.

INDICATOR: PROGRESS ON GOVERNMENT STRATEGIES & POLICIES

BACKGROUND: Between 2004 and 2009, nine bills were passed in the Louisiana Legislature relevant to physical activity or the prevention of obesity among children and youth. The Louisiana Council on Obesity Prevention and Management (LA Obesity Council) has been instrumental in assisting with state strategies and policies to reduce obesity and promote physical activity opportunities in Louisiana. While we have been able to track proposed bills and which ones are passed, or enacted in the Louisiana Legislature, it is also important to assess implementation and progress of those policies. Additionally, a comprehensive list of state strategies or programs in Louisiana that either reduce obesity or promote physical activity opportunities in Louisiana is not currently available. A statewide assessment of not only policies, but current programs and strategies can be used by legislatures and program planners to monitor implementation, progress, and on-going efforts.

OBJECTIVE: Establish a database to track implementation and progress on government strategies and policies related to physical activity or the prevention of obesity among children and youth.

INDICATOR: GOVERNMENT INVESTMENTS

BACKGROUND: It is important to analyze which policies require funding to be implemented and whether they have actually received funding. At the current time, an exhaustive list or database of state appropriations towards policies directly related to physical activity or the prevention of obesity among children and youth is not available. Due to the lack of information available on state funding for the nine bills passed between 2004 and 2009, we have had insufficient information to grade this indicator in past Report Cards. This information is important to differentiate between which policies require funding, and how funding is disseminated for implementation of those policies.

OBJECTIVE: Establish a database to track, monitor, and assess fiscal investments and whether policies related to the prevention of obesity among children and youth require any state funding and of those, which have actually received state funding when anticipated by the act.

INDICATOR: INDUSTRY AND PHILANTHROPIC INVESTMENTS

BACKGROUND: Collective information on industry and philanthropic investments in projects and programs specifically related to physical activity and health for children in Louisiana is not currently available. There are numerous nonprofit organizations, foundations, and other entities that support physical activity and obesity initiatives in Louisiana; however, access to this information in a centralized and transparent manner is not available. Due to insufficient information on this indicator, we were unable to determine a grade in prior Report Cards. This information will be of great importance to the community, funding organizations, legislatures, and program planners about which organizations have funding opportunities and which physical activity and obesity programs/ initiatives are receiving funding.

OBJECTIVE: Establish a database to track, monitor, and assess industry and philanthropic investments that specifically support physical activity and obesity initiatives in Louisiana in a centralized and transparent manner.

2011 REPORT CARD DEVELOPMENT AND DATA SOURCES

2011 REPORT CARD DEVELOPMENT AND DATA SOURCES

An interdisciplinary team of scientists and professionals compiled and assessed the available resources to set goals, objectives, and targets. The continuity and availability of data influenced which sources and indicators were used to set objectives and targets.

Louisiana Health-Related Physical Fitness Assessments (HRPFA)[29]

Louisiana Health-Related Physical Fitness Assessments are conducted by the Cecil J. Picard Center for Child Development and Lifelong Learning and the University of Lafayette's Kinesiology Department. These Fitness Assessments provide information on students' aerobic fitness, which is measured using a 20-meter shuttle run, called the Progressive Aerobic Cardiovascular Endurance Run (PACER). The PACER is just one sub-test of the Fitness Assessments. Results are assessed to place children within age-specific and sex-specific cutoff reference health standards, developed by the Cooper Institute in Dallas, Texas (Fitnessgram).[28] PACER results from the 2009-2010 Fitness Assessments were completed by 12,305 students between the ages of 10 and 18 years in 109 schools from 14 Louisiana parishes. The results from the Louisiana Health Related Physical Fitness Assessments can be found at: http://www.picardcenter.org/Publications/Pages/Publications.aspx.

Louisiana School-Based Health Centers (SBHC) Obesity Data[25, 43]

SBHCs in Louisiana are established, monitored, and provided assistance by the Office of Public Health's Adolescent School Health Program.[43] The SBHCs provide public school students both primary and preventive physical and mental health services.[43] During the 2008-2009 school year, SBHCs in Louisiana served nearly 55,000 students at 62 sites, serving 95 public schools across Louisiana.[43] SBHCs are mandated to serve middle and high school students; however, some sites are located on elementary school campuses and are able to serve children from Early Headstart, Headstart, and Pre-Kindergarten in addition to children in Kindergarten through 12th grade.[43] BMI data was available for 13,000 children (ages 2-19 years) who had visited the SBHCs in Louisiana during the 2008-2009 school year.[25] More information on SBHCs in Louisiana can be found at: http://www.dhh.louisiana.gov/offices/?ID=255.

Louisiana Youth Tobacco Survey (LYTS)[37]

The Louisiana Tobacco Control Program which is housed within Louisiana's Department of Health and Hospitals (DHH) in collaboration with the Centers for Disease Control and Prevention (CDC) administers and collects the LYTS. Survey results and data used in this Report Card were provided by The Louisiana Tobacco Control Program. The LYTS is administered every other year among public middle and high school students in Louisiana to obtain data on tobacco use (cigarettes, smokeless tobacco products, cigars, cigarillos, little cigars, bidis, and kreteks). The LYTS also obtains information on second hand smoke, cessation attempts, tobacco advertising, school tobacco prevention education, and access and availability of tobacco products. The 2009 LYTS was completed by 2,839 middle and high school students, representing a student response rate of 88.2%. The LYTS results are weighted to be representative of all middle and high school students in Louisiana. Some of the LYTS results are also available online: http://www.800quitnow.com/surveysdata/.

Louisiana Youth Risk Behavior Survey (LA YRBS)[3]

The Louisiana YRBS is conducted by the Louisiana Department of Education (DOE), Division of School and Student Learning Support, Health and Wellness Services Section and provided the 2009 survey results for this Report Card. National data is collected by the Centers for Disease Control and Prevention (CDC) under the Division of Adolescent and School Health's Youth Risk Behavior Surveillance System (YRBSS) and coordinates and assists with state-level surveys. The YRBS is administered every other year (odd years) and is designed to assess health-risk behaviors and the prevalence of obesity and asthma among middle and or high school students. For the first time since 1997, weighted data was collected for Louisiana during the spring of 2008 (off its normal survey cycle), and in 2009, was administered again during its normal survey cycle which was completed by 1,035 students in 25 public high schools. Survey results are weighted to be representative of all high school students in Louisiana. National and state level YRBS data can also be found at: http://apps.nccd.cdc.gov/youthonline.

National Survey of Children's Health (NSCH)[18]

The NSCH is a national survey that is conducted every four years by the Maternal and Child Health Bureau within the U.S. Department of Health and Human Services, with the last survey cycle conducted in 2007. Telephone numbers are called at random to identify households with one or more child less than 18 years of age. The NSCH is administered to the parent or guardian concerning one child randomly selected to be the subject of the interview. Thus, child health measures are collected by proxy report. The NSCH collects data on over 100 indicators of child's health including: BMI, physical activity, screen time, and their environment to track data, educate stakeholders, and inform decision makers. Although the NSCH is a national survey, data is collected and available from each state. Data for the 2007 NSCH were collected from 91,642 completed interviews in the United States, while 1,868 interviews were completed in Louisiana between April 2007 and July 2008. Survey responses were weighted to be representative of each state and the national population. The NSCH data can be found at: http://www.nschdata.org.

Pediatric Nutrition Surveillance System (PedNSS)[24]

The PedNSS monitors the nutrition and health of low-income children (from birth to 20 years of age) participating in three federally-funded maternal and child health programs: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program; and the Title V Maternal and Child Health Program (MCH).[44] Data collection includes information on demographics, birthweight, length/height, weight, anemia, infant feeding practices, and health risk behaviors.[44] Annual surveillance data is available through reports which include national information and well as data at the state-level. The 2007 PedNSS included data for nearly 8 million children (birth to 5 years of age) from 44 states, the District of Columbia, Puerto Rico, and 5 tribal governments.[44]
More information on the PedNSS can be found at: http://www.cdc.gov/pednss/index.htm.
The 2007 PedNSS Report is available at: http://www.cdc.gov/pednss/pdfs/PedNSS_2007.pdf.

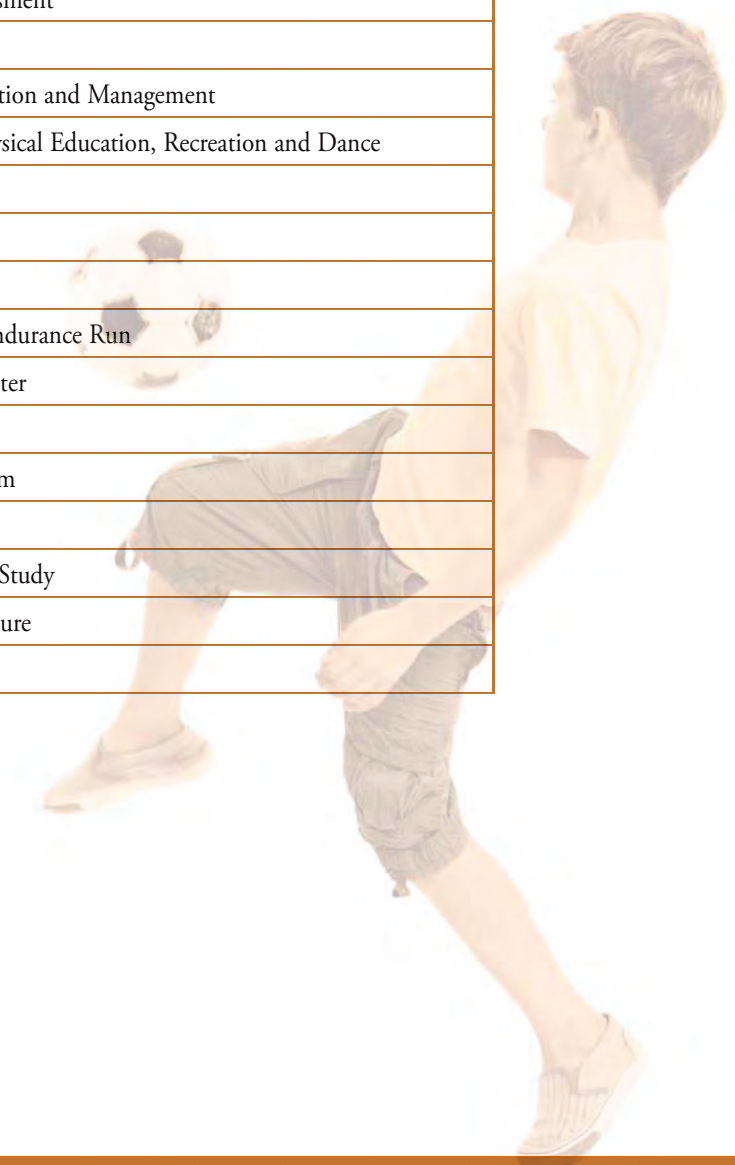
School Health Policies and Programs (SHPPS)[42]

The Centers for Disease Control and Prevention (CDC) conducts the School Health Policies and Program Study (SHPPS), a national survey to assess school health policies. Data is collected at the state, district, school, and classroom levels through computer-assisted telephone interviews or self-administered mail questionnaires to obtain a nationally representative sample. The most recent survey cycle of the SHPPS was conducted in 2006 with the next administration planned for 2012. The 2006 SHPPS included data collected from 50 states and the District of Columbia, 538 districts, 1103 personnel in elementary, middle, and high schools, 912 health instructors, and 1194 PE instructors. SHPPS can be assessed at the following website: http://www.cdc.gov/HealthyYouth/shpps/index.htm.

ACROYNMS AND DEFINITIONS

ACRONYMS AND DEFINITIONS

ACRONYM	DEFINITION
AAP	American Academy of Pediatrics
BESE	Louisiana State Board of Elementary and Secondary Education
BMI	Body Mass Index
CDC	Centers for Disease Control and Prevention
DHH	Louisiana Department of Health and Hospitals
DOE	Louisiana Department of Education
HHS	United States Department of Health and Human Services
HRPFA	Health-Related Physical Fitness Assessment
IOM	Institute of Medicine
LA Obesity Council	Louisiana Council on Obesity Prevention and Management
LAHPERD	Louisiana Association for Health, Physical Education, Recreation and Dance
LYTS	Louisiana Youth Tobacco Survey
MFS	Minimum Fitness Standard
NSCH	National Survey of Children's Health
PACER	Progressive Aerobic Cardiovascular Endurance Run
PBRC	Pennington Biomedical Research Center
PE	Physical Education
PedNSS	Pediatric Nutrition Surveillance System
SBHCs	School-Based Health Centers
SHPPS	School Health Policies and Programs Study
USDA	United States Department of Agriculture
YRBS	Youth Risk Behavior Survey



A LOOK BACK: PAST REPORT CARD GRADES FOR 2008, 2009 & 2010

The grades for the 2008, 2009 and 2010 Report Cards were assigned by the Report Card Research Committee, composed of researchers and scientists from Louisiana, who used the most recent and accurate data available and the consideration of recently published scientific literature and reports. Below is a rubric for the assignment of grades for all of the indicators presented in the Report Card.

A	Louisiana's children and youth are physically active and achieving optimal health
B	Majority of Louisiana's children and youth are physically active and achieving optimal health; however, children who are obese, underserved, and physically or mentally challenged may not have appropriate physical activity opportunities provided
C	Insufficient appropriate physical activity opportunities and programs available to large segments of Louisiana's children and youth
D	Insufficient appropriate physical activity opportunities and programs available to the majority of Louisiana's children and youth
F	Louisiana's children and youth have a sedentary lifestyle with insufficient opportunities for physical activity
INC	Incomplete. At the present time there is not enough information available for grading

CATEGORIES AND INDICATORS	2008 GRADES	2009 GRADES	2010 GRADES
PHYSICAL ACTIVITY/INACTIVITY			
Physical Activity Levels	D	D	D
Screen Time	D	D-	D-
Sports Participation	C	C	C
HEALTH & HEALTH BEHAVIORS			
Overweight and Obesity	F	F	F
Aerobic Fitness	-	-	C-
Overall Physical and Emotional Well-Being	INC	C-	C-
Fruit and Vegetable Consumption	-	D-	D-
Tobacco Use	-	C	C
FAMILY			
Family Perceptions and Roles Regarding Physical Activity	INC	INC	INC
SCHOOL AND COMMUNITY			
Physical Activity Programming at School	D	D	D
Training of School Personnel in Physical Activity	C	C	C
Built Environment and Community Design	INC	D	D
POLICY AND INVESTMENTS			
Progress on Government Strategies and Policies	B-	B-	B-
Government Investments	INC	INC	INC
Industry and Philanthropic Investments	INC	INC	INC
OVERALL GRADE	D	D	D

TABLE 1: PHYSICAL ACTIVITY GUIDELINES AND EXAMPLES FOR CHILDREN & YOUTH

Type of Physical Activity	Guidelines	Examples for Children	Examples for Adolescents
Moderate-intensity aerobic	Children and adolescents should do **60 minutes (1 hour) or more of physical activity every day.** Most of the 60 or more minutes a day should be either moderate- or vigorous-intensity aerobic physical activity	• Active recreation, such as hiking, skateboarding, rollerblading • Bicycle riding • Brisk walking	• Active recreation, such as canoeing, hiking, skateboarding, rollerblading • Brisk walking • Bicycle riding (stationary or road bike) • Housework and yard work, such as sweeping or pushing a lawn mower • Games that require catching and throwing, such as baseball and softball
Vigorous-intensity aerobic	As part of their 60 or more minutes of daily physical activity, children and adolescents should include vigorous-intensity physical activity on at least 3 days a week	• Active games involving running and chasing such as tag • Bicycle riding • Jumping rope • Martial arts, such as karate • Running • Sports such as soccer, ice or field hockey, basketball, swimming, tennis • Cross-country skiing	• Active games involving running and chasing, such as flag football • Bicycle riding • Jumping rope • Martial arts, such as karate • Running • Sports such as soccer, ice or field hockey, basketball, swimming, tennis • Vigorous dancing • Cross-country skiing
Muscle-strengthening	As part of their 60 or more minutes of daily physical activity, children and adolescents should include muscle-strengthening physical activity on at least 3 days of the week	• Games such as tug-of-war • Modified push-ups (with knees on the floor) • Resistance exercises using body weight or resistance bands • Rope or tree climbing • Sit-ups (curl-ups or crunches) • Swinging on playground equipment/bars	• Games such as tug-of-war • Push-ups and pull-ups • Resistance exercises with exercise bands, weight machines, hand-held weights • Climbing wall • Sit-ups (curl-ups or crunches)
Bone-strengthening	As part of their 60 or more minutes of daily physical activity, children and adolescents should include bone-strengthening physical activity on at least 3 days of the week	• Games such as hopscotch • Hopping, skipping, jumping • Jumping rope • Running • Sports such as gymnastics, basketball, volleyball, tennis	• Hopping, skipping, jumping • Jumping rope • Running • Sports such as gymnastics, basketball, volleyball, tennis

Source: United States Department of Health and Human Services (HHS). 2008 Physical Activity Guidelines for Americans. http://www.health.gov/paguidelines/pdf/paguide.pdf.

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REPORT CARD DEVELOPMENT AND DATA SOURCES

The 2011 Report Card goals, objectives, and targets were established by an interdisciplinary team of scientists and professionals, and are based on the continuity and availability of data from the following sources: the 2009-2010 Health-Related Physical Fitness Assessments, the 2009 Louisiana Youth Tobacco Survey (LYTS), the 2007 National Survey of Children's Health (NSCH), the 2009 Louisiana Youth Risk Behavior Survey (YRBS), the Pediatric Nutrition Surveillance System (PedNSS), and the Louisiana School-based Health Centers (SBHCs) Obesity Data.

The development of the 2011 Report Card was guided by a Research Advisory Committee, composed of scientists and professionals who collaborated on the indicators, goals, methods, and 2020 targets. The Research Advisory Committee (in alphabetical order) included: Brandi Bourgeois, MPH (Louisiana Department of Health & Hospitals), Lisanne Brown, PhD (Louisiana Public Health Institute), Stephanie Broyles, PhD (Pennington Biomedical Research Center), Wilson Campbell, EdD (University of Louisiana at Monroe), Raegan Carter Jones, MPH, MSW (Louisiana Department of Education), Catherine Champagne, PhD, RD (Pennington Biomedical Research Center), Kara Dentro, MPH (Pennington Biomedical Research Center), Charles Duncan, PhD (University of Louisiana at Lafayette & LAHPERD), Stewart Gordon, MD (American Academy of Pediatrics, Louisiana Chapter), David Harsha, PhD (Pennington Biomedical Research Center), Peter T. Katzmarzyk, PhD, FACSM (Pennington Biomedical Research Center), Susan Moreland, CAE (North Louisiana AHEC), Robert Newton, PhD (Pennington Biomedical Research Center), Kenneth Phenow, MD (Blue Cross and Blue Shield of Louisiana Foundation), Pamela Romero, RD, LDN, CDE (Louisiana Council on Obesity Prevention and Management), Heli Roy, PhD (Pennington Biomedical Research Center), Ariane Rung, PhD (LSU School of Public Health), Melinda Sothern, PhD (LSU Health Sciences Center), Carl Stages, Jr (BREC Foundation), Jennifer Stenhouse (Center for Planning Excellence), Ashley Stewart, MPH (Rapides Foundation), Billy Stokes, EdD, MBA (Cecil J. Picard Center for Child Development and Lifelong Learning), Samaah Sullivan, MPH (Pennington Biomedical Research Center), and Matthew Valliere, MPA (Louisiana Department of Health & Hospitals). The development of the 2011 Report Card also received assistance from Jennifer Winstead (Pennington Biomedical Research Foundation), Jessica Alleyne Erwin (Pennington Biomedical Research Foundation), and Angela W. deGravelles (deGravelles and Associates).

Louisiana's Report Card on Physical Activity & Health for Children and Youth is based on a similar initiative developed by Active Healthy Kids Canada (*www.activehealthykids.ca*).

For online versions of this long-form report card or a summary version, please visit *www.louisianareportcard.org*.

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