



**State of Obesity 2021: Better Policies for a Healthier America
Virtual Congressional Briefing & Virtual Webinar
Trust for America's Health
November 10, 2021
12:30-2:30 PM Eastern Time**

Live Captioning by Ai-Media

TIM HUGHES:

Good afternoon! And welcome to our congressional briefing on the state of obesity 2021. Letter policies for a healthier America, was a by TFAH for short. My name is Tim Hughes the manager at TFAH. We would like to thank our speakers for being with us today! Next slide please. Lessee will stop! Let's see.

Real time captioning is provided today by a Ai-Media. For captions, click on the three dots at the bottom of your screen. We encourage you all to share your thoughts and questions about today's presentation by typing them in to the Q&A box full stop we will try to answer as many as we can as time permits. To click on Q&A, click on the Q&A icon at the bottom of your screen. And type your question in the queue and a box of next slide.

Now it is my pleasure to introduce our moderator of this event, Doctor Nadine Garcia. She is a national health leader, with management experience in the academic sector, and associations. As president and CEO she leads TFAH to advance health equity, and make health promotion a national priority. Welcome Doctor Garcia!

DR J NADINE GRACIA:

Thank you! As Tim noted, I would like to thank you all and the audience for joining us today! As well as our esteemed panelists that have taken the time to join us for this breathing. We are so happy you have joined us today for sub next slide please full stop the agenda for today's briefing is a high level overview for the obesity findings, followed by a virtual discussion with a fireside chat with renowned chef Jos? Andres. We then will take presentations from our esteemed panelists. And we will then have time for question and answer with our audience.

I like to present with you the key findings of our state of obesity report. This is our 18th annual report on the obesity crisis in the United States for the a copy of the full report as well as state information is available on our website TFAH.org, we will also leave a link in the chat.

Our goal is you learn the latest trends and ranks of obesity in America. And be able to address the actual drivers of obesity, the social and economic conditions that contribute to this growing epidemic. Next slide please.

Let's start with some framing was to note, we are addressing obesity because it is a series chronic disease will stop obesity is unfortunately common, and it puts strains on families. It affects overall health, it affects health cost, productivity, and affects our military revenues.

This is a focus not just on a person's size! But to promote healthy weight to prevent the serious consequences of obesity. Which increases an increased risk for multiple conditions.

Obesity rates have been rising as you can see on the side for decades. And sadly in 2017 to 2018, that was the first year that the national rate of obesity? -- Past 42%. To put that in context in 2012 there were no states with adult obesity rates over 35%. And yet we had adult rates at or above 35%. In this side you can see it is demarcated in a side by red. This increases from 26 info stop not only are we at a record high, we have reached the site at a very rapid pace. -- Reach this high.

Now in 2020, Colorado was the state with the lowest rate of obesity at 44.2%. So in just 20 years, the ceiling has become the floor! The state with the lowest rate of obesity matches the state with the highest rate of obesity from 20 years ago! With the ceiling being 29% in Missouri. Next slide please.

Although the data is not shown on the side, adults with lower incomes, lower education levels, and in rural counties and areas are also more likely to have obesity. It is important to explore that these disparities are linked with the environmental conditions and committees. As you will hear further from our panelists, obesity is a disease with many contributing factors! Including access to affordable healthy foods for top the construction of it is long-standing such as multigenerational poverty, determination, and a lack of community disruptions that promote health. -- Community conditions that promote health.

Not just adults, the ABC rate in children is increasing will stop we had the highest rate of obesity every document at 39%. Since 1976 child obesity rates have more than tripled. Addressing childhood obesity is incredibly important. Because preventing obesity is easier and more effective with children, rather than trying to reverse those trends later in life. This is why so many policies and programs are focused on schools, and the preschool doubles. Next slide please.

This focuses on the social determinants of health. And how these social determinants of health affect obesity because of this slide shows the links between the historical, social, economic, physical, and policy contexts that affect people's lives and the choices that are available to them. The social and environmental factors can increase a person's risk for obesity.

Next slide please! Since the early days of the pandemic, it has exposed overlapping crisis of overlapping disease. With obesity being the underlying disease that is associated with more severe convocations from COVID-19. Recent study from the Harvard organization found that an estimate of 30% of the adult, 19 hospitalizations through November 2020 were attributable to obesity.

Where we work, grow, and age, we have witnessed how the pandemic has had significant impacts. With job losses and food insecurity, which have impacted disproportionately household of color. COVID-19's connection has certainly intensified effects on health, including obesity.

Many of the pandemic's impacts, as I noted earlier with lots of income. Stress, lost opportunities for physical activity full stop these have all been in America's long history of weight gain. There has been a report that reported 2% of US adults reported undesired weight gain since start the pandemic. Whether it is reduced childcare that reduce children's access to healthy lunches. The loss of jobs that increases mental health stress, and alcohol that leads to a coping mechanism for stop housing and food insecurity. These are critical determinants of health.

Our report cited estimates for example. About 42 million Americans would experience food insecurity in 2021. But recent data from the US Department of Agriculture showed that the numbers are not likely to be that high, thanks to policy changes and fomented by Congress. In March 17-29 the 2021 tempered showed a decrease in food insecurity to 18% for all households. This was the first time it fell below 20% since the pandemic. And of course if all the American rescue plan act that passed the following week. While food insecurity overall did not decrease, food insecurity impacted households with children and household of color. -- Households with children.

It extended many social safety programs was a including extending SNAP benefits. In continuing unemployment benefits. Next slide please. What we know is that more work needs to be done.

Our 2021 state of obesity report reviews policies in key areas. And offered over 30 recommendations for some overarching themes of our recommendations is we need to make healthier choices the easier choice for all Americans! Especially for those that are in under resourced communities! That we need to have progress based on funding, adequately resourced and research funding. It has to be conducive to long term approaches to promote healthy eating and physical activity.

These approaches need to take a multi-sectoral approach. It is important that we address communities that have been disproportionately affected by obesity first. These last two points are important, because while obesity is a disease in its own right, it is connected and is broadly connected to systemic disproportions and issues.

When we look at the key federal policy recommendations, only look at decreasing disparities is by further increasing health equity. For example expansion of CDC programs, starting out with funding for CDC's Center for health promotion. And some of our panel members, like Doctor Peter will be describing. But there is some significant underfunding, so not all programs benefit. Such is the ethnic and racial approaches to public health. They also promote the budget's health request for \$1 billion for the CDC's health program. This promotes multisector efforts,

including many that we are discovering today. Secondly we need to decrease food insecurity while improving nutritional quality, especially in the area of COVID-19.

Through programs like SNAP, it is important to make healthy food successful to all children for sub this would be an important step. The next is to change marketing and pricing strategies that lead to health disparities. The TV advertising for unhealthy snacks and things and proportionately advertising to children of color. -- Disproportionately advertised to.

With a tax revenue designed to decrease the disparity. The fourth policy we provide our conditions and is to make sure physical to video built environment safer and works of overall. Congress should look at project such as could

SPEAKER:

Pedestrian infrastructure and safe routes to school. Lastly, strengthen the role of the healthcare system in preventing and strengthening obesity. While the Affordable Care Act has inequities next to care, with sex, race and education and family income. Health insurance and access to care is foundational in the prevention and treatment as well as overall health.

That is why limiting barriers for everyone in healthcare is reported. Also encouraging programs multiple ways in enforcing the US primitive task force for preventative task behavior counseling privilege, and encouraging Medicaid programs for evidence-based political weight management and programs.

With that background and overview, which is a lot of data ? and want to dive in further into understanding the data ? but also understanding what other solutions to help us address the crisis. Next slide.

I am not excited to introduce ? more information, yes, on our report. You could access this on our website link. Contact our staff, Dara Lieberman, the director of government relations. She will be happy to answer any questions regarding our report and recommendation.

Let's turn to our next slide to produce our distinguished panelist for today's briefing. Therefore biographies are available in the webinar invitation, as well as on the TFAH website.

We will save questions until the end. Reminder, please submit your questions into the Q&A box. Preferably, not in the chat. We will get to these questions after their presentations. Our first panelist is Chef Jos? Andr?s. Chef Andreas is a world-renowned chef, Unitarian and best-selling author.

He is the founder of the world -- not-for-profit World Central Kitchen that has created positive change around the globe. Next is Doctor Ruth Petersen. Doctor Petersen is the director of the division of nutrition, physical activity and obesity in the Center for disease control and prevention. This looks at physical activity and obesity prevention the policy and guideline

development, surveillance, ideological and behavioral research, technical assistance to states and communities.

Next is Karol Fink. Karol is the Section Chief of chronic disease prevention and health promotion at the Alaska Division of Public Health, and the Alaska Department of Health and social services. She served in key roles in the state including (unknown name) states physical activity and nutrition team.

Our final panelist is Doctor Dariush Mozaffarian, who is a Dean at the Tufts Friedman School of Nutrition Science and policy. As well as professor of medicine at Tufts school of medicine. Doctor Mozaffarian's work aims to end a food system that is nutrition, -- nutritious, equitable and sustainable. What a esteemed panelist we have joining us today literally from around the world.

We are so excited to begin our conversation with them. We are going to 1st start with a virtual fireside chat with Chef Andres, and will move to presentations by our panelists, followed by our Q&A.

Now, it is my honor to welcome shelf Jos? Andr?s, for our Fireside Chat. Welcome, chef!

JOS? ANDR?S:

Thank you very much, Nadine, for having me with you all today.

DR J NADINE GRACIA:

Wonderful. Chef, let us begin. Today we are going to be talking a lot about food and security as a risk factor for obesity and other chronic health conditions.

What have you seen in terms of the power food and supporting our community's health and well-being?

JOS? ANDR?S:

Listen, I wanted to start very quickly, obviously, saying that you have there Karol, Ruth and Dariush. We are going to hear from them. I am so honored to be with them. Again, thank you for giving me the opportunity to be the one to start this because it is funny. I am the chef, and sometimes we are the ones who are also part of the problem in the obesity pandemic we are facing.

I want to announce that in the last year, I lost 35 kg. More than almost 80 pounds in the last year. I realize I am a lucky guy. Not everybody has the same opportunity as I did to be able to be able losing weight in a way that I did. But now I weigh 220 pounds today. I feel much better. Still, slightly obese, but I am going in the right direction.

With that, I wanted to say that we need to remember food is about community. Food is family. If we are going to be fighting obesity, starting today, community and family are going to be very important.

Culture is defined by food. But we need to make sure that this culture we celebrate is not the same ? the culture we celebrate through food is not the same culture through food that makes us more sick, overweight, and makes our lives in the long term not moving in the right way.

So, how we produce food, how we grow it, and how we serve it is very much who we are. There are stories behind it. You travel through America and you travel to the world, it is always food stories. People are proud.

So, we need to be using that as a tool, a powerful tool to combat obesity pandemic in America and around the world, especially in the rich countries as we see lately.

But one thing is real, that people in communities experience food insecurity, people cannot live with their full lives. I know it is a lot of people that are distended with me when I talk, and I'm sure it happens to a lot of you ? "hey, they're poor. Food insecurity is popular?" Why do we see that this food insecurity places have a lot of people who are obese? We need to understand that one thing is about calories and the other is about nutrients.

We are able to deliver indignities calories, calories, calories. They are cheap, quick and everybody is eating those. It moves away from their traditions from the culture that is defined by that food, by family, by cooking and cooking together, when people have the time to do it.

When people start eating calories versus eating trance that equals culture, Eagles family and equals a longer table is what we see when food insecurity in the process, creates obesity problems in a fascinating, crazy way.

So, food and nutrition insecurity, we know they are time-consuming, and emotionally exhausting. I have seen it and you have seen it. It is not good to be in a community where you know they are poor, hungry and you are a mother with three children who are dying. It has to be exhausting to be them.

It is difficult to be speaking on their behalf because they can only be the ones knowing what they are going through. You know? Hunger really leads people to rely on elderly foods, and we know it, to get through the day. So that is why we need to create disability because instability creates this obesity problem in poor people themselves!

What happens is that no matter the physical or the well-being cause, people will rely on those cheaper foods if they can get away from the hunger at the moment. So, being poor is very costly. We need to make sure that being poor is not so costly. Maybe it might be cheap today, and the way they will eat with whatever they can afford.

This will be shortening their life as we know it, and making their futures much more difficult to achieve. We need to remember that he will buy the food that they have access to. I know this seems very obvious, but that is what I am realizing sometimes the poor neighborhoods ? it can be in Haiti or in America ? in a poor neighborhood, sometimes the food the same rice that I may buy in my more luxurious, rich neighborhood is cheaper than the same rice as a mother of five can afford in her own neighborhood.

How is it possible that sometimes good food seems cheaper in the richer areas than in the poor areas? I have seen it often, and we should not allow that ever happen again because then people will never go to the healthy, most nutritious foods. They will always go to the cheapest, sometimes calorie intensive no nutritional value at all.

So, when people only have access to unhealthy food, that is what we see. That is what they will buy. But when they have access to good and nutritious meals, we know that life can be good and more fulfilling.

(audio issues) my friend may be bigger think about this. Nutrition has been a national security issue. This must be the role of American government and every government in the world to make sure that not only feeding every human being on the country, but making sure that every human being on planet Earth has access to not only food, but nutritious food.

This should be very much at the helm of democracy in every single country. I used to examples like in the Navajo nation. We deliver millions of pounds of produce and dry goods over the course of 2020 and beyond. So families can stay home, be safe, and stay safe from the disease.

In this way, we were not throwing money at the problem but achieving two things: we were fighting COVID in a moment that was the most important thing to protect, especially everybody and especially the elderly.

But at the same time, for nutrition insecurity. Simultaneously, buying good as much local food as we could ? vegetables and fruits ? we were empowering them, as what they said in the beginning, to create longer tables; to create that community and family feeling by cooking together, and cooking healthy meals together.

We provide them those healthier, more nutritious foods, they didn't have any problems. We need to make sure the people have access to them in every town across America, and in every town across the world.

DR J NADINE GRACIA:

Chef, think is a much. First, for starting out with your own story. I commend you with regards to your own journey, as he conveyed and talked about your journey in healthy weight, and thank you for sharing that story.

But we also thank you for your service ? tireless service ? around the world.

JOS? ANDR?S:

No need.

DR J NADINE GRACIA:

? For the community. So World Central Kitchen was able to help many people in the world. As he talked about, and times of crisis to address access to food, and whether that is bringing together community volunteers, chefs, private companies and more.

What advice would you give because we talk about this needing to bring all sectors to the table, right? To be able to address this crisis. What advice do you have to build partnerships to improve access?

JOS? ANDR?S:

Yeah, number one, we need to look at the partnerships. They are only good when the organizations want to partner, and everyone has a very clear understanding of who they are and what they do.

At World Central Kitchen, we understand who we are very clearly. We are an organization that began on the shoulders, and it began 11 years ago. I guess my experience of 30 years is what got me to help organizing this and making this organization.

We go to emergencies, and we feed the hungry and bring water to the thirsty. And we try to do that with the urgency of yesterday, if I can paraphrase Doctor Martin Luther King.

By doing it quickly, we make sure that people can be lifted up from the mayhem they are living in, and starting in our reconstruction. Responding to the emergency of reconstruction in a very crazy way, in our view, should be happening simultaneously because every second you wait for delivering the emergency aid is one week or one month that it takes to start the reconstruction.

So, how do do that ourselves? We do that by buying from local farmers and local fishermen; trying to put help on the working people who are not OK after the catastrophe and hiring them in the last rounds, during the food, giving money to the food trucks, or helping us cook traditional dishes in the area, and trying to always come to the taste of the people.

So, that is who we are and that is what we do. So, how did those partnerships ? how can they be done and how can they multiply? I always say that in our case, it is not like we look for them. It just happens as we go.

Let me give you a example of strange partnerships, not necessarily that have to do with obesity but has to do with health. In the Bahamas, we were the first ones. Almost 7 or eight days before any of the other big numbers came to Ground Zero. We reached (unknown term) a day.

We only did this because we were bold enough to feed 14 islands after a hurricane five category decimated those islands was the helicopters about both was not an option.

At the beginning we wanted to deliver food. That was the only way. By delivering those meals, fresh fruit and water filtration systems, we were bringing in the helicopters? Empty, when the hospital in Navajo (?) had people who had to move to a better hospital in the capital.

All of a sudden, we became a natural partner, them of us and thus of them. It's not like they were helping. They knew what they needed. We never did a lot of calculations. We are a food organization. That made sense in that moment, with boots on the ground that the helicopters bring in food, will take people out like it was in the movie. The impact of the capital to take care of these people. We did more than 50 medical evaluations -- evacuations in that thing. That example, I'm not giving it to you because ? I am very proud. Yes, I am very proud of saying that I cannot believe you're doing this! On such a scale.

But the message I want to send is not bragging rights that we did this. But these boots on the ground, partnerships cannot be achieved in office. Partnerships and the real things need to be achieved on the ground.

The right partnerships will only be achieved in entire conferences where we are talking about hunger, and we are never bringing hungry people. We are doing a conference about the empowering women in rural areas! We never often have those women with real boys, giving them the main moment to tell us, really, what we want and should be listening, not what we want to hear!

That is why, for me, boots on the ground is the most important part of partnerships! My best partnerships, and I speaking now as a person, not even so much as Jos? Andr?s of World Central Kitchen, but part of those partnerships and the boots on the ground allow me to see what all the people were doing.

In the sequence of food, what we do beyond emergency, and this is something I am very proud like we saw in Puerto Rico ? like we saw in Puerto Rico, we invested with almost 200 farmers. All of the farmers have French vegetables, fruits, milk, all local.

I believe that, yes, we have to have a global view to feed the world because we need things global. We are going to be 9 billion people. But they believe the best interest will be when the global is taking care of the local, and the legalistic needs to be taken care of as well. That is the only way we will be able to have Hoosiers meals -- nutritious meals to various families across the world.

This is very much what I want to say. The most import thing is adapting. I don't like to part with organizations ? the same way I am telling you that everybody needs to know what they are what they do, still, and it looks ability.

What was on 2021, 2020, that everybody was following a plan. What happened in 2020? Nothing went as planned. We need to put plans on the side, and start raising. We need to be raising the complexities of the moment. And by telling people that every one is an opportunity for you to stop. We can solve the problems in real time. If we have this still in America today. And I mentioned women with the most are due respect, because we know those who defeat America and defeat the world, are not men, they are women! I say this with the biggest respect!

I see women defeating evil everywhere I go because they are the people defeating everybody for even if the government was to help them they need to go somewhere else, they need to go to a richer neighborhood. You see? When sometimes big problems have simple solutions. With boots on the ground we see what happens, they have a quick reaction to the situation! This is why I'm looking at partnerships!

If not partnerships you spend time... I was a was partnerships first it is me and my wife. Yes it took her time, and yes it took me time to convince her I was the right man. This is not a relationship. It may take a week, month, or more. When we talk about these organizations that created to resolve the problems for the people there in real time! Why? Because hunger, health, being thirsty, being hungry cannot wait!

Every moment that we wait, a child is not being fed right? Every woman and man that gets always in the presence of trying to survive. We are cutting their lives short. This is why we have no time to wait! For me partnerships must be a clear understanding of who everybody is full stop for me boots and a ground are more important. With boots on the ground rather than in an office, you go and start talking about it.

DR J NADINE GRACIA:

Thank you for your insights! Especially when you have said that this cannot be achieved in an office, but with boots on the ground and with people that do this everyday. Is providing the resources, being expedient to do so. And being committed to do stuff was up thank you! For bringing your lines of experience and in the world to the policy arena as well. Your serving as a cochair of the task force on food and nutrition, advancing many of these policies as it relates to SNAP and WIC. We thank you! We know how busy you are. You are in the response mode currently, so just thank you for the time was up we look forward to working with you more for these critical policies, so everybody has a fair opportunity to be as healthy as possible.

CHEF JOSE ANDRES:

Thank you! I am not a man that went to school, I do not have titles. I left school when I was 15. But when I listen to people like you, when I say that we do not need people in an office. At the same time I understand that we need people who do the studies, and bring all of the good technical work to Congress. It does not mean that we will not achieve it. If there is one thing that I want to be achieving, it is that we want free school meals for every child in America! Period!

School lunch -- lunch that that needs to be a thing of the past. We need to stop throwing the money at the problem, and start investing in the beginning! When they have all the potential to be whatever they want to be in this beautiful country of ours.

By being how they, by eating good food that gives them the opportunity to be everything that they want to be. That is what we are doing on the task force, and I know all of us are joining in forces. We have the same heart in the same ideas in many ways. Let's hope we are successful in one or two years.

America needs us to be successful! Let's try to make it happen. Thank you for having me.

DR J NADINE GRACIA:

Thank you chef! We look forward to that important work as it continues to move forward. Thank you! Be well and be safe! For the audience, Chef Jos? Andr?s is not able to sell those. But it was great to hear from him.

Now I am pleased to begin our panel presentations. Again for our audience, please submit any questions! For questions submitted to the Q and a, we will start out with Ruth Petersen. Works at the center for disease control and prevention. Dr. Petersen I will turn this over to you!

DR RUTH PETERSEN:

Thank you so much! It is a pleasure to be with you today. I'm going to do but CDC efforts to advance health equity. Are you seeing the map? I wanted to reiterate that CDC shares is that every year, and we are saddened and what we see every year. We continue to see adult obesity rise across the states was up I want to note this is from self recorded data. From the survey of 2020 we can talk about this with questions and answers. Next slide. You can see the darker colors are the highest rates of obesity reported.

This year, when we split the maps apart between racial and ethnic distinctions, you can see the press pitting trends that continue is that the darker the color, the higher the prevalence.

For adults, we had to add a darker color for the over 40% reporting adult obesity in these areas. You also see problems for Latinos, Hispanic adults. There was a question in the checkbox about what the overall prevalence is... Is about 20% overall. To get the first rural pitcher on the state level for our Asian adults in the country. This data is very important for us to start having these conversations.

Next slide. It has also been noted that a depressing sort of intersection of the increase in childhood obesity, and how it relates to the COVID pandemic. We have seen from studies within our division that have been published as you see at the bottom of the slide, that among children and adolescents with COVID, underlying medical conditions including obesity increased the risk for both hospitalization and severe COVID-19 illness.

This is depressing, and we had new data released that the average rate of body mass index, so the BMI increase approximately doubled during a pandemic for children and adolescents.

At the bottom of the slide you can see her, given these two factors we set -- set ourselves up for decades.

Trying to set the to a more positive tone, what does the DNPAO vision look like? Our vision is to have optimal nutrition class the lifespan.

The ship just mention this as far as starting early, we try to do that. Including maternal nutrition, breast-feeding, we look at early Child nutrition that is supported now for the dietary of Americans. For the very important 02 24 months for nutrition. We look at early Child education, we have healthy weight programs that we are creating that I speak to. -- That I speak to. We look at food and nutrition security, please note the foundation there of achieving health equity.

Next slide. I want to take a breath here and so you are definition for food and nutrition -- security. Because it is important that we are in line. Food insecurity exists when all people, at all times, physical, social and economic access to food which is safe and consumed in sufficient quantity and quality to meet their dietary needs and food preferences, and is supported by an environment of adequate sanitation, health services and care, allowing for a healthy and active life.

There are a lot of words in there, but it is because they're all important for our vision of health equity.

Next side. The COVID-19 pandemic has increased food and nutrition is security which has been noted for sub you can see prior to the pandemic, one in four Native American individuals. One in five black individuals, one is six Latino individuals, and one in 12 white non-Hispanic individuals live in food insecure household.

The paradox is food insecurity is a risk factor for obesity. Health equity is when everyone has the opportunity to be as healthy as possible!

So we work in part with state, local, tribal organizations health organizations, and we see how we remove environmental and systemic barriers to help in advance health and advance equity.

We do this after our funded program -- we do this with our funded program. you can see that DNPAO has funding that goes out.

So it includes people who does virtually affected by chronic disease in obesity. As you can see here in the teal portion of the pack -- map. This supports in healthy nutrition, safe and accessible nutrition and breast-feeding. We also want to have a safe and supportive programs and this is the 50 land grant university, who leverage their convention services increase access

to help their food and opportunities for physical activity in counties that have more than 40% of adults with obesity.

This is from the data that makes them eligible for this funding. Racial and ethnic approaches to community health, the REACH program. We are proud to have this here as well. This is been part of the CDC for over 21 years. We are currently able to fund over 40 organizations to improve health, prevent chronic disease, reduce health disparity among racial and ethnic population with the highest risk or burden of chronic disease.

You will hear from one of our programs. Karol is going to speak about the last program in the panel as well. Next slide, please.

What we ask our recipients to work on? What is the evidence-based strategy? How are we going to make a difference? The nutrition strategy across our grants, programs, span, hop and reach include the things you see on the slide.

We implement interventions to support breast-feeding, and we implement nutrition standards and key institutions such as early care and education centers. We accelerate, adopt or expand formed ECE programs. We implemented food-service guidelines in worksite and community settings to increase the availability of healthy foods.

We are looking at advancing healthcare meant and sales and will are looking at the market for healthier food. Next slide.

We also have a incredible initiative active people, healthy nation that will lead to help move 27 million more Americans to be more physically active by 2027. This increases physical activity, which will improve quality of life, weight maintenance and obesity prevention. This is something we implement our recipients and other partners. You can find more on our website. Next slide.

So, one thing I want to actually share with you is that we are working to develop sustainable healthy weight programs for children. It is interesting about this is the USPF guidelines given that recommended there be focused counseling of 26 hours at an early age to help them create and maintain a healthy weight.

We are working on this program. It focuses on children from 6-13 years of age. We are intervening early. It uses education and counseling to help families establish healthy eating patterns, we are showing BMI reduction for participants children as well as parents.

It can be reimbursed the Medicaid, and can be rented in multiple settings, including Federally Qualified Health Centers. Future work is to increase reimbursement, use innovative tools to measure and evaluate success, and spread and scale this across the country. Next slide.

Thank you so much. I will turn it over to the next panelist.

DR J NADINE GRACIA:

Thank you very much, Doctor Petersen for that informative discussion and presentation. Next, we're going to hear from Karol Fink from the state of Alaska section of current disease prevention and health promotion. Karol, I will turn it over to you.

KAROL FINK:

Good morning from Alaska! The largest state in the union. Next slide, please.

Thank you for inviting me to speak with you today. Alaska is an amazing place and I love being here. Next slide. Alaskans who live in our northernmost communities don't see the sun for 64 days in the winter, but bask in the night of summer sun all summer. Next slide.

Alaskans who live in our Southeast, live in a rain forest. Next slide. About 200 villages can only be reached by airplane or boat, which makes transportation of people and goods difficult and costly.

Next slide.

While Alaskan people in every Alaskan town, many of these people and folks live in these remote locations. Services in these villages are often limited and expensive. Some villages lack full-service grocery stores, running water, flush toilets, and doctors who live there.

These extremes can contribute to our food and nutrition security issues and make physical activity challenging. When I started in the obesity prevention back in the mid to thousands, it was really a emerging field of public health practice.

Number of children adults living with obesity was increasing year after year, and obesity was diagnosed earlier than ever before. The media and public's interest piqued and stories about the shocking headlines begin, headlines. While the media was talking, CDC got to work addressing the issue. They assigned their experts with leadership around obesity prevention at the national level.

The development national strategy. See disease experts conducted commissioned research to find solutions. They help build the CDC prevention expert at the state department. I learned that CDC promising practices and was introduced to the scientific methods to measure our success, and CDC funded state health departments to get to work.

Alaska's health department was one of the recipients of the support, and I was there to receive it and help draft our state plan: Alaska in action.

We have a comprehensive plan to address obesity. I am going to cover childcare, food, digestion, security, friendly routes and sugary drinks.

Through training, other tips and tricks to engage with schools, students, teachers and healthcare providers. At the pandemic, we didn't know I change the course of the trend. But we begin with promising practices. With support from CDC, it helped us in very Alaskan specific unique food nutrition programs.

In Alaska, we focus on our youngest kiddos, when we began working with childcare center staff, we identified a desire discern -- to serve Alaska native traditional foods. We wanted to bring together the agencies needed to engage in the process and preserving of food such as reindeer, Wael and (unknown term).

Through our relationship these agencies develop trainings and resources. Today, numerous childcare centers serve their kiddos Alaskan native traditional foods. This is connecting our kids with their cultural heritage, increasing their food security. Next slide.

Crystal may host the largest commercial wild salmon fishery in the world. Each year, millions of salmon harvested by fishermen to feed the world. However, on the source -- shores of this bay, locally caught fish had no place in school cafeterias. The staff in the schools decided to change that.

The staff work with local fishermen and local fish processor to set up a donation program. When fishermen drop off their fish of the processor, they donated a certain number of pounds to the school. No charge, the process of packaged fish into individual portions, and stored that frozen fish.

What are staff discovered with this innovative solution, we help share the success story with other school districts across the state. Next thing we knew, some Alaska students reading locally caught salmon once a week in their school lunch program.

In Alaska, we focused on schools and students. We provided school district staff the knowledge and tools to improve food and beverage choices. Schools cut amount of junk food inventing machines in half from 2002-2008.

By 2011, Alaska received success.

CDC published our data in the morbidity and mortality weekly report. This report showed our overall obesity trend line had the obesity Ingrid for students. We made national news and the rubber Johnson foundation came to cover what we have done.

While I was part of our efforts, I was really uneasy because it was underlying story that we didn't know to address. The number of Alaska native students was decreasing. However, the number of white kids were at the -- showing how we were at the decline.

Showing the parental education attainment, housing and the students (unknown term), without these variables we didn't know how to impress this disparity.

So (Laughs) We know so much more now about addressing disparities in the social determinants of health. Then we just kept working on what we knew how to do in physical activity and nutrition.

So, we used CDC community putting prevention to work cooperative agreement funding to address food insecurity Alaska with these resources ? our health department staff facilitated these conversations to identified issues. The commission reports, status facts and supported a coalition.

Over time, this cup of sticklers -- This group of people became self-sufficient and the 501(c)(3) Alaskan food policy Council is making Alaska's food system healthier, more self-reliant and more prosperous.

CDC support help us establish relationships in Alaska that still exist today. We had physically active and friendly roots that improved the public health. Through this visit we brought together public health conditioners -- practitioners, engineers, and public facility staff for the very first time ever, while many, many successes follow this visit, the local transportation in Anchorage, which is Alaska's populated city ? formed a advisory committee that requires mentorship from a public health organization.

I served as a founding and current member of that committee. Anchorage is now better integrating health into transportation planning.

CDC provided us with a framework on how to approach the obesity epidemic. They give us six targets: one of which was to decrease sugary drink intake. We use this target to focus our work. We tap into an already established public health information system to collect sugary drink intake of toddlers.

The system will provide us with trends and consumption patterns. It would allow us to tease out the impacts of the social determinants of health.

By 2013, we were surveying and talking with families of young children who were learning their knowledge and attitudes, behaviors related to trickery drinks. By 2016, we were well prepared to break funding from two CDC divisions: division of oral health, and division of physical activity nutrition.

We launched our healthy drinks really kids project with tribal dental partners. These partners serve Alaska native people in remote locations, and our product was tailored to serve those who would benefit the most.

We develop and train tribal dental providers to use a regard to talk with families with large amounts of sugar hiding in drinks, health risks linked to that and sugar, and steps family can take to cut back on sugary drinks.

We also developed the patient to public education materials, and created a short video public service announcement. Our educational guide for dentists, was so innovative and adopted and adapted by the office of oral health in California ? all California public health regions are using these educational materials to help families cut back on sugary drinks.

While our success attracted ? our success also attracted attention from global, public health organizations, the heart foundation of Jamaica, and the heart and stroke foundation of Barbados adapted our public service announcement videos for its campaign.

Throughout the years, we continue to expand our sugary drink prevention Atlas (?).

We of course always develop our work. I will wrap up until you have families of young children are seen and responding positively to our public education messages.

We need from our research that Alaska three-year-olds are more likely to have a sugary drink if they lived with mothers who are younger, had lower incomes, lower education, or if they lived in a rural ZIP Code.

After our campaign was broadcast, results from our survey showed that 38% of Alaska mothers had recently seen our sugary drink campaign messages. Among mothers who learn something new from our campaign, almost half said they changed what drinks they served their children.

These moms are most likely to be younger, have less education, the Alaska native and live in rural areas. Reaching the families will benefit the most, we are helping reduce the disparities.

While the obesity epidemic no longer has media's focus, it is still just as important. Nationally, more people than ever are living with obesity, resulting in poor health and poor quality of life.

The COVID-19 pandemic has reduced food security natively, and impacted the amount of physical activity Americans get, and demonstrated how a healthy body weight can impact one with a chronic disease.

CDC's leadership, expertise and financial support through the years has provided my team the stability, -- sustainability needed to make a difference. I also must talk about my dedicated colleagues. We stuck together over decades and have combined health care expertise.

This stability enabled us to build in our previous compliment, proved our partners that we are committed to be innovated, be daring and continue advancing toward our long-term goal of making Alaska a healthier place to live.

We dropped the PDF of the chat with the lakes to the programs I mentioned. So, please take a look at that. Thank you for listening!

DR J NADINE GRACIA:

Thank you so much! A great overview of how your helping the communities. These are critical messages that your sharing, and as you noted, we actually can address and reduce disparities. That you have been engaging with for so many years in the state of Alaska. We will hear from our final panelist, who is a Dr. Dariush Mozaffarian. Was from the Friedman school of nutrition science and policy. Edit hep C University.again we do see question and answers coming in.

I will turn it over to you.

DR DARIUSH MOZAFFARIAN:

Thank you! I'm going to anchor the conversations, and I'm going to highlight, I think my sort of a view of the causes and solutions for the obesity epidemic.

So I am going to talk about nutrition. I think as it has been highlighted, this obesity epidemic has occurred over the past 30 years. If you look at at what has changed in the past 30 years, there is not a lot of evidence that physical activity has not changed much. Our built environment has not changed much. These are all good solutions to the obesity epidemic, but they have not actually changed. Our food has not actually change. By far our main driving force of the obesity epidemic is changes to our food system. Quantitative data shows food is the number one cause of poor health. Looking at this list of preventable causes of death. There's alcohol and drug use, it is about pretty much any other risk factor that you can find, dietary risks.

This is causing enormous it is. One into American's have diabetes or prediabetes with three and four have overweight or obesity. And only one in 10 are metabolically healthy full stop 9/10 American adults are metabolically unhealthy. So we have a population that is overwhelmingly unhealthy! Being healthy is the exception. One in four teenagers in America today have prediabetes was up one in four are overweight or obese, and one in six have fatty liver disease.

Next slide. The economic cost of this aggression was up in 50 years in healthcare costs have skyrocketed from 7 to 18% of the GDP. One in three dollars in the federal budget was up from 80 billion to \$1.2 trillion for US businesses was up and 80% of healthcare dollars are spent on preventable chronic diseases. Obesity is one of the biggest preventable chronic diseases. Mac mentioned they were supportive of the barn is administration's support for helping increase public health. The US government spends \$160 billion on direct medical costs for diabetes alone was up so think about these numbers. When the government spends 160 billion on direct medical costs for diabetes alone we are absolutely focused on treating the sick. Rather than treating disease, preventing it, and protecting the healthy. We put an exclamation point on this from last summer, this found if you look at the true cost of food. Our nation spends \$2.1 trillion of all because of supplying food. In addition to the \$2.1 trillion of drug cause, our economy is losing another \$2.1 trillion. That is laws for human health, and about half of that due to the

challenges of the environment. Biodiversity, and environments was up think about this for every dollar that we spent, our economy loses two dollars for sub this is not a winning position was up and I think this will get policy makers attention to really make a difference.

If we want to make a difference there is no simple solution! I agree with many of the solutions that were proposed about increasing Americans health. We really need to understand strategy. This is interesting, I mean the 18 years of report. That should be news! With 18 years of reporting obesity, obesity is still going on.

There is no national plan to addresses. We need a national plan. I think across six policies could help increase our help. We need to advance nutrition in healthcare, science, we need to leverage our federal education burdens. We need to coordinate all of this. There has to actually be a plan.

In healthcare we think of this as food is present was up there are a range of interventions. But I think the top four for healthcare for interventions are medically tailored meal programs. Medically tailored food packages. Leveraging registered dietitians. The vast majority of doctrine are not reimbursed for dietitians. And lastly ensuring medical nutrition for doctors and other healthcare providers.

.

Medically tailored meals are a no-brainer. This is getting sick is patient food that may have severe diseases. In this actually saves money for the even accounting for the cost of the program, the state of Massachusetts the state of Governor, the health organizations are testing this. It is time for the centers of Medicare and medication to test this. Next slide.

These descriptions are also promising but this is the meta analysis of 13 produce RX interventions for stop for patients with diabetes it has lowered AOC. We're going to have a trial with (Name). The federal government must also take this up and really test and scale this. Next slide.

There should be animations. Thank you! We have proposed SNAP Plus, rather than including what should be included or excluded which includes lots of moral dilemmas. We should include incentives for a whole bunch of foods, fruits, vegetables, whole grains, nuts and seeds, plant-based oils. And just restrict soda junkfood processes. If this was done nationally this would prevent under 40,000 lifetime CVD events. It is time for the state of Alaska that is here and other state to put waivers into the USDA to test SNAP Plus and other initiatives.

We have to accelerate nutritional science! One of the most shocking things I will tell you is that we don't even know what is causing the obesity epidemic. Reports show that color intake in the United State has gone down every year in the last 15 years! Calorie intake is going down! Physical exercise is not decreasing for them so this idea that we are eating more is not proven by the data. Why do I think? We have overly processed foods that affect our micro biomes, I think it is in intergenerational effects as well. From a mother to baby changing the MR CA. The

idea that it is just marketing and overeating is not supported by the data! We are eating less every year and still gaining weight!

So we have some crucial, crucial science that we need to advance! And we need to put money into this. Our country is losing hundreds of million dollars on nutrition. This is why we propose that the NIH has a nutritional science funded by Congress was up we need to coordinate all this. As I mentioned there is shockingly no plan!

The US accountability report that came out this fall, GAO, they reported that chronic diet - related health conditions are costly, deadly and preventable. All of their words. There are 200 different federal efforts spread across 21 agencies to improve market size. But these efforts are fragmented. Keeping the government from meeting its goals. Congress should consider identifying and directing a federal entity to lead the development and implementation of a federal strategy for diet related efforts aimed at reducing Americans obesity.

One idea we had was a new office of the national director of food and nutrition. There is no office of this today. But we learned our national intelligence, we created an office of the national director of intelligence. This is been very successful, we need an office for food. We need a national director for food and nutrition.

So I would like to just conclude. That we can deal with this. We can deal with the higher and growing disease of obesity. We can improve nutrition, improve that health. Improve our economy, incurs health equity. Increase resilience. But we need a plan! That I outlined his request this leverage was about we need to have school food programs, we need to advance science and innovation. And I also mentioned that USTA research focuses on the advancement of health and research was up this should all be at the crux of health and research. There are lots of jobs that are thinking about and trying to innovate here. Right now we are just relying on the free market for them to be successful. The government has a role to play just in the same way that they have advanced green energy, or the railway system, or have advanced many other industries.

It is time to advance to the food industry. And that should include food entrepreneurs that can provide economic empowerment and nourish our committees for sub we need to leverage health education! The division DNPAO USDA and the FTC. Thank you for having me, and I look forward to the discussion!

DR J NADINE GRACIA:

Thank you for your presentation. As you mentioned reimagining the policies and recommendations as we move forward. I am sure we will go over these details on our Q&A. That concludes our panelists. So now we will open this up for questions from the audience. I'm happy to be joined by my colleague, they will help us moderate our Q&A. They turn it over to you Dara!

DARA LIEBERMAN:

Good morning! Thank you to you and all of the panelists. First we have a question, I think people were pretty struck by the map they should. It showed only 16 states funded 50 nutritional state funded grants, not all states receive a reach grant.

Can you explain a little bit about how CDC selects the state that you receive a grant? Why all states are not funded? And if you see a difference between funded? And none funded states?

DR RUTH PETERSEN:

Thank you for that question. We don't have a competitive nature. We ask people to apply for the grants. We do have screens that are ranked. We do have the highest rank and we fund until he runs out of resources.

Let me just tell you that every state in DC applied for the same funding. Everybody had an application that met the criteria to be funded. So, we call that Approved but Unfunded. We have a list of those recipients now from four years ago. We would've funded all states if we had enough resources to do that.

I will put two caveats here: if we really want states to be effective through the (unknown term) interventions and working with partnerships, and sending the money to subcontract to local areas and local public health, they have to have enough money to do that successfully.

We put out approximately \$90,000 to every state every year for their funding because we know that is what it takes to hire staff, give subcontracts, do real work and develop partnerships.

This is our issue with Span. (?) We were able to fund 16. With reach, we funded 40 now and that is an increase within the last two years because Congress put more funding into the reach categories for funding. We had 260+ applications. So, the demand for this work at the ground level ? this is barely -- really where the boots are on the ground.

We barely have enough resources to meet the demands given the supply resources. As far as the question about outcomes, borrow, can measure the outcomes between funded and unfunded? I would take this to different levels. Look at where the funding needs to go, and where the maps are in dark, dark red colors.

We really need strong applications to come from the state public health and community-based organizations, and that is hard for people to do when they haven't had a assessment and public health ? over the last 10, 20 years, they don't have people who are experts in nutrition or physical activity, or in how you do evaluations.

So, we are actually really trying to figure out how to build capacity in the state as well so they can be more competitive. Thank you.

DARA LIEBERMAN:

Excellent. I'll put in a plug that TFAH put in a plug for dollars in nutrition, physical activity and obesity. We really believe this needs to be 50 state programs. We support the overall aquatic center funding as well.

A question for Carol -- Karol. You put in so many programs in Alaska. You saw disparity in obesity prevalent to Alaska native and Pacific Islander students. What he think that was? Carol Mack --

KAROL FINK:

Well, I am going to -- I'm going to look at how this is to take a lot of byway. We were not able to look at a lot of the states with all the resources. We had 400 elementary schools, not everybody was offering fish to schools. That has to do with reach.

While our programming was really innovated, the dose or the amount of the intervention that each of the students received was insufficient, right? For example, kids really getting salmon once a week in the Schoology program.

So, -- school lunch program. Anyone who tried dieting it takes a lot of work to change body weight. Eating healthy for a day or even a week doesn't result in much change.

We really wouldn't expect with these programs if you're eating fish only once a week to see a change. Doesn't mean our programs are ineffective, but it shows that only some kids were benefiting in the places where we had sufficient like our geographic areas, where we had sufficient reach.

But we didn't have a statewide or in the Anchorage metropolitan area.

DARA LIEBERMAN:

Thank you. Doctor Mozaffarian, you touched a little bit on the priority domains that you think we need to advance in the food system. Can you talk about how you think the federal government could incentivize the private sector to do more to make healthy foods more accessible? I also received a question asking if you can clarify what you meant by Disincentivizing unhealthy foods and incentivizing healthy foods?

DR DARIUSH MOZAFFARIAN:

Yes, well with incentivizing, we can have a program where they can choose enrollment. If they buy the incentivized food they get a dollar, and if they buy dis incentivized event they would get seven cents (?) for the dollar. So think this would be challenging because incentives are quite expensive.

So we set up this dis incentive program, and buying less of the unhealthy foods and buy more healthy foods, then they can shift their basket. In terms of ? shoot. Remind me of your first question again, Dara?

DARA LIEBERMAN:

How to incentivize private sector to take action?

DR DARIUSH MOZAFFARIAN:

I think this is crucial. The private sector is massive and there is lots of companies that are aiming to make more healthier foods, but they tend to cost premium and not accessible to everybody. The science is not always excellent. There is many things. First, there can be direct tax policies and companies the definitions of addressing equity or sustainability, or nutrition, can get tax breaks or tax benefits.

Second, low-cost loans or even grants ? as has been known with green energy ? green energy is a great model for that and governments and lots of things to promote green energy.

Third, government or nongovernment organizations can identify and promote clear investing metrics for companies pursuing nutrition. Right now, the so-called ESG metrics ? Environment Social Governance metrics are being major for major investors to invest in this inability around markets.

They, big investors, venture capital funds, pension funds and investors are demanding the company shows they meet environmental goals to have companies ? sorry, investors either stock. We need to do the same thing for nutrition so we can have an ESG metrics for nutrition.

Then there is B corporation status which is really interesting. It is legal status where companies say to their shareholders that they are not legally responsible to you. They have to extend the responsibilities to society.

The largest Corporation in the United States used to be Patagonia. Now it is North America, and has become the criteria for met B corporations. So they incentivize and reward B corporation status. Those are carrots and I think there are also sticks.

I agree we should have national excise tax on soda. That is an incentive. We have voluntary, and if it were mandatory, guidelines like salt and sugar. These would have penalized companies.

(Mobile phone rings)

Again, there is a lot there and we wrote a lot about this and I'm happy to go into more detail. But at the high level, the federal government has always selected industries that it wants to advance and simulate, I think food should be high on the list of priorities.

DARA LIEBERMAN:

Thank you. We also received several questions about the stigma around the term obesity, or the concept of obesity. Maybe, Miss Fink, you restrict your experiences and how you managed to have a effective way of having these conversations in a school setting with children and their families, or single kids being singled out.

Also, how did you gain buy-in around the situations and schools?

KAROL FINK:

I have been doing this for years now Mr. Duffin public health talking about these people and obesity. As we learn more, we have changed our language, and really, what we work on now is helping every child grow up in a healthy way ? or every student grow up in a healthy way.

We found that this language, and people having obesity, or people with obesity has really framed our conversation, and immediate more practical for our partners that don't work in public health at the level that we do, and the conversations come easy. I think, once we shifted our language.

We did start off in 2004. We were the obesity prevention and control program. We have rebranded our program as the physical activity and nutrition program, and I think it also helps bring people to us.

DARA LIEBERMAN:

Doctor Petersen, do you have anything that is that? And AC/DC approaches the language around the issue?

DR RUTH PETERSEN:

I think Karol gave a great answer. I want to emphasize that we do not call people diabetics anymore. We say people have diabetes. But when I trained in medicine, we still called people diabetics.

So, the same thing with obesity. It is person first language. You don't say that person is overweight or an obese person is a person struggling with obesity. This is somebody who has overweight. It is very awkward, but it does help with signifying that it is not a blame. There is no blame for this person.

It is very difficult. As some of the question in the chat about how to provide these programs, and how we are providing access to kids who need the opportunities to be involved with the preventative service of pediatric management intervention and not to make them ashamed? So, it is a great topic. We are working slowly, step-by-step, to make sure we do not blame people for their weight status.

DARA LIEBERMAN:

Yeah, I think this is what we really should emphasize in the report ? the social determinants of obesity and give everyone an opportunity to be healthy.

DR DARIUSH MOZAFFARIAN:

Can I just add to that? I think the mental health arena is very important here. We have learned to not shame people with mental health, as a real disease, but at the same time we don't say,

"well, you just don't have depression or bipolar disorder. It is OK to be depressed." No, we recognize it is a disease.

I think there has been a very appropriate pushback on shaming or blaming other people who have obesity or are overweight. I think there has been also recent trend in saying it is OK to be obese and we should be happy and elated and fine with that. I think that is not OK. It is a serious condition and devastating to people.

So, we have to find that balance, we recognize it is a disease, deal with it, recognize it is a societal and systems was -- wide problem. When two-year-olds are obese it is not the individuals fault.

But as of recently this push to just stop talking about obesity, and I think that is not good.

DARA LIEBERMAN:

Right, we need to give children a shot. There are many communities where they are not given a shot to be healthy.

Doctor, maybe a last word for you, the State of Obesity has been in the reports for the past two years. How do you think the COVID-19 pandemic has made change the way we address obesity in the future?

DR J NADINE GRACIA:

Thank you, Dara for that observation. I think it handles many -- highlights many of the points are palace talking about just seeing the growing and increasing rates of obesity, both in growing adults as well as children over time, but a greater appreciation and recognition, and sense of urgency that we have in regards to the need to address systems, conditions and social determinants as and think about how to advance policies that truly need sustainable and sustained, systematic, changes.

We are not, as you have been hearing some of these more recent comments, as a nation we are not funding or providing resources for prevention and public health ? that includes obesity prevention ? the magnitude and scale of the problem.

So we must assure that we increasing. Our recommendations in the 18 annual report from State of Obesity, increasing federal funding and how to support evidence-based obesity prevention programs you heard as examples.

This is what is happening in Alaska and other states, or we can actually address obesity rates and disparities. Tells looking at access and ensuring that everyone has equitable access for healthy and nutritious foods, that we are moving those obstacles and barriers. Also, this is a multisectoral issue. This is not solely public health or healthcare, but many sectors: education, transportation, housing, and others in the private sector that have a role to play as it relates to

assuring that everyone can attain healthy weight, maintain a healthy weight. This promotes health and well-being.

This is what we are learning and seeing in the context of this pandemic. We assume the worsening of chronic conditions in the pandemic, inclusive of mental health and well-being, and it should be a clarion a (?) call for us as a nation to prioritize health, retention and equity which is really assuring that everyone has a fair and just opportunity to be as healthy as possible.

DARA LIEBERMAN:

That is all of our questions. You can close up.

DR J NADINE GRACIA:

Yes, we are not the end of our briefing today. As you can see, there was much interest. We really want to thank our panelists for these great insights, and deliver the data and information, but their example school policies and recommendations of how we as a nation can truly address the obesity crisis.

We encourage you to share the resources that we have shared in the chat, and the recording and slides, and additional resources are going to be made available on TFAH's website at TFAH.org in the coming days. Please sit in for that. We will share those coming resources. But when you think your panelist today, thank you all for your commitment and dedication so that we truly can achieve health and well-being for our nation. Thank you, that concludes today's meeting.

Live captioning by Ai-Media