Congressional Briefing and National Webinar
State of Obesity Webinar: Better Policies for a Healthier America 2026Trust for America's Health
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TIM HUGHES:

Good afternoon, and welcome to a congressional briefing and national webinar on the report State of Obesity 2026: Better policies for a healthier America, hosted by Trust for America's Health, commonly known as TFAH. My name is Tim Hughes, the external relations and outreach manager at TFAH. We would like to thank our speakers and audience for being with us today.

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We encourage you all to share your thoughts and questions about today's presentation by typing them in the Q&A box. We will try to answer as many as we can as time permits. To open the Q&A box, click the Q&A icon at the bottom of your screen. From there, select enter when you are ready to submit your question.

Now it is my pleasure to introduce the moderator of this event, Doctor J. Nadine Gracia. Dr. Gracia is the president and CEO of TFAH. She is a national health equity leader with extensive leadership and management experience in the federal government, nonprofit sector, academia, and professional associations. As president and CEO, she leads TFAH's work to advance sound public health policy, address the social determinants of health, advance health equity, and make health promotion and disease prevention a national priority. Before joining TFAH, Dr. Gracia was the deputy assistant secretary for minority health and director of the HHS office of minority health during the Obama administration. Welcome Dr. Gracia.

DR. J. NADINE GRACIA:

Thank you Tim, and greetings everyone. Thank you all for joining us for today's briefing and webinar. Today we will be discussing Trust for America's Health State of Obesity report, which examines the latest data on obesity rates in the US. We will outline key features of

the obesity prevention policy landscape and identify potential policy opportunities to build healthier communities for all people. As Tim mentioned in our background, I'd like to share it again for those of you who are not familiar with our organization, Trust for America's Health, or TFAH, is a nonpartisan, nonprofit public health policy research and advocacy organization. We promote optimal policies for health and well-being for every person and community, and make the prevention of illness and injury a national priority. To give some context before I give an overview of this year's report, between 1999 and 2018, adult and youth obesity rates increased 39%, and represent an urgent public health challenge. Obesity increases risk for a range of diseases and health conditions, including type II diabetes, heart disease, depression, and many types of cancer.

Additionally, a 2025 study found that obesity-related medical spending exceeds $261 billion annually, adding billions of dollars to Medicare and Medicaid costs. Amid the ever-rising concerns of the cost of healthcare and the close association of obesity with many of the leading causes of mortality, there is no more important time than now for effective obesity prevention strategies.

Our agenda for today's discussion is going to cover four areas. First, we will review the latest data on national and state obesity rates and key findings from the 2026 report. Then we will discuss the policy implications of the 2025 Dietary Guidelines for Americans. Next, we will hear from a local public health department about how they are working with the community and federal partners to address obesity. Lastly, we will review key features of the current policy landscape and highlight policy opportunities from the 2026 State of Obesity report to further federal, state, and local prevention efforts. We will then close today's briefing and webinar with a Q&A session with all of our panelists, and we encourage you to submit your questions as you have them.

Since 2003, TFAH has published an annual state of obesity report highlighting key findings from the previous year's CDC Behavioral Risk Factor Surveillance System, also called BRFSS, and the latest iteration of the National Health and Nutrition Examination Survey, also called NHANES. The report tracks the US obesity rates by state, region, race and ethnicity, age, and gender. It provides state-level indicators, such as active transportation, food insecurity, and school nutrition. The report also serves as an index of key federal obesity prevention policies and programs and provides a set of policy recommendations based upon the latest and best available evidence. This year's report includes some encouraging news, as adult obesity rates remained relatively stable from 2024 to 2025.

This year's report also comes amid major shifts in the nation's approach to chronic disease prevention, treatment, and management, including wider use of GLP-1 medications and renewed emphasis on healthy eating. Even as healthy eating is getting more national attention, it is becoming harder for many families to afford healthy meals. This captures two major themes of the report. Now is a critical moment for investment in evidence-based obesity prevention policy and that those policies must take a systems approach to address obesity.

Obesity is a complex, chronic disease. It's influenced by many factors, many of which are beyond an individual's control. Those include economic and community contexts that shape people's daily lives, and their available choices around healthy food, as well as physical activity, education, jobs, stress, and financial security, all of which systematically affect health. For example, a family's ability to purchase healthy food may be limited due to their income. In addition, some neighborhoods have limited or no access to places to shop for fresh fruits and vegetables. Likewise, some communities have limited or no access to safe places to be physically active, such as recreation centers, walking paths, or parks. Health disparities also remain significant. Obesity rates and other chronic diseases vary by income, race and ethnicity, geography, and community conditions, reflecting broader structural barriers and inequity to healthy food, safe physical activity, and healthcare access. These barriers play a role in population specific obesity rates. Our report shows that adult obesity rates remain relatively stable for the second year in a row. Despite this, the number of adults nationwide living with obesity, four in 10, remains alarmingly high. Obesity rates among children and adolescents continue to increase, according to national data from 2021 to 2023 national health and nutrition examination survey.

Our analysis of CDC's 2025 behavioral risk factor surveillance system data finds that 21 states had adult obesity rates at or above 35% in 2025. The 2025 total falls between the 19 states reported in 2024, the 23 states recorded in 2023. The contract, no state reached a 35% threshold in 2012. Adult obesity rates fell significantly in two states: Louisiana's rate dropped from 39.2% in 2024 to 35.6% in 2025, and West Virginia's rate fell from 41.4% to 37.4%. Across state we see that rates continue to vary widely.

Within this context, obesity prevention efforts sit at an inflection point. We will address this in greater detail later in the webinar, but to provide some level setting and an overview upfront, over the last two years, significant federal workforce reductions have weakened the capacity to support chronic disease prevention efforts. This comes as access to nutrition programs have dropped precipitously. For example, a recent analysis found that SNAP participation has fallen by as many as 5 million people, including an estimated 2 million children. A number of significant reauthorizations, such as the Farm bill, and administrative actions, like implementation of front of package nutrition labeling, remain in play.

There is significant uncertainty as to the future path for nutrition and public health in the US. We have an opportunity to build on the stabilization of adult obesity rates, address the wide range of environmental and structural drivers of obesity, and build healthy communities and a strong public health system equipped to prevent obesity and related chronic diseases.

With that overview of the 2026 state of obesity report, I am pleased to welcome our terrific panel who bring deep expertise and experience in obesity prevention programs and policy.

I will introduce our panelists now. First is Alexia Thex, the president of the National CACFP Association, the leading national organization dedicated to education, advocacy, and support for the Child and Adult Care Food Program. She leads the association's strategic initiatives, advocacy efforts, and member engagement programs, working to strengthen access to nutritious meals for millions of children and adults nationwide.

Next is Dr. Sedessie Spivey, who serves as the program manager of the health assessment and promotion department at DeKalb Public Health in Georgia. She manages multidisciplinary teams focused on community health research, injury prevention, chronic disease prevention, and health equity.

Our third speaker is Kristy Anderson, the director of federal government relations at the American Heart Association, a recognized expert and thought leader on nutrition policy. At the American Heart Association, she has oversight of federal legislative activity across the organization's advocacy priorities related to public health, prevention, research, access and care delivery.

Their full bios can be found on our organization's website at TFAH.org, under our Webinars and Briefings page.

With that introduction, I will now turn it over to Alexia Thex with the national CACFP Association to discuss the new Dietary Guidelines for Americans and their potential implications. Alexia, welcome.

ALEXIA THEX:

Thank you so much, Nadine. Rebecca, if you would advance the slides. Today I will talk about policy implications for the US Dietary Guidelines. I will focus more on the CACFP, where my expertise is. With the release of the most recent dietary guidelines, of course, we anticipate corresponding meal pattern updates. The question is not whether the DGAs affect child nutrition programs, they already do.

Nutrition programs, such as school meals, summer meals, summer EBT, SNAP, WIC, and the USDA Child and Adult Care Food Program, work hand in hand to raise healthy eaters. We already know millions of children are already receiving healthier meals each day with the CACFP and other child nutrition programs. One strategy to improve nutrition for future generations is to strengthen programs already serving healthy meals today. Specifically, CACFP serves as an early intervention mechanism to ensure children build good, healthy habits.

Earlier this year, USDA released a memo regarding the most recent DGAs, so we will talk about these points with regard to the CACFP meal pattern. The updated DGAs recommend prioritizing protein foods at every meal. Many protein foods are already creditable in the CACFP meal pattern. Affordability is a major contributing factor influencing the purchase

of protein foods. Any recommendations that increase the cost of meals should be accompanied with increased funding.

The DGAs encourage a wide variety of dairy fat options. While CACFP and school breakfast program were not included in the Whole Milk for Healthy Kids act, USDA did release a final rule expanding these fluid milk options in child nutrition programs. Operators welcome this flexibility, not only allowing providers to choose the milk that best supports the children they serve, but offering alternatives when they are unable to find one type of milk in their area. We hope to see this type of flexibility in any future rulemaking.

The DGAs promote the consumption of fruits and vegetables and all of these types are available throughout the day. Fruit and vegetables are widely served in food programs and often the most sourced components when purchasing through local food procurement.

Of course, incorporating healthy fats from whole foods such as meat, poultry, eggs, seafood, nuts, seeds, full fat dairy, olives, and avocados, is something the DGAs recommend and all of these sources of healthy fats are also creditable in the CACFP. The DGAs recommend prioritizing fiber rich whole grains while significantly reducing refined grains, specifically, those high in added sugars. The two biggest challenges operators face today are finding affordable whole-grain options, and easily determining which whole-grain options are creditable in the food program.

The DGAs recommend limiting certain highly processed foods, added sugars and refined carbohydrates. Added sugar limits already exist in CACFP for yogurt and cereal. Best practices also encourage operators to reduce added sugars. A lot of highly processed foods that are made from refined grain or high in added sugars do not credit in the CACFP because they fall into a category called grain based desserts, which of course are not creditable in the food program. Research consistently finds that children in the CACFP settings receive higher quality meals and consume more milk, whole grains, fruits, vegetables and have diets that are most closely aligned with the federal nutrition recommendations.

Childcare providers are already among the nation's most effective nutrition partners. Children in CACFP settings eat healthier meals than they receive elsewhere. CACFP meal patterns already reflect the Dietary Guideline recommendations. The challenge is not provider willingness, it is resources. Let us talk about these challenges. Currently operators are facing challenges. New updates could exacerbate these challenges. For example, healthier foods and adding components would increase cost. Finding creditable products could become more difficult. The administrative burden of the program could increase. Staff turnover could increase. The disparity between reimbursement, and actual program costs could be even greater.

Reimbursement must align with the true cost of the programs. Operators of nutrition programs care deeply about the children that they serve. In the CACFP, many are serving

additional meals and snacks that they are not getting reimbursed for. The USDA SNACS-II study estimated meal cost for centers in the CACFP. The red bar represents USDA estimates for cost of meals. The green bars represent reimbursement amounts for the program year for which the study was done, 2022 to 2023.

A reminder that these reimbursement rates that you see here included the extra 10 cents for every meal and snack that was in place during COVID. What is important here is that the reimbursement at the time, even though it included the 10 cents, only accounted for an average of 26% of breakfast costs, 35% of lunch costs, and 21% of snack costs.

Any proposed rule must take into account the additional burden for operators. In 2015, USDA submitted a report to Congress providing recommendations for reducing the paperwork burden in the CACFP. For the past decade, the paperwork requirements have increased significantly, driving eligible providers off the program. We must strengthen the nutrition program infrastructure by providing ongoing training and technical assistance, ensuring that practical and reasonable implementation timelines are put in place and making equipment investments, especially if scratch cooking is the goal.

A 2019 study found that 39% of eligible childcare centers and 33% of eligible family homes did not participate in the CACFP. Only one in 16 eligible children receive afterschool meals. Sponsoring organizations serve as a backbone of the CACFP ensuring compliance and providing much needed nutrition training. Some states are implementing innovative childcare solutions to address childcare shortages and yet these new types of sites can not participate in the program.

CACFP operators are caregivers first and foremost, they are small business owners. Strengthening the CACFP also requires adequately funding and supporting the settings in which these meals are served. CACFP helps makes healthcare more affordable for working families. The dietary guidelines shape the meal patterns of nutrition programs. Child nutrition re-authorization, which has not happened in over 10 years, provides an opportunity for strengthening nutrition programs and the CACFP school meals and other nutrition programs provide an effective delivery system. If we want children to meet the goals of the dietary guidelines, we must strengthen the programs that reach them first and reach the best.

Thank you so much, I appreciate being able to speak with you today, thank you Nadine.

DR. J. NADINE GRACIA:

Thank you so much Alexia, for that informative presentation. We are now going to hear from Dr. Spivey with DeKalb Public Health. Dr. Spivey, welcome.

DR. SEDESSIE SPIVEY:

Thank you. At DeKalb Public Health, my work brings communities and partners together to help prevent chronic disease. Today, I will share what more than a decade of CDC REACH support has helped us accomplish and what our experience means for policy. As you listen, think about one person who makes prevention personal to you.

DeKalb Public Health serves more than 760,000 residents, more than one half are Black or African-American. We take much pride in the strength of our diversity. Which means, effective prevention means understanding the different challenges residents face and working with communities to address them. This chart compares causes of death in DeKalb and Georgia from 2018 to 2023. The key takeaways, cardiovascular disease and cancer are two leading causes in both places. Although DeKalb's rates are lower in several categories, these conditions remain major challenges, which means prevention is essential.

The CDC Places 2025 release estimates that about 32% of DeKalb have obesity, which means approximately one in three adults. Obesity increases the risk of cardiovascular disease and is linked to several cancers. Addressing these risks requires information, support and community conditions that make healthier choices easier. Our approach has been straightforward: assess, plan, act, and use the information we learn to inform policy. We use data to identify community needs, we plan with residents and partners, and put those plans into action with partners that we know and trust.

We evaluate our work, and share findings with local, state, federal leaders to help guide decision. CDC REACH funding helped us put this approach into practice. Through Lead DeKalb, meaning Local Efforts towards Addressing Disparities in DeKalb, our work has grown in three phases. From 2014 to 2018, we built a foundation focusing on nutrition and physical activity. This include mobile farmers markets and expanded access to safe places to be active for more than 13,000 residents.

From 2018 to 2023, we strengthened our connections between community programs and clinical care. Our current phase, through 2028 focuses on lasting changes in community design, food service guidelines, and vaccine access. Since 2020, our mobile clinics have vaccinated more than 22,000 adults against COVID 19 and flu. These efforts show what sustained support can help local communities accomplish.

How do we keep work going when the grant ends? REACH helps us get changes started, local planning and policy helps sustain them. We incorporate REACH strategies into our community health improvement plan, with clear goals, partner responsibility, and evaluation. This gives partners a shared direction and helps us track progress, build support, and seek additional resources. Our 2026 Walk It Out challenge offers an example. 400 people registered, 108 active walkers, which resulted in more than 6.6 million steps in 12 weeks.

Now, partner organizations now sponsor walking campaigns, residents serve as walking ambassadors. We also work with municipalities on walking policies, and with County planners to include walkability in the 2055 comprehensive land use plan. What does this mean? That connects a community activity to planning decisions that can support physical activity for years.

We have learned from this experience that trusted community partners, local planning, and supportive policies are essential to sustaining prevention. Based on that experience, we recommend three things. Sustain and expand multi-year federal funding for community led prevention. Fund local health departments directly. And three, invest in local data and evaluation capacity. If I have one request, and that request is simple, keep investing in programs like REACH, and help local health departments get resources to the communities that need them the most.

In closing: I mentioned earlier to everyone, I asked you to think about why prevention matters to you. For me, it was personal and still is. When I was nine, my father had multiple strokes due to high blood pressure. He spent the rest of the life in a nursing home. I often wondered now, and I have been for many years, what might have been different if our family had known more about prevention? And had more support to make healthy choices. I want families to have that information and support before a health crisis similar to ours happens. That includes policies that make healthier food affordable, and create safe places to be active.

As I close, consider one thing you can do or one policy you can support to make prevention more accessible. In the team picture are those that helped make this work possible and I'm grateful to their dedication. That team includes members of the CDC team, members of the DeKalb Public Health team, and members of the Live Healthy DeKalb Coalition, which is an example of how partnerships work and how federal level partnerships can make a major difference in the community. Thank you for this opportunity.

DR. J. NADINE GRACIA:

Thank you very much Dr. Spivey. Thank you for bringing such a critical perspective from the local health department and your emphasis on the importance of partnership and the impact it has for communities. Really appreciate your presentation. Now we will hear from our final speaker, Kristy Anderson from the American Heart Association. Before I turn it over to Christy, a reminder to our audience, please submit your questions to our panel using the Q&A future. Welcome, Kristi.

KRISTY ANDERSON:

Thank you Dr. Gracia, thank you everyone joining us. Those are two amazing speakers that are difficult to follow, but I’m going to try my best. I am going to go over things that the federal government can do outside of the clinical setting. We know that prevention

requires different aspects and avenues, but this focuses on the social determinants of health aspect. It's also going to be a very high-level overview, it will touch on the biggest things that are top of mind. There are so many other things we can do. First off, we have the Farm Bill, which is way overdue. I noted the other day that we are supposed to be in the next cycle for the next Farm bill, we are still working on the previous cycle. These are the programs that are authorized under the farm bill: SNAP, GusNIP, which if you don't know is a fruit and vegetable incentive program for SNAP participants, food distributions program on Indian reservations, seniors farmers market nutrition program, emergency food assistance program, commodity supplemental food program and community food projects.

I often say that the Farm bill is a misnomer because all of these programs are under Title IV, the nutrition title, and that makes up the overwhelming majority of the Farm bill. What is really holding up the Farm bill is the Supplemental Nutrition Assistance Program, which under the One Big Beautiful Bill Act made significant cuts to access to the program. We already heard the statistics about those who have no access to the program, and in particular the numbers of children who are no longer on the program. The other part of that is when you talk about dual eligibility and other ways of… sorry. I'm going to be honest with this crowd, I have perimenopause brain and sometimes it just Swiss cheese and I'm trying to find the right word and that was one of those situations where it did not come through.

Also, eligibility for other programs. There is a downstream effect. If children are cut off of SNAP or are still eligible but their parents can no longer access it, there is that downstream effect of school meals that they may be eligible for, but they are not receiving it for whatever reason.

The farm bill is really at an impasse right now. We have a bill that has passed the house, a bill that just squeaked out of the Senate agriculture committee, prior to them recessing for the election. But at the end of the day, the Senate need 60 votes. It's going to be really interesting to see what happens in the Senate, particularly on the Senate floor. They need 60 votes to pass, and right now the Democrats are holding firm with Republicans, saying there needs to be a two-year delay in one of the provisions, which is a cost share to states. Something else the One Big Beautiful Bill Act did is that it fundamentally shifted the cost share. Previously, the federal government paid for the entire benefit and part of the administration benefit. Now it will be based on the error rate.

I will say error rates are not the same as fraud rates, these are administrative errors. But again as I talked about downstream effects, that is the hold up. As we have the holdup, all these other programs that help our most vulnerable are also in limbo now.

We heard Alexia talk a little bit about child nutrition reauthorization, last time we had a reauthorization was 16 years ago in 2010, these are all the programs authorized under child nutrition reauthorization. Most of these are mandatory programs, which means they do not need reauthorization, but it would be nice, particularly post-pandemic. We have a

lot of lessons learned on these programs, how to make them more efficient, how to make the food served even better for kids, and I have another point on that

We have learned that healthy school meals for all, for example, that we had under the pandemic waivers, does a wonder of making sure that kids are not only fed but fed with healthy foods. Since the 2010 Healthy Hunger Free Kids Act, one of the things we learned is that school meals are one of the healthiest sources of foods for kids. We have seen tremendous progress since the 2010 nutrition standards, they have been updated several times since, they are getting better and better. At the end of the day, we cannot continue to improve on any of these programs without resources. I will harken back to school meals, as we hear the conversation around removing ultra process food from schools, getting to more scratch cooking, we cannot do that without infrastructure. Many schools do not have things like a kitchen to be able to cook food. They do not have the money for labor costs to have enough workers. You have that downstream effect, so many schools also provide these other programs. As we think about ways to continue to improve what our kids receive and their health, we have to have a "come to Jesus moment" on is this a worthy investment? Our opinion is that it is. We need to stop nibbling around the edges, no pun intended, but really invest those resources for infrastructure, technical assistance, training. Way beyond just focusing on the nutrition standards and the type of foods that are being served.

We have agriculture appropriations. For those who don't know, appropriations are one of the bills that have to be passed every single year otherwise the government shuts down. We see a lot of legislating in appropriations, which as a former Senate staffer, is not my favorite thing, but if the only bill going through is an appropriations bill, that's where we see it. You can see under the agriculture appropriations bill, the overwhelming majority is the supplemental nutrition program, child nutrition, and other things that are addressed in the Farm bill. There is this parallel track running here with both the farm bill and agriculture appropriations. We see a lot of appropriations riders year after year. This year, the appropriations riders are pretty benign-ish. I've been at this a long time, there have been a lot of bad ones in the past. I anticipate next year in the agriculture appropriations, as we see in the rulemaking (which I have a slide on in a moment), we will see a lot of legislating on appropriations, a lot of riders. We have seen, too, but there is a lot of influence among industry as far as what it makes it in appropriation and what doesn't. But the American Heart Association, we are gearing up for a wild ride in appropriations.

Other appropriations of interest: Dr. Spivey was talking about the REACH program, under the labor H appropriations. There is also appropriations that deal with social determinants of health and nutrition, under the military construction appropriations. There is also food is medicine, dealing with native communities in the interior, environment and related agencies appropriations. There are lots of little parts in pretty much every single appropriations bill that can touch on this issue of social determinants of health. How do we make our environment set up so the healthy choice is the easy choice. It is safe to say most people want to be healthy but that are so many environmental factors that prevent

them from being healthy.

Transportation reauthorization: this is also one that is pending. I get a lot of, why does the American Heart Association care about transportation reauthorization? This is the only funding line that provides money for active transportation infrastructure. It has funding for active transportation, transportation alternatives program, safe routes to school, vulnerable user safety, complete streets, built environment and green spaces. Basically, making sure that when we are thinking about rebuilding our roads, rebuilding our ways to get from here to there, we think about multi-mobile users, that is not car centric, that we're thinking about those who roll, those who bike, those who walk. Making sure we are thinking about those things and thinking about the user safety. I think a lot of folks—here in DC, we're very lucky. We have a very pedestrian friendly city. Not every city is like that. I hear way too often, I would walk more but my street does not have a sidewalk, my street does not have a curb cut out, or I just don't think it's safe, there are too many accidents.

That technically expired a month ago, but there is a short-term extension through December. I think we are going to get another extension in December, whether it is just to punt it to the beginning of the next congress or next year, I don't know yet. The house has provided a bill. It is OK for active transportation policies. There are some that could be better, there are some that we are pretty happy with. We have not seen a bill out of the Senate. The Senate will not have a bill, unless they pull off a miracle in this recess, they will not have the bill. We are definitely going to have an extension. The question is how long. The next Congress, can we do more to bump up, to increase the investment in these sorts of infrastructure projects so people have the choice to be more active.

I want to touch on regulatory action. I mentioned that a little in the beginning of my remarks. We have several that we are waiting on: child nutrition, which we understand is going to be looking at nutrition standards for school meals, for CACFP, WIC. We are waiting on front of pack, we are waiting on phase II sodium reduction, we are waiting on generally recognized as safe (GRAS). We are seeing these things happen, particularly with GRAS and school meals, a lot of states stepping in. We're seeing states regulate ultra processed foods in schools or trying to close the GRAS loophole in lieu of federal action. Of course the ultra processed food definition, which is not necessarily a regulatory action but a white paper outlining the direction the federal government should take. That is going to affect all of these programs, every nutrition program. Recently finalized implementing rules that will have an effect on everything we do, particularly in the nutrition space: SNAP retail requirements rule, SNAP work requirements, definition of healthy, salt substitutes—that one just happened earlier this month—generally recognized as safe, which is an in lieu situation. I believe that is my last slide. Thank you, I look forward to answering your question a little bit.

DR. J. NADINE GRACIA:

Thanks so much, Kristy. Really informative presentation. To our audience members, as you

heard Kristy illuminate, there's been such a significant amount of change in terms of the obesity prevention landscape recently. Many policy actions that continue to be in flux. Thank you for providing that important overview. With that context, I want to now turn to the specific policy recommendations in the 2026 State of Obesity report, which are organized around seven themes. Some of these areas you have heard have also been addressed by our panelists.

First, investments in the federal public health infrastructure and programs that support prevention of obesity truly should be a priority. Congress and HHS should retain CDC's National Center for Chronic Disease Prevention and Health Promotion and increase investments in CDC's chronic center, including the division of nutrition, physical activity, and obesity. Programs such as the state physical activity and nutrition program also known as the SPAN program and the REACH program that was highlighted by Dr. Spivey to help support state and local efforts to build healthier communities and have a demonstrated track record of effectiveness. For example, evaluations found that communities served by REACH programs experienced decreases in the prevalence of obesity that were not found in comparison communities.

Additionally, the percentage of Black and Hispanic adults reported eating five or more fruits or vegetables daily increased in communities served by the REACH programs, yet we know these programs do not receive sufficient funding to reach every state. Congress and the administration should also ensure funding is delivered in a timely, transparent, predictable way because unexpected disruptions in the flow of funds significantly hinder the ability to engage in long-term planning or sustain efforts that lead to better health outcomes. In addition to providing critical funding, to states, localities, and other partners, CDC has other critical roles it plays in promoting and protecting nation's health. Expert staff at CDC help evaluate programs for effectiveness, they disseminate findings on best practices, and connect partner organizations across the nation to enhance their capacities and abilities and ensuring that federal agencies have adequate staffing should be a congressional and administrative priority. Second, as noted at the top of the webinar, obesity is a complex chronic disease, and systemic and structural factors play a significant role in the risk of obesity. Removing structural barriers like lack of economic opportunity, limited access to safe physical activity, affordable nutritious food and affordable housing should be a priority. Potential mechanisms include an expanded child tax credit to reduce childhood poverty, and a prioritization of multimodal and active transportation projects in infrastructure reauthorization. At the state and local levels, governments can and should expand complete streets and vision zero plans to make active transportation safer, as well as zoning reform that prioritizes affordable housing in communities with multiple sources of healthy food and connection to transit.

With the nutrition policy space being very active, states are grappling—as you heard from our speakers—with changes to the SNAP program. Institutions at all levels are working to implement the Dietary Guidelines, and Congress is working as it relates to the reauthorization of the Farm bill. The first and foremost, Congress should eliminate the cost

shift of SNAP benefits and administrative costs to states as well as eliminate work requirements and other changes to program eligibility. Congress should increase investment in healthy food incentive programs, like GusNIP and expand access to WIC programs that you've been hearing about through this webinar.

All children should have access to healthy school meals, and to support and improve nutrition standards, congress should provide more resources to school lunch programs. A recent school nutrition association survey found that 99% schools will cite a lack of resources as a major barrier to scratch cooking in their schools. Congress and states should increase access to the community eligibility provision, which allows schools in high poverty areas to expand free school lunch access, and consider the adoption of universal free school meals. We know universal school meals have been found to decrease nutrition insecurity, improve health outcomes, reduce lunch shaming and even improve academic performance. Congress should also increase reimbursement rates and fund nutrition education through child and adult care food programs that you've been hearing about today, which have been proven to improve health outcomes and reduce obesity in preschoolers from low income households.

In addition to providing resources for healthy nutrition, Congress should also close tax loopholes and deductions that incentivize marketing of unhealthy foods to children. The Food and Drug Administration should implement a front of pack labeling scheme for packaged foods. We know front of pack labels help consumers make educated decisions about the foods that they purchase and have been shown to reduce consumption of unhealthy foods in countries that have adopted them. Finally, at the state and local level policymakers should consider the implementation of sugary beverage taxes. When implemented with care, these policies have been shown to meaningfully reduce consumption of sugar sweetened beverages and provide significant funding source for other public health investments. The final two categories of recommendations involve increasing access to physical activity and healthcare. Programs like the Student Support and Academic Enrichment grants, help fund physical education in schools, and Every Kid Outdoors, helps families access outdoor recreation and national parks, they help build lifelong healthy habits in children. Congress should increase investment in both as well as similar programs. Lastly, we have primarily focused on the prevention of obesity and chronic diseases outside of clinical settings, support for obesity prevention treatment and management within the healthcare system, and the close collaboration between public health and healthcare truly remain essential. Congress and the Center for Medicare and Medicaid Services should expand coverage under Medicare and Medicaid for obesity preventative services, weight management, food is medicine interventions, and obesity treatment. Congress should reverse cuts to Medicaid and marketplace subsidies that have reduced millions of individual's access to coverage and healthcare. Medicare and Medicaid can also be powerful programs for building and strengthening community partnerships to address non medical drivers of health and health related social needs.

This concludes our panel presentation. We will now open it up for Q&A. As a reminder, please submit your question by opening up the Q&A panel and type your question to all panelists. We will get to as many questions as possible with the plan remaining in our webinar. I'm happy to now be joined by our colleague Drew Wallace, our government relations manager at the TFAH, to help moderate the Q&A. I am going to begin with the first round of some of the questions, then Drew will join me in asking additional questions that are also coming from the audience.

Perhaps let me start, with Dr. Spivey. I was struck by a point in one of your slides, you noted for example the process that you use at DeKalb Public Health, it says federal investment supports every step of the process. Can you talk to us more about how recent changes to federal funding and staffing affected local obesity prevention work?

DR. SEDESSIE SPIVEY:

Thank you for the question, want to preface that: when we submit grant proposals we always plan for change. With that being said, at the local level, the funding has impacted some of our staffing and the contractors that we utilize to complete our goals and objectives. We have had to restructure our staffing responsibilities and we've had to end some of our contractors. One of the ways that we've pivoted to meet our goals and objectives for the REACH funding is that we leverage our relationships with local partners. I mentioned during the discussion, we have Live Healthy DeKalb coalition, which has been around for decades. We usually identify how we can engage the community and mobilize the community to continue those efforts. We was cut from our funding each year, so we are now headed to year four. We have created an infrastructure if you will, where we leverage some of our internal resources as well as the coalition, which means that we're able to continue and have a more long-lasting impact. For example that I use is the relationship with the DeKalb County Planning Department, we are now having meetings and discussing, how do you include walkability as part of your long-term planning? We are using that to sustain our effort from now forward.

DR. J. NADINE GRACIA:

Thank you, Dr. Spivey. Alexia, let's go to you. SNAP participation, we've been talking about this, has dropped by as many as 5 million people. What does that mean for families and states taking on more of the cost?

ALEXIA THEX:

Thanks Nadine I think both you and Kristy covered the fact that the decline is 5 million, which includes an estimated 2 million children. It basically means, and Kristy you touched on this, families need to lean more on school meals, childcare providers, food banks, pantries and other programs to fill those gaps. This decline also affects direct certification for nutrition programs, which affects eligibility for programs such as the community

eligibility provision in school and also universal school meals and area eligibility for CACFP, which affects family homes and afterschool meals programs. What this means is that people are not eligible simply by being on SNAP. Therefore, operators of the program have to pursue paperwork for individuals to get them those meals and programs, which often leads to an incredible amount of administrative burden.

DR. J. NADINE GRACIA:

Thanks so much Alexia for painting a further picture of what this means for families, households, and communities. Let's turn to Kristy and then to Drew, who is getting some additional questions from our audience. What would you say, for folks to understand, why did the 2025 - 2030 get mixed reviews from the public health community?

KRISTY ANDERSON:

Thanks, that's a good question. I think the mixed reviews is twofold. A lot of what was recommended in this latest integration of the Dietary Guidelines for Americans is not new. It recommended increased produce consumption, vegetable and fruit consumption. At the same time, it took a departure of the known nutrition science, particularly around saturated fat. Not only did it recommend eating more red meat, cooking with beef tallow, at the same time the overarching recommendation still has a percentage of calories due to saturated fats. It's a little bit of a mixed bag, these dietary guidelines. At American Heart, we were glad they're recommending more fruits and vegetables but we disagree with the saturated fat recommendation. You have a departure for the first time ever, where the agencies did not take the recommendations from the Dietary Guidelines for Americans committee. I think that also led to some of the controversy within the public health community.

DR. J. NADINE GRACIA:

Thank you, Kristy for helping our audience understands the mixed reviews that we saw. Drew, let's go to you for some additional questions.

DREW WALLACE:

Sure, Dr. Garcia, this one's for you. As you said, we are seeing a stabilization of some adult obesity rates. The audience want to know how much impact GLP-1 medications had on that trend?

DR. J. NADINE GRACIA:

Thanks for the question, obesity, as we have all been saying, it's a complex chronic disease. Multiple factors influence obesity. In addressing obesity, it really requires that we take a holistic and comprehensive approach. That includes prevention, treatment, and

management. GLP-1's are an important development in the treatment and management of obesity and other chronic diseases. At the same time, they do not replace the importance of healthy food environments, physical activity, prevention programs and the other types of support programs and wraparound services needed, like nutrition education. We also know the medications are not affordable and accessible because of the limitations we see for example as it relates to insurance coverage.

What is important here is we continue to have a holistic approach as we think about obesity and address obesity rates in the country. Preventing obesity is more cost-effective and is going to continue to be a critical component to how we address this public health issue. That means investing in prevention programs like the SPAN program and the REACH programs to ensure we have the full suite of tools available to address this important public health issue.

DREW WALLACE:

Thank you Dr. Gracia. Kristy what are some opportunities for supporting healthy nutrition education in schools to help children build healthy habits?

KRISTY ANDERSON:

Thanks Drew, I will first point out in chat, somebody had mentioned that the One Big Beautiful Bill Act also completely eliminated the SNAP Ed program. I would be remiss if I did not bring that up as well. One of the things we can do, is SNAP Ed as it has been known is dead. It's gone. We have been working with lots of other organizations to basically create a new national nutrition program. For what it's worth, I've heard from a lot of congressional offices that there's a lot of buyer's remorse that that happened in One Big Beautiful Bill. I think that is opportunity to do that. One of the challenges particularly in schools is every school sets its own curriculum and we have this mass uncertainly right now with what the Department of Education is doing and what will happen there. We see a lot of great best practices. Schools will integrate nutrition education in math or science courses. We have a lot of great programs with, for example, farm to school where the local farmer that provides produce comes in and gives a lesson on how it is being grown. I was at a site visit where there was a science lesson on soil and pH balance. It was really cool the kids were interested. They planted peppers, it was really a remarkable thing. I think looking at these best practices, the things that we see and integrate into everyday learning and everyday life is one of the best ways we can get to that information out there. We can talk all we want about improving nutrition and physical activity but if you don't have the tools and resources and education on why it is important, we are not going to go very far.

DR. J. NADINE GRACIA:

Thank you Kristy, thank you all for these great questions that you have raised to our speakers today. We appreciate all of you tuning in for today's webinar, that brings our

briefing and webinar to a close. As further resources, a copy of TFAH's 2026 State of Obesity Report newsletter can be accessed through the QR code on the next slide. The report is also available on TFAH.org. I would again like to thank our speakers, AI media captioning service, Keystone interpreting, our behind-the-scenes TFAH staff and all of our attendees for joining today. Thank you for being so engaged with this conversation. You can stay connected with us via subscribing to our newsletters and/or following us on our social media channels. The recording and slides from today's webinar will be available on our website at TFAH.org by next week. Thanks everyone and thanks for joining us. Take care.