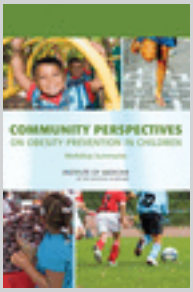

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COMMUNITY PERSPECTIVES
ON OBESITY PREVENTION IN CHILDREN
Workshop Summaries

Paula Tarnapol Whitacre, Annina Catherine Burns,
Cathy Liverman, and Lynn Parker, *Rapporteurs*

Food and Nutrition Board

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"Knowing is not enough; we must apply.
Willing is not enough; we must do."
—Goethe

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JUNE 2008 WORKSHOP SUMMARY

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this report:

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This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this report:

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by the Institute of Medicine, he was responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authors and the institution.

Preface

Obesity among the nation's children has increased dramatically over the past several decades. Recent statistics show that nearly one-third of U.S. children and adolescents are overweight or obese, which puts their physical and emotional health at risk, severely compromises their future well-being, and adds significant costs to the country's already massive health care expenditures. As the public health threat of childhood obesity has become clear, the issue has become the focus of local, state, and national initiatives. Many of these efforts are centered on the community environment in recognition of the role of environmental factors in individual behaviors related to food and physical activity.

These efforts have shown that the seemingly simple formula for preventing obesity of consuming fewer calories than expended must take into account the social, environmental, and policy-related factors that affect eating and physical activity. Otherwise, success is almost impossible to sustain over the long term. In many communities, for example, fresh produce is not available or affordable, streets and parks are not amenable to exercise, and policies and economic choices make fast food cheaper and more convenient than healthier alternatives. Addressing such factors can have an impact on obesity rates across communities by creating conditions that facilitate healthier options for children and their families. In the past few years, recognizing the consequences of inaction, a growing number of nonprofit organizations, government agencies, policy makers, and others have stepped up their efforts to combat the obesity epidemic. Carried out in diverse settings and with diverse populations, these efforts have resulted in

many promising approaches that encompass the community context rather than focusing solely on individual weight-loss programs.

These community efforts vary in scope and scale; overall, however, they remain fragmented, and little is known about their effectiveness. At the local level, communities are struggling to determine which obesity prevention programs to initiate and how to evaluate their impact. Recommendations presented in recent Institute of Medicine (IOM) reports on prevention of childhood obesity[1,2] include actions that can be taken by multiple stakeholders and all sectors to improve children's nutrition, increase their physical activity, and decrease their sedentary time. According to the 2005 IOM report *Preventing Childhood Obesity: Health in the Balance*:

> Given that obesity is a serious health risk, preventive actions should be taken even if there is as-yet-incomplete scientific evidence on the interventions to address specific causes and correlates of obesity. However, there is an obligation to accumulate appropriate evidence not only to justify a course of action but to assess whether it has made a difference. As childhood obesity is a serious public health problem calling for immediate reductions in obesity prevalence and in its health and social consequences, the committee strongly believes that actions should be based on the best available evidence—as opposed to waiting for the best possible evidence. (p. 3)

In this context, the IOM's Food and Nutrition Board held two workshops—in June 2008 and May 2009—funded by The California Endowment. The purpose of the workshops was to inform the IOM's current work on obesity prevention in children through input from individuals who are actively engaged in community- and policy-based obesity prevention programs. Community perspectives were elicited on the challenges involved in undertaking policy and programmatic interventions aimed at preventing childhood obesity, and on approaches to program implementation and evaluation that have shown promise. Highlights of the workshop presentations and discussions are presented in this volume.

[1] IOM (Institute of Medicine). 2005. *Preventing Childhood Obesity: Health in the Balance.* Washington, DC: The National Academies Press.

[2] IOM. 2007. *Progress in Preventing Childhood Obesity: How Do We Measure Up?* Washington, DC: The National Academies Press.

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SUMMARY OF WORKSHOP 1

June 2008

1

Introduction

Participants in the June 2008 workshop included evaluators and site leaders involved in a variety of childhood obesity prevention programs that are part of the California Convergence project, an effort led and sponsored by The California Endowment and Kaiser Permanente. The California Convergence project is aimed at promoting learning, synergy, and collaboration among community demonstration programs that are at the cutting edge of efforts to address the problem of obesity in the state, as well as nationwide. Each program within the project is focused on enabling and encouraging people to make more healthful choices with respect to both diet and physical activity (California Convergence, 2008).

The workshop included two 2-hour moderated discussions—one with program evaluators and one with site leaders. These two groups are involved on the ground in efforts to develop, implement, and evaluate local childhood obesity prevention programs. Their insights are critical to improving use of the current evidence base and understanding the best approaches to implementing and evaluating childhood obesity prevention programs. Based on recommendations of the California Convergence project, approximately 40 individuals representing diverse obesity prevention programs across the state were invited to participate in the workshop sessions; 11 evaluators and 22 site leaders attended. The workshop attendees are listed in Appendix C.

A planning committee convened by the Institute of Medicine (IOM) prepared questions in advance of the workshop to facilitate the discussion. Using these questions as a starting point, the participants described the challenges involved in collecting and using relevant scientific evidence to

inform the planning and implementation of multifaceted community-based obesity prevention programs, as well as opportunities for improving program evaluation. This brief summary highlights the ideas expressed by the program evaluators and site leaders during their respective workshop sessions; it should be noted that these ideas do not represent consensus views or recommendations.

2

Perspectives of Evaluators

During the program evaluators' session, a number of themes emerged regarding actions that hold promise for improving the ability of evaluators to measure the progress and outcomes of community-based obesity prevention programs:

- Address the need for common measures for evaluating obesity prevention programs.
- Sustain long-term commitments by foundations and policy makers so that impact can be demonstrated and better assessed.
- Identify or develop relevant research models that can be applied to evaluation of community-based programs.
- Ease the burden that is often imposed by evaluation, particularly on targeted community members who are frequently oversurveyed.
- Develop solutions to the data burden associated with multifactorial obesity prevention measurements.
- Improve opportunities for publishing and disseminating evaluation results.

ADDRESS THE NEED FOR COMMON MEASURES

A number of the evaluators expressed frustration at the lack of an accepted methodology and common measures for evaluating the complex program and policy changes involved in childhood obesity prevention. According to several evaluators, a set of common measures would facilitate the evaluation process, allow communities to learn from each other, and

permit cross-program analysis. One participant pointed out the significant investments being made by communities in developing their own evaluation tools and assessment instruments, and suggested that the development of common measures would not only save money, but also help consolidate the experience of communities in complementary areas. To date, that kind of exchange has been difficult to achieve.

On the other hand, it was noted that individual obesity prevention programs use different evaluation measures for some good reasons. For example, an important benefit of community-based programming is that it can be targeted to a local population and environment, and evaluation measures need to be tailored to this context. Participants raised concern about applying a one-size-fits-all measure to very different and often diverse communities. Even within the same community, programs serve different needs for different policies, initiatives, and funders, so a variety of measures may be necessary. Some participants suggested that the lack of common measures is a consequence of the multiple factors involved in obesity, including the community environment, physical activity and the existence of safe areas for play, eating behaviors, and access to healthful foods. This multifactorial nature of obesity necessitates multiple interventions within a community, which in turn may require multiple evaluation approaches. A further challenge to the development and use of common measures arises in multisite studies, where the comparisons across sites made possible by such measures may be divisive, creating an atmosphere of competition rather than collaboration. Another issue is how one can compare two programs with the same measures when the two communities involved started from different baselines. For example, community A may already have obesity prevention policies and strategies in place at the start of an intervention, while community B has none. If both communities are evaluated using the same measures, how does the evaluator account for the fact that community B has made fewer gains in obesity prevention because it started from a different point? The end result may be that communities with the greatest need are evaluated as less successful than their counterparts, and their programs are therefore discontinued.

To address this tension between the need for and the pitfalls of using common measures, several evaluators suggested developing such measures as a starting point and giving the evaluator the flexibility to incorporate additional factors so as to tailor the evaluation to the specific program, population, and community environment. It was further suggested that, through the formation of a working group of experts in the field and community-based evaluators, and perhaps through regular workshops and seminars, a range of evaluator perspectives and experiences could be incorporated into the development of common measures.

SUSTAIN LONG-TERM COMMITMENTS BY FOUNDATIONS AND POLICY MAKERS

Several evaluators noted that when funders or policy makers fail to see demonstrable outcomes in the short term, they are unlikely to continue funding a program. Yet the expectation of short-term progress is often unrealistic given the nature of community-based obesity prevention programs. Such programs take time to develop and implement, and hence time to show change. Moreover, many of the strategies used for childhood obesity prevention are new, and approaches and activities are continually being modified as new evidence and ideas emerge. Participants suggested, then, that the challenges of measuring progress toward a sustainable healthier lifestyle at the community level need to be better understood by sponsors of childhood obesity prevention programs. It was suggested that evaluation needs to focus on more than achievement of this ultimate goal. It is also important to capture some of the intermediate steps along the way, as well as such accomplishments as increased support for certain initiatives, engagement of key stakeholders, and other advocacy/coalition-building achievements.

IDENTIFY OR DEVELOP RELEVANT RESEARCH MODELS

A number of participants raised questions about how obesity prevention programs are assessed in the scientific community, particularly when use of the traditional randomized controlled trial (RCT) is considered the gold standard for all researchers. Participants suggested that RCTs often are not feasible for assessing community-based interventions—particularly interventions targeting a multifactorial condition such as obesity that is attributed to the community environment. Evidence-based research models that depend on a controlled environment are simply not appropriate for the problem at hand. One participant suggested that the monetary incentives used to encourage people to participate in academic research trials affect the results, and that such trials are not an accurate reflection of reality.

Thus participants stressed the limited applicability of current research models to the evaluation of programmatic and policy-based obesity prevention programs. One participant proposed that evaluators develop a journal supplement on evaluation tools for such programs. Another participant suggested that this issue needs to be raised more broadly within the scientific community.

EASE THE BURDEN THAT IS OFTEN IMPOSED BY EVALUATION

As noted, obesity prevention involves multiple interventions and therefore a range of measures of progress over time. One concern raised by

participants was the burden this imposes on both community members and evaluators. The same individuals are often asked to respond to surveys multiple times, sometimes by different evaluators whose efforts are not coordinated. Further, funders frequently want progress reports, necessitating evaluation at various points throughout a program. This repeated evaluation has led to complaints by community members that they are continually filling out surveys.

Evaluators participating in the workshop acknowledged that progress reports are important. But they also emphasized the need to ensure that communities do not develop resistance to the research aspect of programs because they are constantly being surveyed, often by various funders that ask similar questions. Moreover, evaluators must work with site leaders on the administration of evaluations. A few evaluators reported that site leaders sometimes think they need to protect community members from feeling like research subjects. It was suggested that site leaders report all current evaluations to a database so as to document the evaluation load on their community. Funders could then determine the optimum timing for their evaluations to ease the burden on the community.

DEVELOP SOLUTIONS TO THE DATA BURDEN ASSOCIATED WITH MULTIFACTORIAL OBESITY PREVENTION MEASUREMENTS

Another issue related to data collection involves the above-noted multifactorial nature of childhood obesity prevention programs, which can necessitate multiple evaluations. This need to examine a range of variables, together with the push to have measurable outcomes or compare favorably with RCT standards, adds to the evaluation burden on community members. It also burdens evaluators by making surveys more complicated and difficult to design while weakening the measures collected as more and more measures are added. As one participant noted, the responses provided to surveys become less reliable as more questions are asked and the surveys grow longer. Although evaluators may have more measures to work with, the accuracy of answers and the difficulty of including so many variables are problematic for evaluators and those being evaluated. The balance between collecting an adequate amount of information and sustaining the strength of the evaluation by not over collecting information needs further discussion.

IMPROVE OPPORTUNITIES FOR PUBLISHING AND DISSEMINATING EVALUATION RESULTS

A number of participants cited the difficulty of publishing and disseminating the results of community- and policy-based obesity prevention

interventions in the scientific literature. The inability to find journals or other venues in which to publish the results and lessons learned from these interventions makes it difficult to share the growing body of knowledge on obesity prevention strategies and programs with colleagues within and outside of the field. One participant attributed this difficulty with getting results published to the lack of comparison groups and traditional measurable outcomes, and suggested that the situation is driving many community-based evaluators to attempt to achieve the "gold standard" for evidence-based results when, as discussed above, its application is not appropriate.

In addition, several evaluators pointed out that articles in scientific journals are not a common source of information on evaluation techniques in community-based settings. Such publications frequently focus on short-term controlled studies involving a single activity that are not applicable in these settings. As a result, published data often are not helpful to those developing or evaluating community-based obesity prevention strategies. Instead, participants reported that they rely more heavily on "gray literature" or unpublished studies to inform their work in community-based settings.

In discussing publication bias, several evaluators expressed their belief that in selecting articles on childhood obesity interventions, journals favor programmatic interventions over sustainable environmental changes, which are more difficult to specify. Yet most of these participants were working to change the community's environment rather than implementing a single, short-term program.

3

Perspectives of Site Leaders

During the discussion in this session, several themes emerged with respect to how better decision making and improved evaluations can be achieved:

- Improve coordination and communication among the various stakeholders involved in the implementation and evaluation of obesity prevention programs.
- Lengthen evaluation periods so that positive change can be demonstrated.
- Enhance evaluation methods to capture progress toward program goals as well as long-term outcomes.
- Develop local data that are helpful in setting baselines for measurement of the success of obesity prevention efforts, and an accessible database to track community-based obesity prevention initiatives and their effectiveness.

IMPROVE COORDINATION AND COMMUNICATION AMONG THE VARIOUS STAKEHOLDERS

Site leaders described what it is like to work in individual communities. They are relied upon as the contact point for various stakeholders, including funders, evaluators, and policy experts. A number of site leaders believe this creates an overreliance on one individual without an adequate infrastructure or additional staff to support the types of programs that are needed. One of the concerns raised was the lack of a clearinghouse func-

tion that would allow communication among the various stakeholders and reduce this reliance on a single community site leader. Often policy experts, funders, evaluators, and site leaders fail to communicate with one another. As a result, information is not available to those who need it, and goals are set and strategies implemented without the input of important stakeholders. A number of site leaders suggested that regular forums involving all stakeholders would be helpful in addressing this concern.

LENGTHEN EVALUATION PERIODS

Site leaders acknowledged the important role of evaluation in childhood obesity prevention programs. However, a number of them also expressed frustration with evaluation on several fronts. Sustainable, multifaceted changes to the community environment take time, especially given the nature of working with local city planners, councils, and neighborhoods, among other stakeholders. The initiation of projects and the achievement of progress often require agreement and action by multiple parties at the community level. Yet evaluations are commonly conducted in a short time frame.

ENHANCE EVALUATION METHODS TO CAPTURE PROGRESS AS WELL AS LONG-TERM OUTCOMES

Several site leaders suggested the need to develop evaluation methods that can capture a community's interim gains toward childhood obesity prevention instead of just ultimate outcomes. They described working in low-income communities where a significant proportion of children are struggling with being overweight or obese, and where the local environment poses several obstacles to children's engaging in healthful eating and physical activity. In such a context, an exclusive focus on measuring outcomes could be problematic. For example, as discussed earlier, a community's obesity rate may be so high that it is infeasible to achieve measurable positive changes in a relatively short time frame. Several site leaders emphasized that progress in environmental change is difficult to achieve but is a necessary step in obesity prevention. Typical evaluations fall short in capturing this important point. As one site leader suggested, the key is determining how to measure change, not necessarily an end point; evaluations of childhood obesity prevention programs are always, in a sense, process evaluations because communities are never going to complete the improvements they are seeking to effect. Site leaders proposed that discussion and development of progress measures for childhood obesity prevention programs would be a positive step and that they could be helpful if called upon to contribute to such efforts.

DEVELOP LOCAL DATA AND AN ACCESSIBLE DATABASE

A number of site leaders reported that, to work effectively within a community, they need readily available local data on various aspects of the community. The availability of community-based data that have already been collected would allow them to spend more time designing and implementing interventions and less time collecting preliminary information.

During the discussion of local data needs, two major issues emerged. First, local data about the built environment, population characteristics, and other factors would facilitate tailoring work to the community's needs and benchmarking progress. Yet several participants cited a lack of access to such data; rather, data often are available only at the state or national level.

A second data issue is a lack of access to information on obesity prevention programs and successes within the site leaders' own or other communities. Several participants were unaware of how to access past evaluations or other data previously collected, or even how they would know that such data had been collected in their own or similar communities. Although they know the data are being collected, they do not know where and how the data can be accessed.

One way to address this issue would be to institute a web-based forum or database that would report details of initiatives, studies, measures used, and evaluation results. Such a web-based resource could document past and current studies and evaluations and be easily searchable by community, town, district, or county. Having this resource would render more useful the large amount of data being collected and save valuable time that could then be devoted to program development and implementation.

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SUMMARY OF WORKSHOP 2

May 2009

Summary

The May 2009 workshop brought together policy makers, advocates, researchers, program staff, and others seeking to understand how the environment affects the prevalence of obesity and to develop policies and programs based on this understanding. Presenters in three panels discussed how they use the relationship between environmental variables and health outcomes as obesity-related evidence in planning, implementing, and evaluating prevention efforts and in shaping policies that support such efforts. (See Appendix A for the workshop agenda.) Presenters drew on experiences as varied as the environments in which they work—from urban neighborhoods in Baltimore to rural central California, from grassroots-led research in Seattle to senior-level policy-making bodies in New York City. Comment and question periods after each panel session brought the audience's rich knowledge and experience to bear on the discussion.

LESSONS FROM COMMUNITIES

Presenters in the first panel session focused on the role played by evidence in community-based initiatives in Santa Ana, California; Baltimore; central California; and Washington, DC. As described in Chapter 5, the following themes emerged from this on-the-ground experience:

- **Each location has unique characteristics that must be understood before programs or policies are developed.** Each community has its own health-related concerns, eating preferences, and activity patterns, as well as socioeconomic conditions, opportunities, and con-

straints created by the built and natural environments. Presenters explained how they have drawn on different data sets, inventoried existing programs, and talked with experts and community members to further their understanding of the local obesity problem, its causes, and potential solutions. In some cases, they noted that they would have benefited from more localized data than are currently available.

- **Obesity prevention fits within a broader context.** All four presenters spoke of the need to define obesity prevention as a component of healthy living, rather than just as individuals' attempts to lose weight. Obesity relates to issues as varied as public safety, education, and economic development. Successful approaches therefore involve law enforcement agencies, planning agencies, schools, neighborhood associations, public health departments, and many other stakeholders.
- **Sustainability must be built into community-based obesity prevention efforts.** While foundations and public entities focus vital resources and attention on the obesity problem, each presenter noted the need to look beyond such finite sources of funding. For example, the presenters reach out to churches and other community-based organizations, push to have public health departments integrate obesity prevention into their regular services, and provide targeted assistance in leadership development and other skills to nonprofit organizations that can carry on the work. They value receptive elected officials, but also recognize that they must establish relationships that extend beyond the election cycle.
- **Obesity prevention is a long-term goal.** As promising as many of these initiatives are, the presenters noted that eating and physical activity behaviors developed over generations will take many years to change. They stressed the need to view efforts to address the obesity epidemic as a movement and not a program with a narrow focus or fixed period for implementation.

LESSONS FROM RESEARCH AND ADVOCACY ORGANIZATIONS

The second panel consisted of representatives from nonprofit organizations that serve as a bridge between community-based programs and policy makers. These organizations provide research and other support to communities while also building on community experience to advocate for resources and policies at the local, state, and national levels. As reported more fully in Chapter 6, the presenters made the following key points:

- **Decision makers have different frames of reference in dealing with obesity prevention.** While some easily grasp the connection between obesity and community environments, others frame the issue solely as a matter of individual choice. Some see a clear role for government; others remain skeptical. Some expect to see clear financial benefits to obesity-related and other preventive health expenditures. Organizations must find ways to deal with these different frames of reference.
- **Research is only one type of evidence upon which policy makers draw.** Only in rare cases do research findings alone, however definitive, move policy; the expectation that science alone will lead to policy change is unrealistic. Policy makers are confronted with political considerations, views of trusted advisors and constituents, their own experiences, economic analyses, and numerous other inputs. A related point is the need to collect consistent health and economic data from those obesity programs that are in place to permit clearer conclusions about what is working and the cost implications.
- **The way the evidence is presented is critical.** Policy makers are barraged with information. The organizations represented on the panel continually seek the most effective ways to build on the evidence to draw the attention of policy makers, the media, other opinion leaders, and the public. These methods include mapping and other visuals, easy-to-grasp metrics, brief summaries of relevant research, and personal stories and testimonials.
- **Research, action, and policy can be linked to increase impact.** The presenters shared examples in which communities, instead of just serving as the subject of a research study, participated in collecting, analyzing, and disseminating the evidence. The community thus becomes more engaged in the research, and the result is often tangible changes in policies or programs.

LESSONS FROM POLICY MAKERS

In the final panel of the workshop, elected and appointed officials presented their first-hand perspectives on how obesity- and other health-related evidence enters into the policy-making arena. As summarized in Chapter 7, the presenters shared valuable insights about what it is required to enact policies aimed at reducing childhood obesity. These insights included the following:

- **Local governments have a large role to play in obesity prevention.** From recreation and open space, to the food served by public

agencies, to planning and zoning issues, cities and counties are the entities that enact policies with a direct bearing on the health of their citizens.

- **Many types of evidence influence policy making.** Echoing the previous panels, these presenters confirmed that policy makers are confronted with an overwhelming number of issues and concerns. The fact that scientific evidence points to the need for a certain policy is rarely in itself sufficient to ensure enactment. Instead, advocates for such policies must form coalitions, present the evidence in a clear and timely manner, and look for champions both inside and outside of government. The level of evidence needed before a policy is enacted also depends on the costs, both monetary and political. Often, evidence is presented to justify a decision based on a particular issue. It is helpful to policy makers if the context for local government, cost, and feasibility are all addressed when a policy decision is being advocated.
- **Accountability and constituent contacts are important inputs for local policy makers.** In Minneapolis, the fact that the obesity rate is one of 20 indicators measured and reported on annually helps spur action and call attention to the issue. Local officials heed even relatively small numbers of phone calls or e-mails from voters in favor of or against an issue.

OVERALL THEMES

Taken as a whole, the presentations and discussions with the audience conveyed the critical need to listen to and build on community voices in fighting childhood obesity. Approaches that involve a wide range of partners—including neighborhood groups, government agencies with a range of missions, and businesses—characterize many of the promising efforts discussed throughout the workshop sessions. As many speakers noted, a paradigm shift that recognizes the role of the community environment in obesity prevention is emerging, but is far from universally accepted. Other common messages that emerged were highlighted in the workshop's closing remarks and are summarized below:

- **The diversity of community efforts represents both a strength and a drawback.** It sparks innovation and empowers people to work toward their own better health. However, this diversity also complicates efforts to measure impact and build the strongest possible evidence base. The field must grapple with this dichotomy to achieve the ultimate outcomes of improved health and a reduction in obesity rates.

- **Obesity-related policy must occur "in all places" to form a long-term movement toward better health.** The development of comprehensive frameworks for community efforts to create healthy environments is under way. The need persists to educate, convince, and inform actors and decision makers in other sectors that health and health policy are their allies in changing the shape of community environments for the better.
- **Communication is key to this work.** Communication is needed to develop a common understanding of obesity prevention and to articulate the shift from individual interventions to environmental change in combating the obesity epidemic. Differences in expectations and professional paradigms can lead to a breakdown in communication. Dialogue on how different sectors view evidence, for example, can help bridge these divides. The importance of communication also relates to how best to present research and other evidence to draw the attention of policy makers.
- **The question remains of whether a set of data should be collected consistently across communities.** Some divergence of opinion arose about the use of body mass index (BMI) data in community-based interventions, yet no recommendation for an alternative has emerged. Another issue voiced by several speakers is whether assembling the entire chain of evidence—from environmental interventions, to changes in food and physical activity behaviors, to changes in BMI—is necessary for every intervention. Moreover, many community residents have expressed that they do not want to serve constantly as the subject of research studies that lead to no visible improvement.
- **Community knowledge is an essential building block in reducing childhood obesity.** Community knowledge is the cultural context. Local information about the population and knowledge about what programs are more likely to work or have been shown to work help form and set policy priorities for communities and different contexts, from soccer fields in Santa Ana to green carts in New York City. Ongoing engagement of neighborhoods and residents strengthens leadership and power within communities, which in turn helps create and sustain change.

4

Introduction

The May 2009 workshop brought together policy makers, advocates, researchers, program staff, and others seeking to understand how community environments affect the prevalence of obesity and to develop community-based policies and programs built on this understanding. The Institute of Medicine (IOM) staff and planning committee organized the workshop around three interrelated panels: the first comprised representatives of community-based programs who discussed the information they need to move ahead; the second involved staff of research and advocacy organizations that provide a link between communities and policy makers; and the third consisted of decision makers who explained how community perspectives affect policies in their jurisdictions. After each series of presentations, the audience was invited to ask questions and make comments. These discussions reflected the broad background of attendees, including urban planners, nutritionists, activists, and researchers. (See Appendix A for the workshop agenda, Appendix B for biographies of the planning committee, IOM staff, and the presenters, and Appendix C for a complete list of the workshop attendees.)

WORKSHOP THEMES

Approaches that involve a wide range of partners—including neighborhood groups, government agencies with a range of missions, and businesses—characterize many of the promising efforts discussed throughout the workshop sessions. As many speakers noted, a paradigm shift that recognizes the role of the community environment in obesity prevention is

emerging, but is far from universally accepted. Other common messages that emerged during the day were highlighted in the workshop's closing remarks and are summarized below:

- **The diversity of community efforts represents both a strength and a drawback.** It sparks innovation and empowers people to work toward their own better health. However, this diversity also complicates efforts to measure impact and build the strongest possible evidence base. The field must grapple with this dichotomy to achieve the ultimate outcomes of improved health and a reduction in obesity rates.
- **Obesity-related policy must occur "in all places" to form a long-term movement toward better health.** The development of comprehensive frameworks for community efforts to create healthy environments is under way. The need persists to educate, convince, and inform key players and decision makers in other sectors that health and health policy are their allies in changing the shape of community environments for the better.
- **Communication is key to this work.** Communication is needed to develop a common understanding of obesity prevention and to articulate the shift from individual interventions to environmental change in combating the obesity epidemic. Differences in expectations and professional paradigms can lead to a breakdown in communication. Dialogue on how different sectors view evidence, for example, can help bridge these divides. The importance of communication also relates to how best to present research and other evidence to draw the attention of policy makers.
- **The question remains whether a set of data should be collected consistently across communities.** Some divergence of opinion arose about the use of body mass index (BMI) data in community-based interventions, yet no recommendation for an alternative has emerged. Another issue voiced by several speakers is whether assembling the entire chain of evidence—from environmental interventions, to changes in food and physical activity behaviors, to changes in BMI—is necessary for every intervention. Moreover, many community residents have expressed that they do not want to serve constantly as the subject of research studies that lead to no visible improvement.
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ferent contexts, from soccer fields in Santa Ana to green carts in New York City. Ongoing engagement of neighborhoods and residents strengthens leadership and power within communities, which in turn helps create and sustain change.

COMMUNITY VOICES AND EVIDENCE

As Marion Standish, Director of Healthy Environments for the California Endowment, observed in her opening remarks, community experience is part of the overall effort to understand what does and does not work, and how well it works, in combating obesity. Despite the power of community experience, researchers and policy experts have found it difficult, according to Standish, "to articulate the 'hows' and 'whys' of that experience and how it should inform and influence our work." The Endowment supported this workshop, she said, to detail community experiences and better use those experiences to inform policy and research and build a body of evidence.

"Often we think we have a good policy. It passes, but it doesn't work in a community. The value of community eyes and community voices … is an immeasurable asset in the work that we do."

—Marion Standish

Loel Solomon, National Director of Community Health Initiatives and Evaluation for Kaiser Permanente, reminded workshop participants and audience members of the statement of Goethe often cited in IOM publications: "Knowing is not enough; we must apply. Willing is not enough; we must do." Those words, he said, set the stage for the workshop. Credible evidence is essential, but "what we really are about," he said, "is changing our environments, changing our communities so people are healthier." He described a complementary IOM study cofunded by Kaiser Permanente to develop a framework for how evidence on obesity prevention is developed and translated into action (A Framework for Decision-Making for Obesity Prevention: Integrating Action with Evidence). Planning for that study affirmed that end users' perspectives are vital because the social context for decision making is larger than the development of credible evidence. Solomon described a challenge presented to the steering committee for the framework to "reinvent" the abbreviation RCT (which traditionally stands for "randomized controlled trial"), with R standing for "relevant," C for "communicate," and T for "timely." These three attributes, as much as the rigor of a study's design, are what communities and policy makers take into account in their obesity prevention efforts.

As demonstrated in projects funded by The California Endowment, The Robert Wood Johnson Foundation, Kaiser Permanente, and others,

evidence does play a role at key junctures in community change processes. In planning, evidence is used to determine what has worked elsewhere. It improves programs as they are under way, and can be a vital tool for influencing policy change and decision makers. At the same time, however, Solomon stressed the importance of recognizing that different audiences and different kinds of decisions require different levels of evidence.

For instance, community groups find useful many tools that do not adhere to accepted cross-experimental design; an example is PhotoVoice, in which community members document their experience and viewpoints through photography. In contrast, the Congressional Budget Office is debating the kinds of evidence it needs to generate what have been termed "scorable savings" for prevention. As highlighted in the workshop, policy makers draw on different levels of evidence depending on the issue under consideration and the myriad of other issues competing for resources and attention. Solomon urged the IOM, as well as workshop participants, to play a role in determining what constitutes evidence to support change.

"It is really important for us to hold to the fact that different audiences and different kinds of decisions require different levels of evidence."

—Loel Solomon

REPORT ORGANIZATION

This report follows the organization of the workshop. Chapter 5 summarizes the presentations of community-based representatives and the discussion that followed. Chapters 6 and 7 highlight the presentations of nonprofit organizations and policy makers and ensuing discussions, respectively. Chapter 8 summarizes the closing remarks of representatives of two foundations that have supported many community-level programs. It should be noted that consensus recommendations were not sought during the course of the workshop, and thus are not presented in this report.

5

Community-Based Programs: How Does Information Help Them Achieve Their Goals?

Communities across the country are at the front line of efforts to reduce childhood obesity. Presenters in the first panel of the workshop are involved in local and regional efforts that work directly with children and adults on obesity prevention and other health-related goals. Understanding how organizations like theirs use and produce evidence provides insights into how to structure research that community groups can use effectively, as well as how to build and evaluate programs that respond to each community's context and priorities.

In introducing the session, planning committee chair Patricia Crawford, Co-Director of the Center for Weight and Health, Cooperative Extension Nutrition Specialist, and Adjunct Professor, University of California, Berkeley, noted that the four presenters have different perspectives on the information needs of community programs and initiatives based on their diverse contexts and experiences—rural and urban settings, government agencies and private organizations, efforts targeting young children and adolescents. Despite this diversity, their presentations reflected some common messages with respect to how communities gather, use, and produce evidence:

- **Each location has unique characteristics that must be understood before programs or policies are developed.** Each community has its own health-related concerns, eating preferences, and activity patterns, as well as socioeconomic conditions, opportunities, and constraints created by the built and natural environments. Presenters explained how they have drawn on different data sets, inventoried

existing programs, and talked with experts and community members to further their understanding of the local obesity problem, its causes, and potential solutions. In some cases, they noted that they would have benefited from more localized data than are currently available.

- **Obesity prevention fits within a broader context.** All four presenters spoke of the need to define obesity prevention as a component of healthy living, rather than just as individuals' attempts to lose weight. Obesity relates to issues as varied as public safety, education, and economic development. Successful approaches therefore involve law enforcement agencies, planning agencies, schools, neighborhood associations, public health departments, and many other stakeholders.
- **Sustainability must be built into community-based obesity prevention efforts.** While foundations and public entities focus vital resources and attention on the obesity problem, each presenter noted the need to look beyond such finite sources of funding. For example, the presenters reach out to churches and other community-based organizations, push to have public health departments integrate obesity prevention into their regular services, and provide targeted assistance in leadership development and other skills to nonprofit organizations that can carry on the work. They value receptive elected officials, but also recognize that they must establish relationships that extend beyond the election cycle.
- **Obesity prevention is a long-term goal.** As promising as many of these initiatives are, the presenters noted that eating and physical activity behaviors developed over generations will take many years to change. They stressed the need to view efforts to address the obesity epidemic as a movement and not a program with a narrow focus or fixed period for implementation.

As summarized in this chapter, Gerardo Mouet, Executive Director, Parks, Recreation, and Community Services Agency, Santa Ana, California, discussed the challenges his agency faces in making maximum use of limited open space to benefit city residents. Leslie Bernard, Director of Special Projects, Associated Black Charities, Baltimore, Maryland, spoke about a citywide partnership to reduce rates of obesity, especially among adolescents, and described how its "blueprint" was created. Genoveva Islas-Hooker, Regional Program Coordinator, Central California Regional Obesity Prevention Program (CCROPP), explained how a regional initiative has been more effective than eight separate jurisdictions competing against each other for funding and other resources. Finally, Canary Girardeau, Senior Program Associate, Summit Health Institute for Research and Education,

Inc. (SHIRE), Washington, DC, described work in the District of Columbia Ward 8 that targets young children in home-care settings. Through these four presentations and the discussion that followed, this session of the workshop highlighted various types of community-level initiatives across the country, explored their use of and need for evidence, and provided an on-the-ground perspective as new approaches are developed and refined.

PROVIDING OPPORTUNITIES FOR RECREATION IN DENSELY POPULATED SANTA ANA, CALIFORNIA

When Mr. Mouet became Executive Director of the Parks, Recreation, and Community Services Agency in Santa Ana, he led an effort to change the agency's mission to include health and fitness. Mouet listed six agency goals that connect use of the park system with healthy living:

1. Increase places for youth to play sports, with expansion of joint-use areas (such as school fields) as a key approach.
2. Increase the effectiveness of programming on existing recreational open space, given that Santa Ana's open space is very limited.
3. Encourage healthy eating at parks and recreational facilities.
4. Encourage healthy lifestyles in all Santa Ana homes through a variety of classes and other programs.
5. Maintain public safety at parks and recreational facilities.
6. Keep parks green, clean, and beautiful to encourage people to visit them.

Using Information to Promote Program Goals

The agency uses a variety of data to understand community characteristics and make changes to programs. Santa Ana, the largest city in Orange County, is very densely populated. Fully 76 percent of the population is Hispanic, and a great percentage of these residents are foreign born. The median age is 26. According to the U.S. Census Bureau, 24 percent of Santa Ana children under age 18 live in poverty, double the average in the surrounding county. The state's open space average is 3 acres per 1,000 residents, but it is less than one-third that amount, or 0.9 acres per 1,000 residents, in Santa Ana. According to data from the California Physical Fitness Test, 40 percent of fifth and seventh graders in the Santa Ana Unified School District are overweight or obese, compared with 29 percent in the rest of Orange County and 32 percent statewide, and fewer of these students meet the state's six physical fitness standards than is the case elsewhere.

Mouet said soccer is not only the most popular recreational sport in the city, but also an important support and information network for many

Gathering and Using Information in Santa Ana

- A review of soccer team rosters revealed the extent of resident versus nonresident use of city facilities, which led to policy changes to give priority to local youth.
- Park rangers and neighborhood associations serve as "eyes and ears" to learn what is happening on park grounds. Without this monitoring, policies to promote the safe use of facilities by youth would not remain effective.
- Foundations not only provide needed funding, but also elevate the issue with policy makers.

people with limited English proficiency. Soccer leagues flourish, and the soccer fields are continually in demand. However, monitoring field activity and examining team rosters made clear that nonresident adults were the primary beneficiaries, often excluding Santa Ana's youth. Mouet adjusted policies so local youth soccer organizations have first priority in obtaining field-use permits to encourage their physical activity. Yet because the fields are so limited in Santa Ana and elsewhere compared with demand, he admitted the reform process took "years and years of pain and agony and lots of politics." Today, an estimated three-quarters of the 12,000 regular soccer players on the city's fields, children and adults, are Santa Ana residents.

Finding Information with Which to Run and Assess Programs

Mouet said the agency takes many approaches to ensure that its programs, many of which take place after school and on weekends, remain effective. Perhaps most valuable is having reliable "eyes and ears" on the ground to keep tabs on the parks and joint-use areas. Park rangers, many of whom are retired police officers, walk around the areas and file end-of-watch reports. They monitor what is being sold by vendors and concession stands and encourage them to offer healthier menu items. Mouet and his staff follow up on issues and complaints raised by neighbors near the fields and other members of the public. Otherwise, the primarily nonresident adult soccer leagues would again dominate use of the fields, and many public safety concerns would go unresolved.

Fields and other recreational spaces on school property sit unused after school hours. The school district does not want to spend its budget on opening up its facilities after hours, so Mouet's agency also manages these joint-use areas despite a severe budget crunch. The agency partners

with nonprofit organizations, churches, and others to continue recreational programming at these sites.

In another effort to gather and use information, the agency commissioned a 1-year assessment of the lack of open space as a contributing factor to risks associated with problem behaviors in youth, including childhood obesity and gang involvement. The assessment is integrating surveys, focus groups, geographic information systems (GIS) mapping data, and other information. Mouet plans to share its findings with the mayor and city council, the school district, the planning agency, and others to demonstrate the impact of open space on the city's youth.

Linking Nutrition and Physical Activity to Broader Community Priorities for Sustainability

Working with policy makers, foundations, and neighborhood associations helps link nutrition and physical activity with broader community priorities. Having the right policy maker in place makes a big difference. Mouet said that when he began his job in 2002, a city council member interested in health and fitness was in office and served as a champion for these issues.

Mouet noted that foundations provide more than funding. When they select a grant recipient, they raise awareness of the issue with local policy makers. Santa Ana's grant from The California Endowment has built momentum and excitement with the mayor, the city council, and other officeholders.

Even so, elected officials come and go, with differing priorities. Working with neighborhood associations links obesity-related goals to broader priorities that outlast electoral changes. For example, complaints from a neighborhood association about graffiti in a nearby park led to a partnership whereby the agency keeps the space safer. Since then, residents have become more physically active and help monitor park safety. This partnership serves as a model for the agency's work with other groups. Future plans include finding ways to work with the soccer leagues and with Mexican-area clubs (made up of people who come from the same Mexican state). Because of the community's high interest in both of these types of organizations, they have great potential to help with outreach and increase awareness of health and nutrition goals.

> *"I believe in civic engagement, getting the immigrant population involved, the soccer league organizations, … the neighborhood associations … because policy makers come and go, and funding cycles come and go...."*
>
> —Gerardo Mouet

DEVELOPING A CITYWIDE BLUEPRINT FOR HEALTH IN BALTIMORE

Ms. Bernard discussed the Baltimore Blueprint for Healthy Outcomes in Children, a partnership to address childhood obesity. A grant from The Robert Wood Johnson Foundation enabled Associated Black Charities and the Association of Baltimore Area Grantmakers to bring together a diverse group of community partners, including neighborhood and youth-serving organizations, communities of faith, and health agencies, to understand and recommend how to reverse the rising trend toward childhood obesity in the city. The partners developed the Baltimore Blueprint to Reduce Community Obesity, which they released in spring 2008 at "Eat Right! Get Moving!," a community summit attended by nearly 500 residents. In discussing the blueprint and related activities, Bernard stressed that she spoke on behalf of the many people involved in the effort.

To develop an action plan to halt the rise in childhood obesity in Baltimore, the project formulated four objectives:

1. Define and describe the problem of childhood obesity in the city to understand contributing risk factors.
2. Identify innovative, evidence-based local and national approaches to increase healthy eating and physical activity.
3. Educate citizens and community leaders about childhood obesity and opportunities for its prevention to build informed constituencies that can serve as effective advocates.
4. Advocate for policies to decrease childhood obesity at the local and state levels.

Using Information to Promote Program Goals

Bernard said data from three main sources defined the scope of the problem in Baltimore: the Women, Infants and Children (WIC) program of the U.S. Department of Agriculture, the Youth Risk Behavioral Surveillance System (YRBSS) of the Centers for Disease Control and Prevention (CDC), and eight school-based health centers. These data revealed, for example, that 37 percent of Baltimore public high school students are or are at risk of becoming overweight, compared with 29 percent statewide. The data also demonstrated a significant gender component: more than 40 percent of the city's female students are overweight or at risk, compared with 25 percent nation- and statewide.

In addition to estimating the prevalence of obesity, the partnership researched why the problem exists. Five categories of risk factors that contribute to obesity prevalence in certain areas of the city were identified:

Some Lessons from Baltimore

- Focus on obesity prevention as part of a movement for health equity, not a separate program.
- Engage youth (community residents, university interns, and others) in gathering evidence. As they learn, they also question and analyze.
- Learn from each other. Many positive efforts are already under way. A group such as Associated Black Charities can forge connections among such efforts.

(1) the local food environment, in which healthy food is more difficult to obtain and more expensive than less healthy options; (2) physical inactivity in schools without gyms or other facilities; (3) the built environment, including planning and transportation issues; (4) crime and safety concerns that influence the use of parks and other recreation facilities; and (5) socioeconomic factors and racial disparities. Combining and mapping of data sets showed that neighborhoods with higher rates of poverty had higher rates of overweight and at-risk high school students (Figure 5-1).

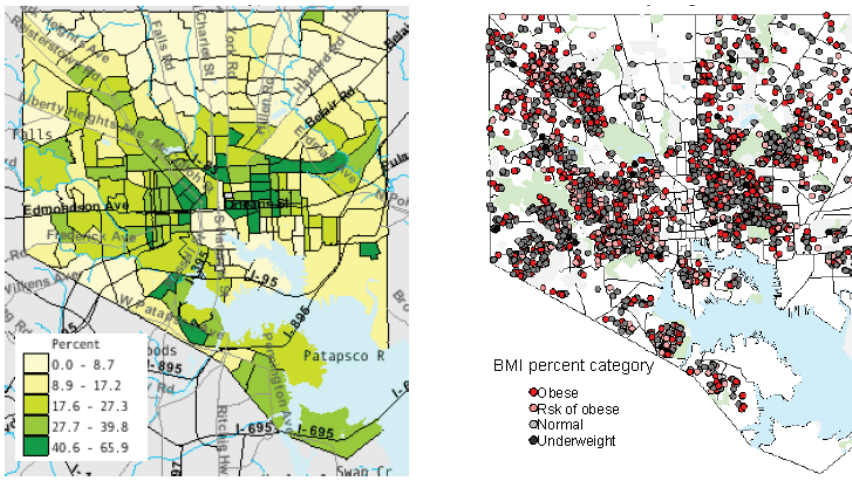

FIGURE 5-1 Community mapping in Baltimore linked the prevalence of obesity and overweight with poverty levels.
SOURCE: L. Bernard, Associated Black Charities, based on U.S. Census and school health center data.

Finding Information with Which to Run and Assess Programs

In addition to quantitative data, the partnership gathered information through a literature review of best practices; an inventory of the work of local organizations; a risk-factor assessment conducted by interns at the health department; meetings with youth, faith-based, and other organizations; and meetings with experts. This information was also disseminated at the 2008 community summit mentioned above. Drawing on this experience, Bernard offered the following insights on gathering and building on evidence:

- Leveraging existing expertise and knowledge of promising approaches provides important ideas. For example, the partnership learned about the value of a food policy council in other cities in addressing systemic problems and is now working to establish such an entity in Baltimore.
- Assessing organizational capacity is key because community-based programs often have staffing deficits. By discussing these deficits openly, the grantmakers at the table learned about situations in which even small grants could make a big difference.
- Using assessment tools, including community mapping performed by students, uncovered important information, such as the food offerings in corner stores.
- Committing to continuous improvement means letting go of programs that do not work, or figuring out why they do not work and doing something different.
- Building a movement versus a program means focusing on health equity, with people becoming their own advocates and organizations such as Associated Black Charities serving as a catalyst to jumpstart efforts.

Linking Nutrition and Physical Activity to Broader Community Priorities for Sustainability

Related to the idea of building a movement rather than implementing a specific program, Bernard stressed the importance of linking nutrition and fitness with broader priorities. She shared the socioecological model used by Associated Black Charities (Figure 5-2), which shows how individual knowledge, attitudes, and skills fit within interpersonal, organizational, community, and public policy contexts. The most effective interventions, she said, affect multiple levels, recognizing the health implications that underlie educational, housing, land use, and zoning policies. Examples

FIGURE 5-2 A socioecological model that links individuals with a broader context.
SOURCE: L. Bernard, Associated Black Charities.

include engaging the community to understand how the prevalence of corner stores in lower-income communities is a land use and zoning issue, working with schools to enforce wellness policies and serve healthier food, and changing traffic patterns to improve accessibility.

Community-based groups have the will and spirit to succeed, Bernard said, but many of them need targeted assistance to sustain their efforts: organizational capacity in the areas of funding, staffing, and community contacts; strategic partnerships; enhanced communication and information sharing; and the ability to enlist diverse stakeholders.

> *"We are all about building a movement, with all kinds of advocates for change, educating kids that you can have an impact, you can make a difference."*
>
> —Leslie Bernard

A website and community directory have helped sustain Baltimore's efforts and enabled diverse stakeholders to share what they are doing. In closing, Bernard emphasized that building an informed constituency and sharing evidence are keys to long-term sustainability.

COLLABORATING ON A REGIONAL LEVEL IN CENTRAL CALIFORNIA

Ms. Islas-Hooker began her presentation by describing the large area within California covered by CCROPP: almost 300 miles from one end to the other, with a population of 3.8 million people expected to more than double by 2050, and with high rates of unemployment and family poverty, particularly in the rural, primarily Latino communities. Although central California is one of the richest agricultural regions in the nation, many local families struggle to put food—especially healthy food—on the table. Dire health conditions and persistent poverty plague the region despite the prosperity generated by the agriculture industry.

Central California's obesity rates are the worst in the state. One of every three children under age 12 and 15.5 percent of adolescents aged 12–17 are overweight. Rates of adult obesity and diabetes also are significantly higher than state averages. Islas-Hooker recounted that from her early years, she served as an interpreter at medical visits for family members and friends who did not speak English. She once assumed educating them about healthier choices would save them from negative health consequences, but "the reality is that was only half the equation . . . [the other half] is the environment." A program to prevent obesity must take into account the region's poverty, languages, rural–urban mix, and lack of transportation, among other environmental factors.

CCROPP, which is funded by The California Endowment and The Robert Wood Johnson Foundation, was formed when public health directors from six (now eight) different jurisdictions came together in a regional initiative. The program's advantages include collective decision making and planning, pooled resources, and collaborative implementation. The partners have also found it easier to pursue resources collectively rather than compete against each other. Islas-Hooker is Regional Program Coordinator, but stressed that the initiative is community driven, and people on the ground carry out the work.

CCROPP's interventions fall within two large categories: (1) increasing access to healthy food, such as through greater acceptance of electronic benefit transfer (EBT) payments at farmers' markets and conversion of small stores to selling healthier food; and (2) increasing opportunities for safe places to play, such as through park improvements and greater joint use of facilities with schools. CCROPP has already had successes, including an effort by Latina women in Bakersfield that resulted in improvements to a local park and a zoning change in Fresno to facilitate the establishment of more farmers' markets.

What Has Worked in Central California

- Join forces to collaborate and attract more funding, rather than compete for limited funding.
- Reframe the issue from obesity prevention to social equity and justice.
- Use a variety of methods to learn about community choices and preferences.

Finding and Using Information to Promote Program Goals

Islas-Hooker said that historically, obesity has been addressed through interventions aimed at individuals, so few data have been collected about the impact of the community environment. Information is needed to better understand access issues related to food and physical activity environments, utilization issues related to community choices and preferences, and obesity and chronic disease rates for specific target locations. Relevant policy models from geographic areas with similar demographics also are necessary. Islas-Hooker quoted a CCROPP program lead, who said that framing the obesity problem in terms of the need for a series of local, environmental, and policy changes has made the problem easy for people to grasp and mobilize around, particularly when they see how these changes relate to the health and future of children.

Islas-Hooker listed the many sources of information CCROPP has drawn on, including the California Health Interview Survey (CHIS); Communities of Excellence in Nutrition, Physical Activity and Obesity Prevention (CX3), which covers some of the region; the California-based study *Designed for Disease*, authored by UCLA Center for Health Policy Research, the California Center for Public Health Advocacy (CCPHA), and PolicyLink; and evaluation data. Methods used to gather information have included GIS satellite mapping, PhotoVoice documentation, interviews, focus groups, polling, and walkability assessments. In one county, polling consisted of choosing among photos of potential park amenities—a simple but powerful tool for low-literacy residents to express their preferences for their local park.

Linking Nutrition and Physical Activity to Broader Community Priorities

Islas-Hooker reiterated a theme expressed throughout the workshop when she said, "Policy and environmental change work is not program work in the traditional sense." Instead, it involves engaging the community,

advocating, and building relationships over a period of time. It also requires new ways of looking at implementation and evaluation.

CCROPP reframes obesity prevention within the context of larger issues of social equity and justice. For instance, promoting the sale and consumption of more fruits and vegetables is connected to economic development. Increased access to space for physical activity is linked to greater community cohesion and community ownership, thus engaging law enforcement and planning officials, among others.

"Promoting the sale and consumption of more fruits and vegetables is linked to economic development in our region. . . . Increasing access to physical activity space is linked to greater community safety, increasing community cohesion, and community ownership. Using this frame has been helpful in engaging nontraditional partners."
—Genoveva Islas-Hooker

Islas-Hooker noted that community empowerment and engagement lead to sustainability beyond funding cycles. She elaborated on three ways in which CCROPP hopes to sustain its efforts:

- Leadership development within community organizations, which CCROPP is undertaking with a grant from The Robert Wood Johnson Foundation's Healthy Kids Initiative;
- Reorganization of public health departments to be involved in (and fund) chronic disease prevention; and
- Smart redistribution of resources to match changing community needs.

In many communities, said Islas-Hooker, the need for nutrition education is not as strong as the need to build capacity for work toward policy and environmental changes. She urged that federal funding reflect these changing needs.

FOCUSING ON AN UNDERSERVED WARD IN WASHINGTON, DC

Ms. Girardeau was the final speaker on the community-based panel. Her organization, SHIRE, works with communities, government agencies, educational institutions, and foundations to identify inequities and galvanize grassroots groups to address issues of access to health care and quality of care among the underserved, particularly people of color.

SHIRE became involved in the obesity issue upon learning about the District of Columbia's high rates of overweight and obesity in children. With a grant from the Kaiser Foundation Health Plan, SHIRE is focusing on young children in home-care settings in the city's Ward 8, a community with a particularly high incidence of obesity and other chronic diseases.

What SHIRE Has Learned in Ward 8

- Teaching rather than changing behaviors can be easier—thus the focus on young children.
- At a certain point, communities grow tired of being the subject of research when they see no improvements in conditions.
- Churches with large memberships, strong leaders, and buildings for meetings and activities are among the community assets with which to work.

Girardeau said the emphasis on young children stems from the observation, expressed by New Hampshire First Lady and physician Susan Lynch, that it is easier to teach than to change a behavior.

Initial priorities include raising community awareness of the effects of obesity and obtaining community buy-in to prevent it, increasing access to healthy food, and increasing opportunities for physical activity. The Early Childhood Obesity Prevention (ECOP) Collaborative serves as SHIRE's "think tank" and recommends policies and programs. ECOP grew from 30 members in 2006 to more than 120 in 2009. Its members include health care providers, community leaders, government representatives, parents, faith leaders, child care providers, and others. With the goal of halting and reversing childhood obesity trends and promoting healthy living, ECOP developed a "healthy living opportunity tree" (see Figure 5-3) to illustrate how partners and programs can work toward healthy living, obesity prevention, and supportive policy initiatives.

Using Information to Promote Program Goals

SHIRE, like the other organizations represented on the panel, needs various types of information to implement initiatives. Demographic data have come from the National Urban League's Environmental Scan, funded by The Robert Wood Johnson Foundation. The scan showed, for instance, that Ward 8 has a population of 71,000 people, more than 99 percent of whom are African American. For 12 years, it had no supermarket (it now has one), and it now has one farmers' market (down from two). Other information gathered included an understanding of the ward's key politicians, conveners, and opinion leaders, as well as its gathering places. Community members spoke about what they consider to be the causes of childhood obesity, and about the level of willingness and community assets to work on the problem.

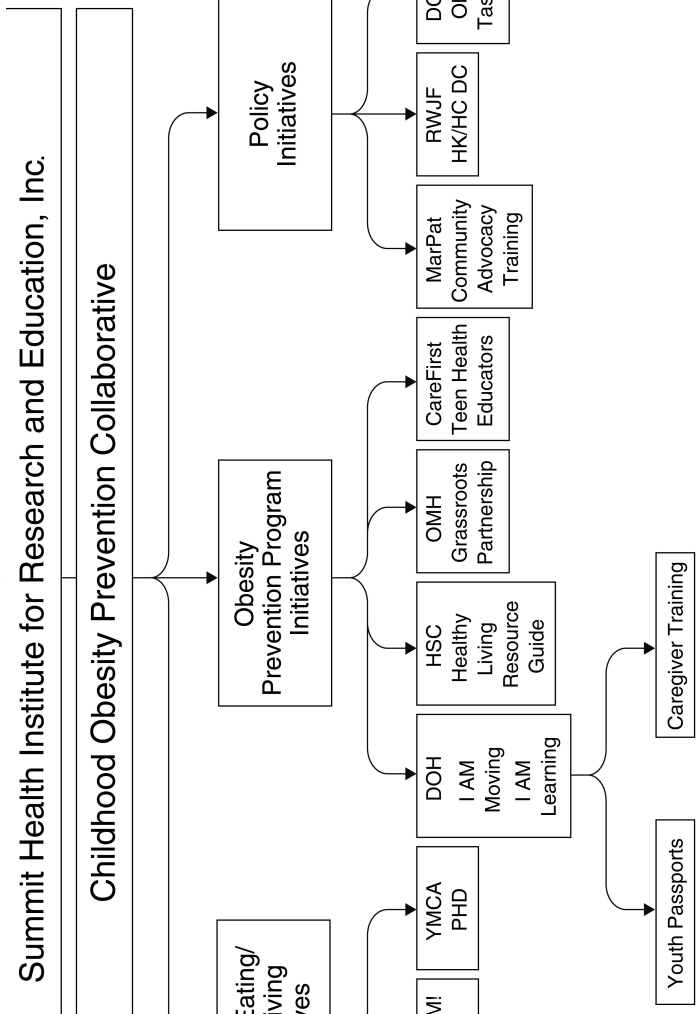

FIGURE 5-3 Early Childhood Obesity Prevention Collaborative's healthy living opportunity tree.
NOTE: DOH = DC Department of Health; HK/HC = Health Kids, Health Communities; HSC = Health Services for Children; MarPat = The MARPAT Foundation; OMH = Office of Minority Health; RWJF = The Robert Wood Johnson Foundation.
SOURCE: C. Girardeau, SHIRE.

Finding Information with Which to Operate and Assess Programs

SHIRE has also obtained information from literature and Internet searches, as well as from asking questions of ECOP members and focus groups. Parents, child care providers, health care providers, and government representatives have offered input. At community meetings, churches, and community centers, the goal was to listen, rather than to "talk about what we want to accomplish." The Ward 8 Heath Council has become strong, and as Girardeau noted, it is beginning to question why so many agencies are funding research in Ward 8, but the statistics show no change.

Assessment is important to this project and will encompass pre- and post-surveys, telephone interviews, and other strategies. An outside evaluator will help SHIRE distill significance and guide future efforts through its documentation and assessment.

Linking Nutrition and Physical Activity to Broader Community Priorities for Sustainability

Girardeau said ECOP's message is about healthy eating and active living, not just losing weight. The question to people becomes, "What in your community prevents or helps you eat healthy and be active?" This question stimulates responses that highlight the relationship between obesity prevention and the larger environment: food outlets that sell outdated products, unsafe parks and playgrounds, vendors selling unhealthy food. By stimulating conversations within the community on how to improve health, ECOP is helping community members contribute to the development of a citywide obesity action plan.

> *"What in your community prevents or helps you eat healthy and be active? What would you like to change? What are you willing to do to get those changes? These questions stimulate conversations."*
>
> —Canary Girardeau

SHIRE is seeking to sustain its efforts by producing data that show program effectiveness, determining entrepreneurial possibilities for community members, providing education and support to institutionalize policies, collaborating with other agencies and stakeholders to keep resources flowing, determining entities that can incorporate SHIRE programs into their ongoing activities, and sharing lessons learned. Girardeau expressed gratitude to foundations and agencies that have helped fund SHIRE's work, particularly the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., which recognize that behavior change takes time.

DISCUSSION

At the end of each panel, workshop attendees had the opportunity to ask questions of the presenters. Among the topics raised in this first session were the following:

- **Stimulating community action with little funding.** Crawford launched the discussion by asking presenters how they would suggest that organizations without foundation or other funding start to engage the obesity problem. Mouet said that in a city government setting, grassroots involvement, such as speaking at city council meetings, brings an issue to the forefront. Islas-Hooker noted the "six degrees of separation between obesity prevention and everything else"; thus, supporting healthy eating and physical activity is related, for example, to violence prevention and safety. Bernard agreed that advocacy efforts can accomplish a great deal with little money.
- **Role of BMI data.** When an audience member asked the presenters about the priority of using local BMI data to measure the outcomes of their interventions, the responses varied. Islas-Hooker said CCROPP hoped desired behavior changes would lead to lower BMIs, but local BMI data were not available as a baseline. Although having BMI data would be helpful to communicate with decision makers, the fact that the focus of the program is on environmental and policy-level change makes these data less necessary. In Baltimore, according to Bernard, collection of BMI data has not emerged as a high priority. In contrast, Mouet said it was essential for Santa Ana to show progress over the course of the 10-year effort funded by the California Endowment; thus measuring and hoping to improve upon BMI percentages is a higher priority. Girardeau said the Washington, DC, community with which SHIRE is working is resistant to using BMI data. In four separate focus groups held by SHIRE, residents stated their belief that the BMI charts are not applicable to the African American community because they are based only on a white population. Girardeau also observed that changes in BMI would take a long time to show.
- **Gender considerations in encouraging physical activity.** A participant asked Mouet, who had spoken about the role of soccer in encouraging more physical activity, whether girls are as likely as boys to become involved, especially as they reach middle school and older ages. Mouet agreed that a gender gap persists, although more young girls are now playing soccer. Islas-Hooker said a preliminary assessment in central California's Latino community showed a high

level of interest, but few programs, in folkloric dance. She noted that physical activity is not just about sports, and dance and other arts-related programs are physical activities that merit support.

- **Working with small stores to offer healthier food.** Islas-Hooker was asked how CCROPP has worked with small stores to stock healthier food. She said the process involves engaging storeowners, who are worried about the risk of perishable food that may go unsold. CCROPP is surveying residents to see what kinds of produce they would buy at what prices. The program is also working with the California Association of Family Farmers to create a distribution mechanism that would encompass a local market for the region's small farmers. Finally, Islas-Hooker noted that storeowners need business plans and marketing strategies to sell produce.
- **Need for long-term, sustainable support.** A participant underscored the need for interventions to take place over the long term, since time is needed to build trust, produce results, and reverse many years of poor eating habits. She asked how funding institutions could be encouraged to commit to longer time frames. Bernard agreed with the need for long-term funding, but also stressed the importance of diverse streams of funding to avoid an overdependence on one or two foundations. Another avenue of sustainability is to work closely with city agencies so they will institutionalize the work begun under a grant or other special funding.
- **Working with planners.** Planners, noted one participant, think in long-range terms. She asked presenters about the challenges and opportunities they have faced in working with planning agencies. Mouet said collaboration is critical, although it can be frustrating. Bernard said Baltimore's planning department is rewriting the zoning code for the first time in 30 years, which she termed an opportunity to promote healthier communities. The commissioners of the planning department and the health department co-lead a food policy task force.
- **Role of nutritionists and others in educating about healthier eating.** Agreeing with the need for environmental changes, a nutritionist in the audience urged the organizations represented by the presenters to consider individual and group counseling, cooking and meal-planning education, and other ways to improve eating. Girardeau noted that a focus group of Washington, DC, children said their family members should cook more. Bernard reported that some participants in Baltimore focus groups said that removing home economics from the school curriculum had led to a generation of parents not knowing how to cook. The Baltimore Blueprint includes nutrition education in its recommendations. Another way

to increase demand is to hold cooking demonstrations in corner stores, farmers' markets, and other locations. Islas-Hooker noted that time pressures often prevent people from cooking, even in cultures that traditionally emphasize cooking.

- **Access to WIC data.** The panelists were asked whether they thought community groups were aware of and had access to WIC data, which contain real-time BMI numbers. Bernard said her group began to share this information with community groups, but sensitivity is necessary, particularly with parents whose children are overweight. Mouet said it takes time to enable the community to have access to and understand the data.

6

Research and Advocacy Groups: How Does Evidence Inform Policy?

As described by moderator Sarah Samuels, President, Samuels and Associates, the organizations represented on the second panel serve as middlemen. They work with community groups, such as those represented on the first panel (see Chapter 5), to produce and provide evidence for program development and evaluation. They also marshal the evidence and serve as advocates to help policy makers adopt, endorse, and support policies and programs aimed at preventing obesity.

The messages that emerged from the four presenters reflect their experiences in presenting evidence to very different audiences, including grassroots organizations, health economists, policy makers with varying levels of familiarity with obesity-related policies, and others. These messages include the following:

- **Decision makers have different frames of reference in dealing with obesity prevention.** While some easily grasp the connection between obesity and community environments, others frame the issue solely as a matter of individual choice. Some see a clear role for government; others remain skeptical. Some expect to see clear financial benefits to obesity-related and other preventive health expenditures. Organizations must find ways to deal with these different frames of reference.
- **Research is only one type of evidence upon which policy makers draw.** Only in rare cases do research findings alone, however definitive, move policy; the expectation that science alone will lead to policy change is unrealistic. Policy makers are confronted with

political considerations, views of trusted advisors and constituents, their own experiences, economic analyses, and numerous other inputs. A related point is the need to collect consistent health and economic data from those obesity programs that are in place to permit clearer conclusions about what is working and the cost implications.

- **The way the evidence is presented is critical.** Policy makers are barraged with information. The organizations represented on the panel continually seek the most effective ways to build on the evidence to draw the attention of policy makers, the media, other opinion leaders, and the public. These methods include mapping and other visuals, easy-to-grasp metrics, brief summaries of relevant research, and personal stories and testimonials.
- **Research, action, and policy can be linked to increase impact.** The presenters shared examples in which communities, instead of just serving as the subject of a research study, participated in collecting, analyzing, and disseminating the evidence. The community thus becomes more engaged in the research, and the result is often tangible changes in policies or programs.

The panel consisted of representatives from three policy and advocacy organizations and a community organizer. Jeffrey Levi, Executive Director, Trust for America's Health, Washington, DC, identified five challenges to communicating with federal policy makers about obesity prevention. Allison Karpyn, Director of Research and Evaluation, The Food Trust, Philadelphia, Pennsylvania, focused on the policy-making process and what it means for advocacy organizations that present evidence to policy makers. According to Rebecca Flournoy, Associate Director, PolicyLink, Oakland, California, convincing policy makers about the role of community environments in childhood obesity means communicating research findings in compelling ways; indeed, if the issue is compelling enough, policies may be enacted even absent the most definitive evidence, as occurred with tobacco use. Derek Birnie, Executive Director, Delridge Neighborhoods Development Association, Seattle, Washington, described how, as a community organizer, he serves as a bridge to grassroots groups, researchers, and policy makers in his work with the King County Food and Fitness Initiative.

UNDERSTANDING CHALLENGES TO ADVOCACY FOR OBESITY PREVENTION

Dr. Levi explained that the Trust for America's Health focuses on reaching federal policy makers on a range of public health issues, includ-

Challenges to Advocacy for Obesity Prevention

- Policy makers define prevention in many different ways.
- Policy makers have differing views about the role of government in obesity prevention.
- Policy makers look for prevention measures that save money, but some measures do not yield a financial return on investment.
- Health economists require answers to questions that are not always as applicable to prevention as they are to biomedical interventions.
- Prevention researchers and program implementers need to collect consistent data, including data on costs, with which to compare and better communicate program effectiveness.

ing changes to reverse the obesity epidemic. He structured his presentation around five challenges the Trust encounters in communicating with policy makers on these issues. Four of the challenges, he said, are external to those doing obesity prevention work and research, while the fifth is internal.

Definitions of Prevention

To Levi, the first and probably most significant challenge is that every policy maker has a different definition of prevention, which creates enormous confusion. While the Trust and other groups talk about true primary prevention to avoid the development of disease, others think of prevention as disease management, clinical interventions, or a host of other variations. Compounding the confusion, policy makers like simple answers, which do not exist for this issue.

Perceptions About the Role of Government

Policy makers also have differing concepts of the appropriate role for government in fighting obesity. Many people, including policy makers, frame the issue in terms of personal responsibility: individuals can solve the problem by eating less and exercising more. Levi suggested that an effective response is to acknowledge personal responsibility but then to question the environmental obstacles to healthier individual behaviors. In many cases, policy makers will then agree on a role for government. Levi termed this a stepwise progression; by comparison, policy makers instinctively recognize a government role in combating swine flu.

Focus on Saving Money

Policy makers support prevention that saves money, Levi stated, particularly within a certain window of time. He argued that improved health outcomes, quality of life, and productivity should also matter, as they do when one is considering the effectiveness of biomedical interventions. Yet because so much of the debate about prevention is centered around money, the Trust undertook a study to model the savings associated with community-level obesity prevention. The study, funded by The Robert Wood Johnson Foundation and The California Endowment and conducted in collaboration with other organizations, yielded findings that were released in the report *Prevention for a Healthier America* (Trust for America's Health, 2008).

For certain conditions, physical activity, better nutrition, and smoking cessation result in a savings of $5.60 for every $1 invested. Levi cautioned against extrapolating these findings to all kinds of prevention and conditions for two converse reasons: some supporters have exaggerated the cost-benefits, and on the other hand, some skeptics may now argue that only interventions that meet this standard of a large return on investment should be funded.

Convincing Health Economists

Health economists represent a formidable group whose views are considered in policy choices. An impetus behind producing *Prevention for a Healthier America* was to start to engage health economists in looking at different models. According to Levi, the report has initiated a dialogue with the health economics community and with the Congressional Budget Office and the Office of Management and Budget.

The questions raised by health economists that must be considered include the following:

- **What is the standard of evidence?** Levi said health economists want to understand the link between community-level interventions that increase physical activity and better health outcomes, and between those outcomes and cost savings.
- **How do we know an intervention works?** The health economics community, Levi asserted, has a bias toward randomized controlled trials, while community prevention interventions vary from place to place. Levi suggested a dialogue between evaluators, who are used to this complexity, and health economists.
- **What is the scalability of interventions?** Will interventions that are successful in individual communities work when scaled up, and will they be sustainable? Levi urged learning to measure answers

to these questions, although he observed that a double standard exists in that clinical trials for drugs need only show a benefit for the period of the trial itself. "Scalability is a two-edged sword," he said. "I think we need to have answers to some of these questions, but I'm not sure they should be barriers per se."

"We are not that young of a field that we should not be able to decide what are the measures that should be consistently collected across programs."
—Jeff Levi

- **What is the time frame for showing a return on investment?** In the case of childhood obesity, the time frame may be even longer than the 5 to 10 years considered for other types of health interventions.

Consistency of Data

Levi directed his fifth and final challenge to those working on community-level interventions. He urged more consistency in the measures collected across programs to permit measurement of cumulative impact. Developing *Prevention for a Healthier America* underscored how inconsistency in data collection makes it difficult to report on effectiveness. Levi urged the National Institutes of Health (NIH) and CDC to recommend consistent collection of certain data to enable better comparison of programs. He also urged ready availability of information about program costs.

The bottom line, Levi concluded, is that many policy makers, including President Obama, support community-level obesity prevention. There is still a long way to go, however, in reaching other influential policy makers who are less receptive. It is important to utilize the diversity of community experiences by tailoring the message to the policy maker. The prevention community must also define and articulate its standards of evidence.

ESTABLISHING THE BURDEN OF EVIDENCE

Dr. Karpyn centered her presentation on the level of evidence needed to inform policy makers. By way of introduction, she quoted a former Robert Wood Johnson Foundation staff member who was looking back on his work with the foundation. He wrote, "Journals favored by policymakers were filled with thought-provoking articles containing the kind of pertinent information that ought to fire them up for change and told them ways to do it . . . [but the studies] didn't move the needle one bit" (Newbergh, 2009).

Karpyn suggested that many in the audience could relate to the notion that compelling research findings are not effecting policy changes. The issue is not just informing policy makers, but doing so in a way that causes them

Traditional Levels of Evidence Valued by Researchers (in descending order of impact)

- Systematic review of randomized controlled trials (RCTs)
- RCTs with a narrow confidence interval
- All-or-none case studies
- Systematic review of cohort studies
- Cohort studies/low-quality RCTs
- Outcomes research
- Systematic review of case-controlled studies
- Case-controlled studies
- Case series, poor cohort case controlled
- Expert opinion

SOURCE: Sackett et al., 2000.

to take action. The issue comes down to how policy is made. According to John Kingdon's Multiple Streams Model, three "streams"—a problem, a policy that might address it, and politics that will affect the inclusion or exclusion of a topic on the policy agenda—must be aligned (Kingdon, 1984). Policies are not the product of rational actions because policy makers generally do not evaluate alternatives systematically. Researchers focus more on the problem, but they must acknowledge the role of the other two streams to see movement on a problem.

Evidence has several roles to play in this model. It must make policy makers understand that a problem is urgent and that members of the public (including constituents) care about it. The challenge is to align the problem and the evidence with a politically feasible solution. Organizations like The Food Trust try to bridge the gap between research and policies.

"Agencies like ours start to bridge the gap between the reearch body and policies. Again, it is about aligning [the problem, policy, and politics] together before you get a policy movement."

—Allison Karpyn

The research community's traditional framework of levels of evidence has at its pinnacle the systematic review of randomized controlled trials, followed by other types of controlled studies (see box above and, for example, Sackett et al., 2000). Policy makers favor a very different hierarchy, Karpyn said, often relying on expert opinion (at the bottom of the researchers' traditional hierarchy) and polls (which did not make the Sackett et al. list). The level of evidence needed to move an issue forward varies: When the multiple

streams of problem, policy, and politics align, such as with tobacco or obesity prevention, the burden of evidence can be much lower than otherwise.

A crucial aspect of establishing the burden of evidence is communicating the evidence. It is not enough to generate data and hope that policy makers will use them. Instead, Karpyn suggested a different paradigm in which researchers and advocates collaborate on effective ways to present research results so they will lead to desired policy changes.

Presenting evidence in easily understood, visual ways is necessary to reach policy makers. Examples include maps, poll results and other media attention–getters, visuals, and one-page summaries with bulleted points. Highly technical reports alone are too dense, although they serve as the basis for these more easily digested presentations. Karpyn's examples included the well-known animated state-by-state map of obesity prevalence, based on research from CDC, and a map of the "grocery gap" in Philadelphia, based on research conducted by The Food Trust (Figure 6-1). A jar of sugar sent

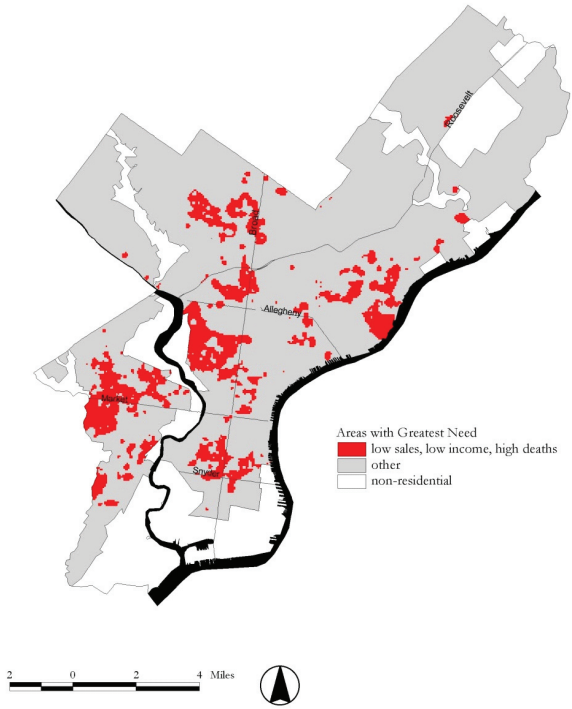

FIGURE 6-1 Mapping that linked supermarket sales, income, and diet-related deaths illustrated the impact of Philadelphia's "grocery gap."
SOURCE: A. Karpyn, The Food Trust.

to city officials, which represented the amount a Philadelphia child ingests from soft drinks every week, helped change the availability of these beverages in schools (Figure 6-2).

Presenting data is a science and an art. The data must be based on reputable research, but they also must affect the policy maker's district or state, be easily understood, and clearly address a proposed policy solution.

CONNECTING RESEARCH AND ACTION

Ms. Flournoy explained that PolicyLink is a national research and action institute that advances policies aimed at achieving economic and social equity by "lifting up what works." Its Center for Health and Place works to create neighborhood conditions that encourage health.

FIGURE 6-2 A jar of sugar dramatically illustrated the amount of sugar in the average child's weekly intake of soft drinks, resulting in changes in the availability of soft drinks in public schools.
SOURCE: A. Karpyn, The Food Trust.

Evidence for Policy Making

Flournoy began by stepping back from the obesity issue to ask a broader question about the level of evidence needed to spur policy makers to address other public health issues. For example, it was not until the 1990s that researchers identified the biochemical mechanisms linking cancer with cigarette smoke. Policy makers did not wait for this definitive evidence before enacting measures to curb tobacco use, nor would the public have wanted them to.

As observed during the previous panel (see Chapter 5), many community residents state that researchers enter their communities to study their neighborhoods and populations, but nothing changes as a result. Flournoy urged researchers to think about how to connect their research with action. PolicyLink applies some of the principles of community-based participatory research, such as sharing preliminary findings at community meetings and implementing aspects of programs and then evaluating them. Researchers, said Flournoy, need to think about the policy implications of what they study.

PolicyLink has developed a model of policy change in which research and information gathering are part of a larger advocacy process (see Figure 6-3). Research alone is rarely sufficient to effect a policy change, although it can contribute to an atmosphere in which the climate is ready for change.

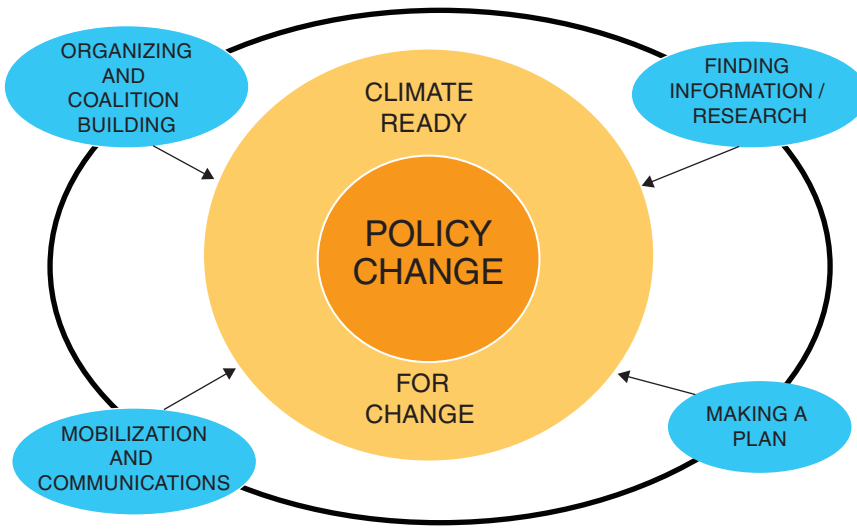

FIGURE 6-3 The advocacy process, in which research is part of a larger whole.
SOURCE: R. Flournoy, PolicyLink.

The Retail Food Environment Index (RFEI)

RFEI calculations from different communities dramatically show the link between the retail food environment and health. To calculate the RFEI:

$$\frac{\text{No. fast food restaurants + no. convenience stores}}{\text{No. grocery stores + no. produce vendors}}$$

SOURCE: PolicyLink, the California Center for Public Health Advocacy, and UCLA Center for Health Policy Research, 2008.

Community Environments

Policy makers are used to thinking about individual behaviors that affect health. Making the leap to the role played by community environments requires that organizations like PolicyLink communicate research findings in compelling ways, such as packaging quantitative data; illustrating with maps and images; and recounting stories, especially successes.

For example, PolicyLink, the California Center for Public Health Advocacy, and the Center for Health Policy Research at the University of California, Los Angeles (UCLA) developed the Retail Food Environment Index (RFEI). The RFEI shows the effect of the retail food environment on obesity rates by comparing a community's numbers of grocery stores and produce vendors with its numbers of convenience stores and fast food restaurants. On average, the RFEI of lower-income communities in California is 20 percent higher than that of their higher-income counterparts, with obesity rates and diabetes prevalence showing similar trends. Publicizing the RFEI generated media attention in the state and nationwide. Policy makers asked about their area's RFEI and how to improve it. Producing the index was, Flournoy concluded, an effective way for policy makers to consider how community environments affect health.

"Maps can be incredibly powerful in making the case."
—Rebecca Flournoy

Flournoy agreed with other presenters about the power of maps. When used in Louisville, Kentucky, and New York City, for example, mapping revealed disparities in the food environment and the effect of those disparities on health in an easily grasped and compelling way (see Figure 6-4).

Policy makers also respond to images and stories. As noted earlier, PolicyLink emphasizes "lifting up what works"—highlighting cases in

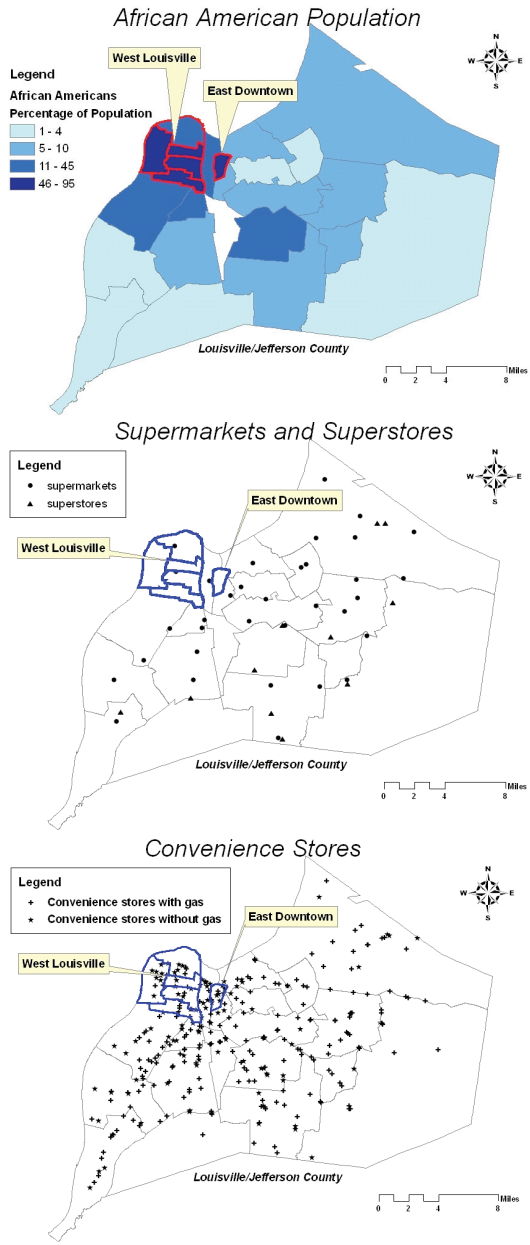

FIGURE 6-4 Mapping made clear that Louisville's predominantly African American neighborhoods had few supermarkets but numerous convenience stores and fast food restaurants.
SOURCE: R. Flournoy, PolicyLink.

which people in low-income communities recognize a problem, figure out how to address it, and see some success. These stories are powerful because they provide concrete examples of success that can be adapted or replicated elsewhere and because they provide cause for optimism.

ORGANIZING THE COMMUNITY IN SUPPORT OF OBESITY PREVENTION

Mr. Birnie was the final presenter in this session. In his role with the King County Food and Fitness Initiative (KCFFI), in which the Delridge Neighborhoods Development Association is a partner, he serves as a bridge between grassroots leaders, who are passionate about what they are experiencing in their everyday lives, and the more systematic approaches of researchers and policy experts.

The King County Food and Fitness Initiative

KCFFI is one of many initiatives the W.K. Kellogg Foundation is supporting in communities across the country. These initiatives are based on the premise that health is a product of the systems surrounding an individual, which can either promote or harm health. While the Delridge and nearby White Center communities feature many positive local efforts connected to food and fitness, they are also characterized by systemic characteristics that have resulted in the highest prevalence of diabetes and overweight in the city. Through a cross-sectoral approach involving many partners, KCFFI is building healthy communities through healthy food and safe places to play. Birnie shared KCFFI's vision and values, echoing comments made earlier in the workshop about building a movement rather than just a program.

The initiative is at the end of a 2-year planning phase conducted to guide the next 8 years of collective policy collaboration. The three goals of its implementation are to (1) create policy and system changes, (2) engage in strategies to make the initiative's vision a sustainable reality, and (3) create community environments that support access to healthy food and safe places for physical activity. The goals do not currently include measuring outcomes; however, Birnie said that, based on the workshop discussions, this is something he will discuss when he returns to Seattle.

Use of Experience to Inform Policy

The experience of coalition members, including grassroots organizers and leaders, advocates, public health practitioners, academics, and service providers, informs policy. Separately, the members have achieved much, including neighborhood and comprehensive plans, financing tools, school

Benefits of Participatory Research

- Good data developed by those affected by the conditions studied
- Attention from policy makers and the media
- More engaged community leaders and members

nutrition policies, and land use policies. An initial success for KCFFI was farm-to-school legislation that allows school districts to buy locally grown produce, even if it is more expensive.

The research that informs KCFFI's policy initiatives is documented in the report *Food for Thought* (University of Washington, 2008). The developers of that report drew on community-based participatory research carried out by youth, coalition members, and others. They investigated grocery store offerings, accompanied by elected officials and reporters. The result, according to Birnie, was "great data that [could] be used for advocating the policies, but also informed, invested leaders who [would] do the advocating and an audience that [was] a little bit more familiar with what [was] going to be represented at the end of the research."

The case for the problem has been made, Birnie said. KCFFI must now strengthen the analysis that connects health impacts with historical policies and systemic causes. The initiative needs more information about best practices and case studies, analysis to determine the long-term value of the investments under consideration, and information about the intersection of public policy and private-sector decision making.

Policy makers have been enthusiastic; as Birnie said, "the Seattle way" embraces study, discussion, and community engagement. Funding for commitments and regulatory changes are more difficult to obtain. Enthusiasm is strongest when the KCFFI strategy is linked with other regional initiatives focused on smart growth and economic development.

Birnie closed by summarizing some lessons he has learned through his work:

- Producing convincing data should be a priority, but community leaders must find effective ways to convey the data to decision makers.
- Various stakeholders and constituencies value different qualities and sources of data.
- Community-based participatory research produces a wide range of results, such as partnerships, data, and momentum.

- Organizers' work involves translating between constituencies as much as conducting research and analysis.
- The need is well documented, but still lacking are data-based projections for the outcomes of strategies.

DISCUSSION

Discussion following the panel presentations revolved around two principal topics: (1) results when evidence does inform policy and (2) conversely, any evidence on the effects of inaction.

Examples of evidence that resulted in policy change. Over the past 5 years, the focus on obesity prevention has shifted from individual responsibility alone to strategies aimed at changing food and physical activity environments and policies to support those changes. Samuels said the work of many members of the audience had helped provide the evidence to effect those changes. She asked the panelists to identify one piece of evidence that has either been particularly effective or backfired.

Karpyn replied that The Food Trust's graphing linking data on diet-related mortality to poverty and supermarket access helped move policy forward. Flournoy cited data from the Fresh Food Financing Initiative, first developed by The Food Trust, which showed benefits in terms of jobs created, new retail space, and housing values when supermarkets in underserved areas were supported.

Levi said that the Trust's report, which he had discussed in his presentation, had resonated with policy makers who want to believe prevention saves money. He warned participants, however, not to assume that all policy makers have made the transition from framing obesity in individual to environmental terms. Birnie concurred. He said that when he originally brought KCFFI to the Delridge board for consideration, the first response was to question how the initiative related to Delridge's mission to support affordable housing. Another response was wariness, expressed as, "Who are you to tell me what I should be feeding my kids, or that I am not healthy?" How the issue is framed from the outset and the evidence used to support it is important in engaging community groups and policy makers.

Data on the cost of doing nothing. A participant asked whether data exist to demonstrate the cost of not taking action to address the obesity problem, which would resonate with some policy makers. Levi said The Food Trust's report contains some such data, and Flournoy referred to research conducted by Manuel Pastor on how the conditions in a specific community can have an impact on the economy of a larger region.

Organizations like those represented on the panel link community programs and policy makers in developing approaches to reduce obesity. They

collect and share best practices, data, and other evidence; communicate evidence in ways that can break through the "information overload" faced by policy makers; and look for ways to keep obesity prevention efforts on the policy agenda.

7

Decision Makers: How Do Community Perspectives Influence Policy?

The final panel brought the workshop from efforts to change policies to policy makers themselves. While all six presenters were extremely supportive of the broad range of policies available to local governments to reduce childhood obesity, they presented real-world accounts of the challenges they face in enacting policies amid competing demands.

The presenters were both elected and appointed and from jurisdictions of various sizes—from Fairfax City, Virginia, with a population of 23,000, to New York City. The key messages they stressed included the following:

- **Local governments have a large role to play in obesity prevention.** From recreation and open space, to the food served by public agencies, to planning and zoning issues, cities and counties are the entities that enact policies with a direct bearing on the health of their citizens.
- **Many types of evidence influence policy making.** Echoing the previous panels, these presenters confirmed that policy makers are confronted with an overwhelming number of issues and concerns. The fact that scientific evidence points to the need for a certain policy is rarely in itself sufficient to ensure enactment. Instead, advocates for such policies must form coalitions, present the evidence in a clear and timely manner, and look for champions both inside and outside of government. The level of evidence needed before a policy is enacted also depends on the costs, both monetary and political. Often, evidence is brought to bear to justify a decision based on

other considerations, rather than being the primary reason behind a policy decision.

- **Accountability and constituent contacts are important inputs for local policy makers.** In Minneapolis, the fact that the obesity rate is 1 of 20 indicators measured and reported on annually helps spur action and call attention to the issue. Local officials heed even relatively small numbers of phone calls or e-mails from voters in favor of or against an issue.

Planning committee member Mary Story, Professor in the School of Public Health, University of Minnesota, moderated this panel. The panel's three elected representatives articulated a clear role for local governments in obesity prevention efforts in various ways. According to Fairfax City Council member Daniel Drummond, local governments can promote healthier living by supporting needed infrastructure, offering recreational and other programs, and encouraging citizen involvement. Arlington County Board member J. Walter Tejada elaborated on how local zoning and other regulations can encourage smart growth, which in turn translates to amenities such as sidewalk connectivity and transportation options. George Leventhal, Montgomery County Council member, also favors an active role for county government, but noted some pitfalls in pressing for strong policies, including pushback from some constituents and even from the school system, which has other priorities.

The panel's appointed officials also shared valuable perspectives on the role of evidence in policy making. Benjamin Thomases, New York City Food Policy Coordinator, observed that costs (including political costs) play an important role in determining how much evidence is needed before a policy moves forward. Gretchen Musicant, Minneapolis Health Commissioner, discussed the many types of evidence policy makers consider as much or more than scientific data. Finally, Pierre Vigilance, Director of the District of Columbia Department of Health, urged exposing a wide range of stakeholders to the evidence so they understand the public safety, educational, and fiscal impacts of obesity.

SUPPORT FOR RECREATION AND OPEN SPACE IN FAIRFAX CITY, VIRGINIA

Mr. Drummond focused on how Fairfax City is trying to increase physical activity and fight obesity by supporting recreation for youth and families. Fairfax City is a small jurisdiction (a population of 23,000 within 6.3 square miles) surrounded by much larger Fairfax County. It has made a significant investment in parks and recreation, spending $3.5 million annu-

ally and devoting 10 percent of its land mass to open space. Designating land as open space guarantees that it will not be developed, thus providing places for children and youth to play.

The Role of Local Government

Drummond asserted that "local government really matters. We are the ones who have to implement." The challenge is to adhere to the basics because "in government, we have a tendency to overcomplicate things." Finding ways to keep children active is challenging, especially in a crowded school day. The best solution for a community will depend on its specific needs and pressures.

According to a study conducted for the Metropolitan Washington Council of Governments, only one local jurisdiction provides the recommended 45 minutes per day of activity for elementary school–aged children. Drummond urged less testing and more appropriate ways of educating children to ensure balance in their lives. Parental involvement and personal responsibility are also important, and policy makers must be willing to spend money on initiatives to increase children's physical activity.

> *"We need to get in the vocabulary of kids that it is good to be healthy, because at one point in time, they are going to be voters."*
>
> —Dan Drummond

Drummond identified three areas in which local governments can play a role: infrastructure, programs, and opportunities for citizen involvement. Fairfax City invests in open space, parks, and recreation facilities; supports public–private partnerships to offer youth sports; and organizes after-school "functional fitness for kids" and other programs for children of all ages throughout the year. Trails Day, Bike-to-Work Day, the National Parks and Recreation Association's Step Up to Health Day, and a task force for families are among the initiatives undertaken to engage the public in increasing their physical activity.

The Importance of Starting Young

Policy makers often support anti-obesity measures based on their own or their family's experiences, and Drummond acknowledged that personal experience was one motivator for his strong support of recreational opportunities for youth. According to Drummond, teaching children about healthy lifestyles is as important as teaching them to read, write, and do math in preparing them for life.

RIGOR OF EVIDENCE IN NEW YORK FOOD POLICY

As Food Policy Coordinator for the City of New York, Mr. Thomases holds a new position created within the Office of the Mayor to integrate responses to the paradoxical challenge that hunger and obesity coexist in many communities. The city's Food Policy Task Force, which Thomases is responsible for convening, has developed four approaches to addressing that challenge:

- Food supports—increasing enrollment in and utilization of Food Stamps, school lunches, the Child and Adult Care Food Program, and similar programs;
- City policies—improving the nutritional value of food served by city agencies and contractors;
- Retail access—helping to expand opportunities for low-income people to purchase healthier food; and
- Healthy choices—using public awareness and education to help people make food choices that are better for their health.

While city officials are committed to using evidence in policy decisions, cost is a key factor in determining the level of rigor necessary before a policy is enacted. Decision makers are more willing to try a program or policy if it carries low or no costs (including political costs) even without a large body of evidence. In contrast, they want to see more extensive evidence before agreeing to more expensive options.

"The level of rigor [of evidence] required very much depends upon the cost.... The costlier [an intervention] gets, the more we need to know it is going to work."
—Benjamin Thomases

City Agency Food Standards

The city serves, on average, more than 1 million meals a day in its schools, prisons, and other facilities. The goals of new nutrition standards for these agencies are to create sustainable improvements in nutritional quality, reinforce public health messaging, reduce illness and mortality related to poor nutritional intake, and create a market for healthier institutional food. The standards target dietary improvements shown by evidence to prevent and control chronic disease, and they guide food purchases and preparation related to fat, sodium, fiber, and the like.

A new standard now covers vending machines in the city's 1,400 schools. Based on evidence on the intake of sweetened beverages, the new

policy permits the sale of only water, seltzer, and lightly flavored beverages, with stricter standards for elementary and middle schools.

Retail Access

In another example of the use of evidence to inform policy making, Thomases referred to studies showing that access to healthy retail food affects eating patterns. The disparities in access to such food in New York, as elsewhere, have health and economic implications. A Supermarket Need Index was developed to identify neighborhoods with high obesity and diabetes rates, low consumption of fruits and vegetables, and reduced household income and access to health care, among other characteristics (see Figure 7-1). In these neighborhoods, residents obtain most of their food from corner stores or bodegas, very few of which stock fresh fruits and vegetables.

As an example of a low-cost intervention that did not require a high level of evidence, the city is encouraging sidewalk vendors to sell fresh fruits and vegetables in underserved neighborhoods. Vendors had applied for permits to operate carts selling hotdogs and soft pretzels. The city contacted those on the waiting list to give them the option of staying on the list or selling fresh produce in a designated "green cart neighborhood"

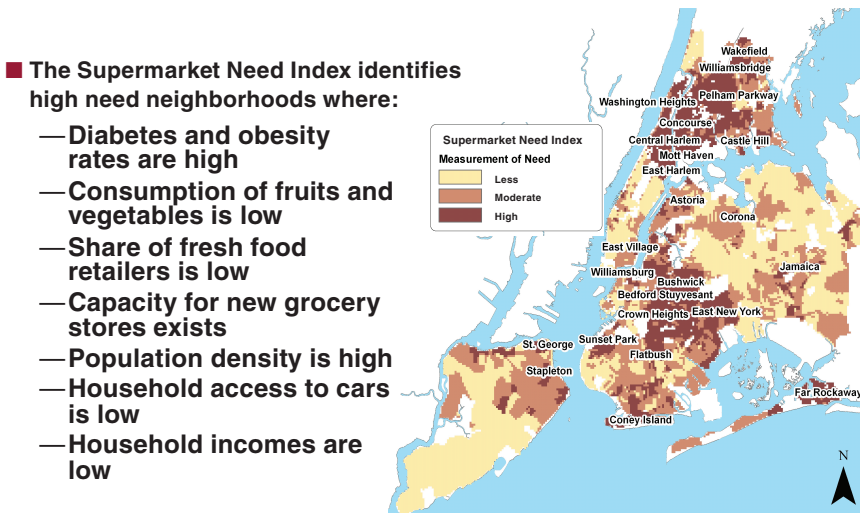

FIGURE 7-1 A Supermarket Need Index applied to New York City revealed high-need areas with limited access to healthy food.
SOURCE: B. Thomases, New York City Office of the Mayor.

without a wait. One thousand permits for green carts were issued in the five boroughs immediately. This initiative helped bring access to fresh fruits and vegetables to neighborhoods lacking grocery stores quickly while also solving the problem of long waiting lists for vendors.

A more extensive and more costly initiative to address the need for supermarkets is being planned. Based on research conducted by The Food Trust, PolicyLink, Columbia University, and others, this initiative encompasses zoning incentives and tax and other financial incentives to support new supermarkets in underserved areas. In this case, evidence played a critical role in showing initially skeptical economic development officials, deputy mayors, and others that access to a supermarket has a significant effect on obesity rates. Drummond stressed that while public health officials understand the importance of obesity prevention, the message needs to be conveyed to the broader community so that all stakeholders understand that obesity is not just a matter of individual choices.

"People who are making decisions in the health field, they are sold. But when you raise the stakes up to the level beyond that, you get to where people are not so sure."

—Benjamin Thomases

"CULTURE OF FITNESS" IN ARLINGTON, VIRGINIA

Mr. Tejada discussed how his county's programs and policies attempt to introduce a new paradigm through an initiative called Fit Arlington. "We are creating a culture of fitness in Arlington in almost everything we do," he explained, citing as an example sidewalk connectivity to encourage walking.

Publicizing What Already Exists

Community discussions held with residents made clear that many did not know what the county was already doing to encourage fitness. The county is publicizing trails, recreational programs, and other offerings online and through the public-access cable television channel, but Tejada also stressed the "old-fashioned way" of using flyers at libraries and other locations.

An attempt to enact county law to ban trans fats in restaurants turned out not to be possible because of Virginia law covering what local governments can and cannot legislate. Instead, the county has launched a voluntary campaign to encourage restaurants to exclude trans fats from their menus.

Linking Evidence, Smart Growth, and Health

Tejada said that evidence from reputable organizations, such as NIH or CDC, is important as a basis for developing consensus among policy makers. Many different groups are getting involved. The National Association of Hispanic County Officials, in which Tejada plays a leadership role, and the National Association of African American County Officials have joined forces to combat obesity. Within the Washington, DC, region, educators and elected officials will hold a regional summit on combating obesity in fall 2009, based in part on findings from the Metropolitan Washington survey referred to previously by Drummond.

> *"It is important to get residents involved with what is already happening. Sometimes, we think because we are involved in this discussion, everybody else should know. This is not the case."*
>
> —J. Walter Tejada

Arlington County is 89 percent residential and 11 percent high-density "smart growth" around the Metro corridor. In this corridor, developers have participated in a voluntary program to gain additional density in exchange for investing in community benefits such as parks and sidewalks.

People in government and leadership roles need to base decisions on the best evidence available, Drummond said, and the evidence makes clear that the country has a problem with obesity and diabetes. Development decisions need to be based on that evidence. Drummond also urged the design of development improvements to combat obesity for everyone, including children and people with disabilities.

EFFORTS TO SPEAK OUT ON OBESITY PREVENTION IN MONTGOMERY COUNTY, MARYLAND

Mr. Leventhal learned that visibility on the obesity issue carries political risks. When he criticized school fundraisers held at McDonald's restaurants, he received a good deal of negative publicity. However, the controversy did lead the county's PTA council to suggest alternatives to selling unhealthy food for fundraising purposes, although it did not set policy for individual school PTAs.

Leventhal described some of the county's efforts to support healthier living. The county council enacted a ban on trans fats served in restaurants; a requirement that chain restaurants list menu items' nutritional content is pending. The county has developed a program called 7-3-3-1 for children and families with health risks associated with overweight and obesity. (The name of the program derives from the goal of 7 servings of fresh produce, 3 ounces of whole grains, 3 low-fat dairy servings, and 1 hour of physical

activity per day.) The six-lesson program has been offered since 2005 in English and Spanish to families who participate in the county health plan for uninsured residents.

Montgomery County is implementing the wellness plan required by the U.S. Department of Agriculture for districts participating in the School Lunch Program. Leventhal characterized the school system as a reluctant participant because "they see their role as educational; they don't see their role as health based." Nonetheless, he reported on accomplishments, including online listing of information on nutrients and allergens in school menu items and healthier items at lunch, in after-school programs, and in vending machines.

Despite these accomplishments, Leventhal expressed frustration with the lack of good data, which he said impedes progress. The Maryland Adolescent Survey, Maryland Youth Tobacco Survey, and Youth Risk Behavior Survey (part of CDC's Youth Risk Behavior Surveillance System) all provide data, but those data need to be consolidated. The Youth Risk Behavior Survey in particular is controversial because it includes questions about sexual activity. Until recently, parents had to consent actively for their children to participate, which resulted in low response rates and nonscientific samples. Now for the first time, the survey will be administered with passive rather than active consent (parents must opt out rather than opt in), which Leventhal hopes will result in a more representative response.

The state has several committees and task forces working on obesity-related issues. Leventhal is not optimistic, however, that recommendations aimed at schools, such as more time for physical education, will be implemented.

EVIDENCE IN MINNESOTA HEALTH POLICY DECISIONS

Minnesota regularly ranks high in national surveys of the healthiest states, but Ms. Musicant said the ranking masks significant health disparities, including those in three parts of Minneapolis. The city is one of four federal Steps Program grantees that received funding for programs related to nutrition and exposure to tobacco. In addition, the city council adopted 20 sustainability indicators, including one for healthy weight. Musicant supports these indicators because the city must report progress on them publicly, so they provide for accountability.

Local policy achievements have included ordinances to increase the number of farm stands operating in the city and efforts to improve food offerings at convenience stores. The State Health Improvement Program, a $47 million, 2-year program addressing physical activity, nutrition, and exposure to tobacco, was built on experience with the Steps grant. Musicant described it as a good start, but noted that tremendous pressure exists to

show that it has been a worthwhile investment. Work is in progress on several other policy initiatives.

In discussing the role of evidence in policy making, Musicant clarified that she did not speak from her own perspective as a health expert, but from the point of view of an elected official dealing with a myriad of issues. In terms of obesity prevention, if a proposed strategy dovetails with a policy maker's other objectives and personal opinions about healthy behaviors, his or her interest in taking action increases. If the strategy is singularly about improving health, evidence must be paired with community advocacy before a policy maker takes action. If little or no evidence for the effectiveness of a proposed policy exists, a local pilot or demonstration can help.

In discussing the role of evidence in decision making, Musicant said she was revisiting the topic of her master's thesis on health care cost containment. In that research, she found no relationship between what policy makers said they needed in terms of evidence to make a decision and how they actually made their decisions. She said her experience tells her this occurs because the evidence is not available in a meaningful way when policy makers need it. Instead, they are influenced by the opinions of trusted advisors, constituents' advocacy for the change, the strength of opponents' arguments and their clout, and the decision maker's own personal and family experience with the issue. Evidence is used most often as a justification after a decision has been made, rather than as the reason for the decision.

> *"Food and exercise are so personalizable. Everybody has their own anecdote that they carry around with them constantly. That is the most powerful information for most decision makers."*
>
> —Gretchen Musicant

When they do seek evidence for health-related policy changes, policy makers need it to be localized to track the changes; timely; capable of being broken down in meaningful ways, such as by age or race; affordable; and reliable. Also helpful are anecdotal evidence, data on the magnitude of the problem, information showing how to balance civil liberties with health, and parallels with other successful public health efforts to change behaviors.

Much remains to be discovered about the most effective ways to enact obesity-related policies. It is necessary to build evidence based on community wisdom and to promote health-enhancing behaviors, in some cases helping groups rediscover their own traditional, more healthful ways. Health impact assessments, which have been used in Europe and Canada, may be effective in bringing new perspectives into planning and engaging the public. The government has many tools available. The question remains how best to use them to optimize health.

Factors Influencing Policy Decisions

- Opinions of trusted advisors
- Advocacy by constituents
- Strength of opponents' arguments
- Decision makers' personal and family experiences

REFRAMING OF THE CONVERSATION IN WASHINGTON, DC

Mr. Vigilance was the final speaker in this panel. He said it was refreshing to be among people who understand the obesity issue because convincing others of the role that agencies need to play in changing the environments in which people live, work, and play can be challenging.

People, Places, and Policy

The health field focuses on the conversation between a patient and a health care provider, but many people do not go to a doctor or do not heed their doctor's advice. Instead of framing the discussion in terms of patients and providers, Vigilance urged speaking about people, places, and policy. By places, he meant not just physical locations but also "the place you are in your head around your own health and wellness."

Economics and Health

Washington, DC, has the one of the highest rates of obesity in the nation, with significant disparities depending on the particular neighborhood. Vigilance noted that the same issues that affect economic development in a neighborhood also affect wellness. His department's practice is to reach out to partners, such as the police department and the education system, to involve them in health and wellness issues. According to Vigilance, New York serves as a model for what a city can do. To those who think food-related actions are too difficult, he noted they are similar to those relating to tobacco.

"The fiscal impact of obesity is something to make more clear to people."

—Pierre Vigilance

The department's community activity takes place on different levels, such as development of a District of Columbia obesity action plan and

a children's health action plan and efforts to increase the availability of grocery stores in underserved neighborhoods. As in other cities, corner stores are the main source of food in poorer neighborhoods. When Vigilance spoke with the owner of one local store, the owner said what he stocks is a function of what sells, not necessarily what is healthy. Vigilance urged teaching children, businesses, and stakeholders differently so more people will understand the impact of obesity on the workforce, educational outcomes, and long-term medical costs.

DISCUSSION

Questions and topics raised during the discussion that followed the panel presentations included the following:

- **The First Family and others as role models.** One attendee expressed the belief that the Obama family serves as a positive model, with such examples as the children playing soccer and planting of a White House vegetable garden. Vigilance agreed but noted that not everything the First Family does applies to all parts of the country, citing as an example community gardens. Leventhal said the problem is not a lack of messages about diet and exercise, but rather reaching the percentage of the population that is not receiving or acting on those messages.
- **Advice for working with policy makers who may not be receptive.** Panelists responded to a question on dealing with unreceptive policy makers. Leventhal suggested not just going to particularly sympathetic officials because then the issue becomes branded as their special issue. Instead of working with one individual, he urged working with an entire council or other body. Tejada suggested finding ways to encourage citizen participation by asking the mayor and other elected representatives what the jurisdiction is doing to combat obesity and having information to give them. Coalitions raise the visibility of an issue, such as through a forum where people can discuss the issue and not just reinvent the wheel. Drummond agreed that community consensus is important. He also suggested following the "path of least resistance," which he defined as agencies, such as parks and recreation or health, that would be most receptive to obesity prevention efforts. Local universities have facilities, such as recreation centers or departments, that can offer community classes. Public–private partnerships can get people active through sports, gardening, or other activities. Thomases noted that in local settings, small numbers of votes really matter. A few dozen voters in a district with 100,000

people who call an elected official about an issue can make a big difference.

- **Strategies for addressing opposition from the restaurant industry.** A participant asked panelists how they dealt with opposition to menu labeling and banning of trans fats in restaurants. Thomases explained that the New York City Board of Health enacts these policies. It is separate from the City Council and not elected, which keeps it relatively insulated politically from the restaurant industry. However, the industry sued the city three times on the menu labeling initiative. The first time, the city lost and had to reshape the initiative. Thomases recommended that jurisdictions considering menu labeling initiatives research these court cases because legal precedent was ultimately established. Leventhal said a menu labeling bill is still pending in Montgomery County. When the recession hit, he pulled back on trying to obtain its passage. In the meantime, he is collecting data on the costs it would require, such as new menus. Policy makers have heard only opposition to the bill; would-be supporters see the issue as somewhat obscure and have not rallied behind it. Leventhal noted that the industry did not offer much opposition to the trans fat ban beyond asking for time to make changes to their offerings. The experience with making restaurants smoke free has been instructive. The industry opposed the measure on financial grounds, but 3 years of data show, in fact, that restaurant revenues have increased.
- **Institutionalizing change.** Vigilance emphasized the need to work with others besides elected officials, who eventually leave office; the issues outlive their terms. He suggested pressuring elected representatives to put plans in place and fund them so they will continue past the politicians' terms.
- **Levels of evidence for policy making.** An audience member commented on what panelists had said throughout the workshop about evidence. When Karpyn discussed levels of evidence from a scientific point of view, expert opinion ranked last. In contrast, policy makers consider the opinions of experts to be highly valuable. It is important to have good science, but based on the workshop discussions, it is only part of what is needed to effect change.

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Closing Remarks

To conclude the workshop, Marion Standish and Loel Solomon returned to the podium to thank the panelists, moderators, and attendees for their participation in the discussions. They also commented on themes and ideas related to community practice, policy, research, and evidence that had resonated with them throughout the day.

DIVERSITY OF EFFORTS

The diversity of obesity prevention efforts is, said Standish, a strength in that it sparks innovation and empowers people to work toward their own better health. However, this diversity is also a drawback in that it complicates efforts to measure impact and build the strongest possible evidence base. Standish urged the field to grapple with this dichotomy to achieve the ultimate outcomes of improved health and a reduction in obesity rates.

A MOVEMENT VERSUS DISCRETE POLICIES AND PROGRAMS

Standish suggested that health policy must occur "in all places." The development of comprehensive frameworks for community efforts to create healthy environments is under way, but the need persists to educate, convince, and inform actors and decision makers in other sectors that health and health policy are their allies in changing the shape of community environments for the better. Local government is a good resource in which to find allies. Echoing many speakers throughout the day, Standish expressed

hope that as local initiatives to combat obesity continue to emerge, the result will be the building of a movement rather than a series of discrete policies or programs.

COMMUNICATION IS KEY

Communication is key to this work, as speakers illustrated in several ways. Communication is needed to develop a common understanding of obesity prevention, given stakeholders' many definitions of "prevention." Another challenge that requires communication is articulation of the shift from individual interventions to environmental change in combating the obesity epidemic.

Solomon observed that a breakdown in communication results from differences in expectations and professional paradigms—even within the research community, for example, between public health researchers and health economists. Communication on such issues as how different sectors view evidence can help bridge these divides.

The importance of communication also relates to how evidence is communicated to policy makers. Workshop presenters demonstrated the impact of maps and other ways of packaging and summarizing research results in the policy process.

CORE DATA

Standish voiced a fundamental question raised during the workshop: whether there is a body of data that can be consistently collected across communities to tell the story to policy makers with the necessary impact. More discussion is needed to reach consensus on this question. Standish also urged all those involved in obesity prevention to share data more effectively. Wide dissemination of innovations in data, such as the Supermarket Need Index in New York City, avoids duplication of efforts.

Solomon acknowledged the divergence of opinion among workshop participants on the use of body mass index (BMI) data. He questioned whether assembling the entire chain of evidence—from environmental interventions, to changes in food and physical activity behaviors, to changes in BMI—is necessary for every intervention. He suggested looking at the entire body of work on obesity prevention and not expending time, energy, and community capital on developing this evidence for each intervention. Moreover, as reflected in comments made during the workshop, communities do not want to serve as the subject of research studies that lead to no visible improvement.

COMMUNITY KNOWLEDGE

Community knowledge is an essential building block that helps form and set policy priorities for communities and different contexts, from soccer fields in Santa Ana to green carts in New York City. Ongoing neighborhood and resident engagement builds leadership and power within communities, said Standish, which can create and sustain change. As Solomon closed the workshop, he reminded the group that community knowledge and experience in obesity prevention are important sources of evidence for creating change now and in the future.

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Appendix A

Workshop Agendas

Workshop on Community Perspectives on Obesity Prevention in Children and Youth

June 1, 2008

The California Convergence Conference
Sheraton Grand Sacramento

10:30 am Focus Group with Program Evaluators

Key Questions:

- What measures are currently in use to evaluate obesity prevention programs?
- How are decisions made on which measures to use?
- How effective are current measures in capturing both process and outcome?
- What are the greatest challenges faced by evaluators?
- What evaluation strategies are used in culturally diverse neighborhoods?
- What linkages do evaluators see between environmental and policy changes and outcomes?
- What gaps exist in the evaluation field with respect to obesity prevention programs?
- What opportunities exist for collaboration in meeting the challenges faced by evaluators?

3:30 pm Focus Group with Program Site Leaders

Key Questions:

- What types of initiatives are obesity prevention sites currently conducting?
- What kinds of information are most useful to site leaders in making decisions about which projects to initiate in their communities?
- How do site leaders go about finding information on potential childhood obesity prevention programs?
- What kinds of data do they wish they had?
- Do they believe that their initiatives have had a positive impact on childhood obesity?
- Do they use evaluation in their work?
- How do they tailor projects for culturally diverse neighborhoods?
- Do they believe they have the information they need to decide what programs to initiate and what to evaluate?
- What information do they need to convince various stakeholders of the progress or success of a community-based childhood obesity prevention program?
- Do evaluations successfully capture the most important changes their programs have brought about?
- What are the greatest challenges they have faced?

4:30 pm Adjourn

Workshop on Community Perspectives on Obesity Prevention in Children and Youth

May 6, 2009

Lecture Room
The National Academy of Sciences Building
2101 C Street, NW
Washington, DC 20418

8:30 am Registration

9:00 am Welcoming Remarks
Patricia Crawford, PhD, University of California, Berkeley
Marion Standish, Director of Healthy Environments, The California Endowment
Loel Solomon, National Director of Community Health Initiatives, Kaiser Permanente

9:45–11:40 am Panel I: What information do community base programs need to meet their goals?

Moderator: *Patricia Crawford, PhD*

Key Questions:
- What information do community-based programs use?
- How do you find information on how to run and assess programs?
- Do you link nutrition and physical priorities to broader community priorities?
- What information do programs need to sustain their efforts?

Speakers:
Gerardo Mouet, Parks, Recreation, and Community Services Agency, City of Santa Ana, California
Leslie Bernard, Associated Black Charities, Baltimore, Maryland
Genoveva Islas-Hooker, Central California Center for Health and Human Services, Fresno, California
Canary Girardeau, Summit Health Institute for Research and Education, Inc., Washington, DC

11:40 am–12:40 pm Lunch

12:40–2:10 pm Panel II: What is the level of evidence needed to inform policy?

Moderator: *Sarah Samuels, DrPH*, Samuels and Associates

Key Questions:
- What is the practitioner's experience with informing policy?
- What evidence does a community-based program need to inform policy?
- What information does the program feel it needs to inform policy?
- What is the response of policy makers?

Speakers:
Jeffrey Levi, Trust for America's Health, Washington, DC
Joseph Curtatone, Mayor, City of Somerville, Massachusetts
Allison Karpyn, The Food Trust, Philadelphia, Pennsylvania

Shireen Malekafzali, PolicyLink, Oakland, California
Derek Birnie, Delridge Neighborhoods Development Association, Seattle, Washington

2:10–2:30 pm Break

2:30–4:00 pm Panel III: How do community perspectives influence decision makers?

Moderator: *Mary Story, PhD, RD*, University of Minnesota

Key Questions:
- Where does obesity prevention evidence fit into public policy decision making?
- How do policy makers gather, use, and evaluate evidence in decision making?
- What challenges do policy makers face in finding and using evidence?
- What types of evidence are most useful to policy makers?
- What are examples of policies in obesity prevention that have been influenced by specific programs?

Speakers:
Dan Drummond, Fairfax City Council Member, Fairfax, Virginia
Ben Thomases, City Food Policy Coordinator, New York, New York
J. Walter Tejada, Arlington County Board Member, Arlington, Virginia
George Leventhal, Montgomery County Council Member, Rockville, Maryland
Gretchen Musicant, Commissioner, Department of Health and Family Support, Minneapolis, Minnesota
Pierre Vigilance, Director, Department of Health, Washington, DC

4:00–4:30 pm Closing Remarks
Marion Standish
Loel Solomon

Appendix B

Biographical Sketches

Leslie Bernard is Director of Special Projects for Associated Black Charities, a public foundation established in 1985 to represent and respond to issues of special significance to Maryland's African American communities. With an extensive career in philanthropy, Ms. Bernard has worked as a Program Officer for The Kresge Foundation, a Development Officer for The Philadelphia Foundation, and a Director of Outreach Efforts for a community partnership of The Annie E. Casey Foundation. Ms. Bernard has been involved in local, national, and international grant making, working with underserved populations in various communities to address issues related to health care, education, the arts, the environment, and public affairs. Currently, she oversees Associated Black Charities' health initiatives. She works with local community organizations and public officials to inform and develop policy, strategies, and initiatives to reduce health disparities in Baltimore, particularly in the area of childhood obesity. Ms. Bernard holds a B.S. from Georgetown University's School of Foreign Service and an M.A. from Tufts University's Fletcher School of Law and Diplomacy.

Derek Birnie is Executive Director of the Delridge Neighborhoods Development Association, a community development organization serving one of Seattle's most diverse and underinvested neighborhoods. The Association is the lead community partner for the King County Food and Fitness Initiative, a Kellogg Foundation–funded effort to address childhood obesity and other disparate health outcomes resulting from regional inequities. In 2009, Mr. Birnie completed an executive master's in public administration

at the University of Washington and celebrated 20 years of community organizing.

Daniel Drummond is serving his first term on the Fairfax City Council, in Fairfax, Virginia. He serves as the city's representative to the Metropolitan Washington Council of Governments Board of Directors, the Transportation Planning Board, and the Virginia Municipal League's General Laws Committee. Previously, he served on the city's Economic Development Authority, the Parks and Recreation Advisory Board, the Crossings Condominiums Board of Directors, and the 2004 School Bonds Task Force Steering Committee. Mr. Drummond is also on the Board of Directors for the Virginia Economic Bridge, a partnership between George Mason University and Southwest Virginia communities; the Board of Directors for the Barter Theater (Virginia's state theater); the Southeast Fairfax Citizens Association; the Knights of Columbus; and various other economic development task forces throughout Virginia. Professionally, Mr. Drummond is a Director in the public affairs practice of Burson-Marsteller, a global public relations and strategic communications firm. Prior to joining the private sector, he was communications director for Virginia Congressman Jim Moran. He also had a career in journalism, last working as a reporter at *The Washington Times*, as well as other small and regional newspapers across Virginia.

Rebecca Flournoy is Associate Director with PolicyLink in Oakland, California, where she leads research, policy analysis, capacity-building, and advocacy efforts to improve community environments in ways that support good health. Her work focuses on ensuring equitable access to high-quality and affordable healthy food, as well as healthy school and housing environments, clean air, appealing and safe opportunities for physical activity, and other components of healthy communities. Ms. Flournoy has more than 15 years of experience in public health and holds an M.P.H. from the University of Michigan. Before joining PolicyLink, she was a researcher at the Kaiser Family Foundation, collaborating on survey projects with reporters at *The Washington Post* and National Public Radio.

Canary Girardeau has been a leader in nursing for more than five decades. After completing her Registered Nurse certification at the University of Wisconsin, she served as Head Nurse at Milwaukee County Hospital. She served as a Public Health Nurse in the Milwaukee City Health Department and completed her certification in public health nursing at Marquette University. Ms. Girardeau went on to complete her bachelor's and master's degrees in early childhood and child development. In 1972, she was called to Washington, DC, to work with the Child Development Associate

Consortium and traveled nationwide to promote the credential. In 1989, Ms. Girardeau moved to Jacksonville, Florida, and became a Senior Community Health Nurse Supervisor for the Duval County Health Department. She was recognized as Florida Public Health Nurse of the Year in 2001. Ms. Girardeau is presently serving as Senior Program Associate at Summit Health Institute for Research and Education in Washington, DC. She heads a Childhood Obesity Prevention project funded by the Office of Minority Health in the Office of the Secretary of Health and Human Services.

Genoveva Islas-Hooker is Regional Program Coordinator for the Central California Regional Obesity Prevention Program (CCROPP). CCROPP addresses environmental and policy-level factors that contribute to the escalating incidence of obesity in the central California counties of Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare. Ms. Islas-Hooker earned a B.S. in health science with an emphasis in community health from California State University Fresno and received an M.P.H. in health education and promotion from Loma Linda University. Her experience in public health spans more than 18 years in both the public and private sectors. As a health educator, she has worked in the arenas of HIV/AIDS education and prevention as well as diabetes prevention and control. In addition, she has taught at the junior college level and lectured within the California State University system. In the health care arena, she has worked in medical managed care and supervised cultural and linguistic services. Ms. Islas-Hooker is a board member for the Latino Coalition for a Healthy California, an advisory board member for Radio Bilingue, and a steering committee member for California Convergence. In her spare time, she serves as a tutor for the Tulare Read literacy program.

Allison Karpyn is Director of Research and Evaluation at The Food Trust, a Philadelphia-based nonprofit organization committed to providing access to affordable nutritious foods. In addition, she teaches program planning and evaluation as well as community assessment courses in the M.P.H. program at Drexel University. Ms. Karpyn is a member of the American Public Health Association, the Society for Public Health Education, and the American Evaluation Association and is certified as a professional researcher by the Marketing Research Association. She earned her bachelor's degree in public health at the Johns Hopkins University and her master's and doctorate degrees in policy research evaluation and measurement at the University of Pennsylvania.

George L. Leventhal was elected to an at-large seat on the Montgomery County Council on November 5, 2002, after many years of active involvement in local politics and community affairs. He served a 1-year term as

Council President in 2006 and is currently serving his second term in office. Councilmember Leventhal chairs the Council's Health and Human Services Committee and is a member of the Transportation and Environment Committee. He also serves on the Metropolitan Washington Council of Governments Human Services Policy Committee.

Jeffrey Levi is Executive Director of Trust for America's Health, where he leads the organization's advocacy efforts on behalf of a modernized public health system. Dr. Levi oversees the Trust's work on a range of public health policy issues, including its annual reports assessing the nation's public health preparedness, investment in public health infrastructure, and response to chronic diseases such as obesity. Dr. Levi is also an Associate Professor at The George Washington University's Department of Health Policy, where his research has focused on HIV/AIDS, Medicaid, and the integration of public health with the health care delivery system. He has also served as an Associate Editor of the *American Journal of Public Health* and as Deputy Director of the White House Office of National AIDS Policy. Dr. Levi received a B.A. from Oberlin College, an M.A. from Cornell University, and a Ph.D. from the George Washington University.

Gerardo Mouet is Executive Director of the City of Santa Ana's Parks, Recreation, and Community Services Agency. When he became head of Parks and Recreation 5 years ago, he led an effort to change the mission of the agency to incorporate the promotion of health and fitness for all agency programs. The City of Santa Ana is the ninth-largest city in California, with a population estimated at 370,000. The city is very densely populated, is 76 percent Hispanic, and has very little recreational open space compared with most cities in the nation. Parks and Recreation is responsible for all parks, bike trails, recreation centers, senior centers, pools, stadiums, libraries, and the zoo.

Gretchen Musicant is Minneapolis Health Commissioner, overseeing the Minneapolis Department of Health and Family Support, whose mission is "to promote health equity in Minneapolis and meet the unique needs of our urban population by providing leadership and fostering partnerships." Prior to working for the city, Ms. Musicant was Vice President of Community Health for the Minnesota Hospital Association and a Government Affairs Specialist for the Minnesota Nurses Association. She holds both a B.S. in nursing and an M.P.H. from the University of Minnesota. She has substantial public policy experience as a state-level lobbyist and as a fellow with the Humphrey Institute. She has chaired several statewide and regional efforts, including the Universal Coverage Committee of the Minnesota Health Care Commission, the Minnesota Visiting Nurse Agency Board,

the Social Conditions and Health Action Team of the Minnesota Department of Health, the Healthier Minnesota Community Clinic Fund, and the University of Minnesota School of Public Health Alumni Society. She is the 2007 recipient of the Paul and Sheila Wellstone Public Health Achievement Award, given by the Minnesota Public Health Association, and has been designated one of the 100 Distinguished Nursing Alumni of the University of Minnesota School of Nursing.

Loel Solomon is National Director of Community Health Initiatives and Evaluation at Kaiser Permanente's Community Benefits Program, a philanthropic venture that seeks to improve the health of communities through partnerships, education, sharing of clinical expertise, research, and grants and services to vulnerable populations. Since joining the program in 2003, he has been responsible for a national effort to improve health outcomes in Kaiser Permanente communities by focusing on environmental and policy change. Earlier, Mr. Solomon served as Deputy Director of the California Office of Statewide Health Planning and Development for Healthcare Quality and Analysis, where he oversaw hospital outcomes and analyses of racial and ethnic health disparities. He was also a Senior Manager at the Lewin Group, where he helped design and facilitate community health initiatives sponsored by the United Auto Workers and the automobile industry. Mr. Solomon's policy experience includes service on Sen. Edward Kennedy's health staff and former President Bill Clinton's Task Force on National Healthcare Reform. He received his Ph.D. in health policy from Harvard University and his master's degree in public policy from the University of California, Berkeley. He is the author of several journal articles and a book chapter.

Marion Standish is Director of Healthy Environments at the California Endowment in Oakland, California. She leads the Endowment's efforts to develop initiatives to address the health disparities and environmental factors that contribute to the poor health of underserved communities. In that capacity, Ms. Standish serves as lead officer on many of the Endowment's major funding initiatives, including Healthy Eating Active Communities, which supports community coalitions to develop and implement policies and programs to reduce obesity; Community Action to Fight Asthma, which focuses on reducing environmental triggers for asthma among school-aged children; and The Partnership for the Public's Health, a 5-year program designed to build strong, effective partnerships between local public health departments and the communities they serve. Ms. Standish also designed the Endowment's partnership project with the Rockefeller Foundation, California Works for Better Health, a 4-year effort to build the capacity of community-based organizations to improve neighborhood health status

through regional employment strategies. She serves on the Board of Directors of the Food Research and Action Center, the San Francisco Community Boards Program, and the Neighborhood Funders Group. She was recently appointed by California's Chief Justice to the Judicial Council's Legal Services Trust Fund Commission and by Mayor Gavin Newsom to San Francisco's Children, Youth and Families Commission. Ms. Standish received her J.D. from the University of San Francisco School of Law, and both her M.A. and undergraduate degrees from New York University.

J. Walter Tejada is serving his third term on the Arlington County Board in Arlington, Virginia. He served as Chairman of the Board in 2008 and Vice Chairman in 2007. A community advocate, Mr. Tejada has distinguished himself as a leader committed to enhancing the diversity of Arlington and the region's community voice. During his tenure, he has reached out to local communities and encouraged residents to be active participants in various efforts throughout the county and the Washington, DC, metropolitan region. He has been instrumental in convening community stakeholders to address a wide range of issues, including health and fitness, among others. In 2004 and 2005, he was elected to serve as Chairman of the Human Services Policy Committee of the Metropolitan Washington Council of Governments (COG), and he also serves on COG's Public Safety Policy Committee to address regional matters. Additionally, he is a member of the National Association of Counties' Member Programs and Services Committee and the Justice and Public Safety Steering Committee, as well as the Virginia Association of Counties' Administration of Government Committee, and he serves as Vice President of the National Association of Hispanic County Officials. Mr. Tejada studied government and communication at George Mason University and has worked as an investigator, a business consultant, and an aide to Congressman Jim Moran.

Benjamin Thomases is Food Policy Coordinator in the Office of the Mayor in New York City. Thomases began at the Mayor's office after serving as President of FirstSource Staffing, a company that works to help low-income people with barriers to entering the workforce get jobs that will put them on a path to self-sufficiency. Mr. Thomases earned an M.B.A. from Columbia Business School where he studied building an antipoverty program that is not overly reliant on government and philanthropic support. As Food Policy Coordinator, Thomases will try to ensure that those who are eligible for food stamps receive them as well as oversee a plan to expand to 1,000 stores a program that encourages bodegas (corner stores) in low-income areas to offer more products like low-fat milk and fresh vegetables. The newly created position of Food Policy Coordinator is responsible for coordination between the many city agencies that will play

a role in expanding the range of easily accessible, affordable, and nutritious food options to New Yorkers.

Pierre Vigilance is Director of the Washington, DC, Department of Health. He joined the District government after having served as Director and Health Officer for the Baltimore County Department of Health since 2005. In that capacity, he led an agency of 500 staff covering a jurisdiction of approximately 800,000 residents with a $50 million annual budget. He established a quantitative management reporting system to improve performance management and was responsible for improving access to care for the medically uninsured by increasing the number of Kaiser Permanente "Bridge" program slots from 300 to 525 (75 percent) in just 2 years. Mr. Vigilance has been instrumental in local legislative changes aimed at reducing youth access to tobacco and has been a collaborator with the Johns Hopkins University Bloomberg School of Public Health to provide regular applied public health internship opportunities. He has also served as incident commander for local and statewide emergency preparedness deployments and drills.

STUDY STAFF

Annina Catherine Burns is a Program Officer and Study Director with the Food and Nutrition Board. She serves as Study Director for Community Perspectives on Childhood Obesity Prevention and Perspectives from United Kingdom and United States Policymakers on Obesity Prevention. She is also a Program Officer for Childhood Obesity Prevention: Austin, Texas. Ms. Burns previously worked for the United Nations World Health Organization (WHO) in Geneva, Switzerland, on the Global Strategy on Diet, Physical Activity and Health. At WHO, she led the development of a report titled *Interventions on Diet and Physical Activity: What Works*. Ms. Burns was a Marshall Scholar at Oxford University, United Kingdom, where she pursued her master of science in economic and social history; her thesis was on *The Emergence of Obesity in Scotland: Historical and Contemporary Dietary Intakes*. She is currently completing a Ph.D. from Oxford University, with a focus on nutrition policy, obesity, and economics. Ms. Burns holds a B.S. in nutritional sciences and a B.A. in media studies from Penn State University.

Nicole Ferring is a Research Associate with the Food and Nutrition Board. She works with the Standing Committee on Childhood Obesity Prevention and the Committee on Childhood Obesity Prevention Actions for Local Governments. Ms. Ferring previously worked for the Center for Science in the Public Interest on the *Nutrition Action Healthletter.* She recently

finished a year-long dietetic internship through Virginia Tech to obtain the registered dietitian credential. The internship allowed her to rotate through different types of nutrition settings in the Washington, DC, area, including hospitals, community nonprofits, policy organizations, and even a farm. She holds a B.S. in magazine journalism with a minor in nutrition from Syracuse University and an M.S. in nutrition communication from Tufts University.

Lynn Parker is a Scholar and Study Director for the IOM's Standing Committee on Childhood Obesity Prevention, Committee on Childhood Obesity Prevention Actions for Local Governments, and Committee on an Evidence Framework for Obesity Prevention Decision Making. She received a B.A. in anthropology from the University of Michigan and an M.S. in human nutrition from Cornell University. Before joining the IOM, she was a nutritionist at the Food Research and Action Center (FRAC), a national organization working to end hunger and undernutrition in the United States, serving most recently as Director of Child Nutrition Programs and Nutrition Policy, directing FRAC's work on child nutrition programs, research, and nutrition policy. She also led FRAC's initiative on understanding and responding to the paradox of hunger, poverty, and obesity. Ms. Parker served on the Technical Advisory Group to America's Second Harvest 2001 and 2005 National Hunger Surveys, on the National Nutrition Monitoring Advisory Council (appointed by then Senate Majority Leader George Mitchell), and as President of the Society for Nutrition Education. She also served two terms as a member of the Food and Nutrition Board and was a member of its Committee on Nutrition Standards for Foods in Schools. Before joining FRAC, Ms. Parker worked with New York State's Expanded Food and Nutrition Education Program at Cornell University.

Matthew Spear is a Senior Program Assistant with the Food and Nutrition Board. He works with the Standing Committee on Childhood Obesity Prevention, the Committee on Childhood Obesity Prevention Actions for Local Governments, and the Committee on an Evidence Framework for Obesity Prevention Decision Making. Mr. Spear holds a B.A. in economics from Boston College. He recently completed a year-long course and internship studying culinary arts in Florence, Italy, and working as a private chef. International travel and interest in languages drew him out of the kitchen and formed his interest in public policy, leading him to the IOM.

Appendix C

Workshop Attendees

JUNE 2008 WORKSHOP

Evaluators Session

ALLEN CHEADLE, University of Washington
PATRICIA CRAWFORD, University of California, Berkeley
LISA CRAYPO, Samuels and Associates
MONA JHAWAR, The California Endowment
MARTHA QUINN, University of Michigan
SARAH SAMUELS, Samuels and Associates
LIZ SCHWARTE, Samuels and Associates
PAMELA SCHWARTZ, Kaiser Permanente
MARY STORY (Moderator), University of Minnesota
SHARON SUGERMAN, California Department of Public Health
MARNI VOSSLER, Save the Children

Site Leaders Session

SHARON BRISOLARA, Evaluation Solutions
CAROLE COLLINS, HEAL-CHI of West Modesto
TERRY DUARTE, Sacramento County Department of Health and Human Services
DARLENE FUJI, HEAC Alameda
ESMERALDA GONZALEZ, HEAL-CHI of West Modesto
GAYLE HOXTER, Riverside County Public Health Program

TAMIKO JOHNSON, HEAC Oakland
LAURA KETTEL-KAHN, Centers for Disease Control and Prevention
DANIEL KIM, Kern County Department of Public Health
PHOEBE LEUNG, HEAL-CHI of West Modesto
JOYCE NAKASHIMA, Los Angeles County Public Health
AVTAR NIJJER-SIDHU, Kern County CCROPP
DURREEN QURESHI, Riverside County Public Health Program
DANA RICHARDSON, HEAC Chula Vista
TANYA ROVIRO-OSTERWALDER, HEAC Chula Vista
CHRIS SEARLES, HEAC Chula Vista
ROSA SOTO, HEAC Baldwin Park
CLARA STROMBERG, HEAC Baldwin Park
ANTHONY TAYLOR, HEAL Sonoma County
ANGIE TIPTON, Tulare County Public Health
SANDRA VIERA, HEAC Santa Ana
DIANE WOLOSHIN, HEAC Alameda

MAY 2009 WORKSHOP

S. SONIA ARTEAGA, National Heart, Lung and Blood Institute
ALEXIS ASHBROOK, DC Hunger Solutions
MARIHELEN BARRETT, Nemours Foundation
WHITNEY BATESON, Chartwells-Thompson, DC Public Schools
MARY BETH BIGLEY, Office of the Surgeon General
JENNIFER BISHOP, Department of Health and Human Services/ Assistant Secretary for Planning and Evaluation
DONNA BLUM-KEMELOR, Center for Nutrition Policy and Promotion, U.S. Department of Agriculture
LAUREL BOROWSKI, National Cancer Institute
WENDY BRAUND, Department of Health and Human Services
MEREDITH BROWN, Dietetic Intern
ZANETA BROWN, BET Foundation, Inc.
AMANDA CASH, Health Resources and Services Administration
NANCY CHAPMAN, N. Chapman Associates
VERONICA CONTI, Food Research and Action Center
JUDITH DAUSCH, American Heart Association
JENNIFER DAYRIT, Ventura County Public Health Department
KAREN DONATO, National Heart, Lung, and Blood Institute/National Institutes of Health
PAUL EARHART, K Consulting
EVE ESSERY, Department of Health and Human Services/Office of Disease Prevention and Health Promotion
AMANDA EXNER, Georgetown University

LISA FORD, Healthways, Inc.
ALLISON GERTEL-ROSENBERG, Nemours Foundation
JESSYE GOERTZ, University of Nebraska
LAURA GOODSON, Independent
LISA GOODSON, Trinity University
GEMMA GORHAM, Brown University
NURA GREEN, Aban Institute
JOANNE GUTHRIE, Economic Research Service, U.S. Department of Agriculture
JASMINE HALL RATLIFF, The Robert Wood Johnson Foundation
HEATHER HARTLINE-GRAFTON, Food Research and Action Center
DANIEL HATCHER, Alliance for a Healthier Generation
PAULETTE HELMAN, Consultant Nutritionist
GERALDINE HENCHY, Food Research and Action Center
KIMBERLEY HODGSON, American Planning Association
JAMES HOLLY, Independent
KEITH HOWELL, George Mason University
JENNÉ JOHNS, Summit Health Institute for Research and Education
JEAN JOHNSON, University of the District of Columbia Cooperative Extension
MEGHAN JOHNSON, Share Our Strength
BRIDGID JUNOT, Tufts University
LISA KATIC, K Consulting
MELINDA KELLEY, National Heart, Lung, and Blood Institute/National Institutes of Health
PATTI KIGER, Eastern Virginia Medical School
BRAMARAMBA KOWTHA, International Life Sciences Institute Research Foundation
JUDITH LEVIN, Diamond Healthcare Corporation
LAURA C. LEVITON, The Robert Wood Johnson Foundation
GRACE LIM, Georgetown University
IRIS MABRY-HERNANDEZ, Agency for Healthcare Research and Quality
JAMES MARKS, The Robert Wood Johnson Foundation
REYNALDO MARTORELL, Emory University
JEANNE MATTHEWS, Arlington Department of Human Services
LINDA MIN, LYM Consulting
LILLIE MONROE-LORD, University of the District of Columbia
MEREDITH MORRISSETTE, National Heart, Lung, and Blood Institute/National Institutes of Health
MELISSA MUSIKER, Grocery Manufacturers Association
ELANA NATKER, FoodMinds
JILL NICHOLLS, National Dairy Council

SUSAN NITZKE, University of Wisconsin, Madison
JULIE OBBAGY, N. Chapman Associates
JANICE OKITA, CopyeditingPlus, LLC
RACHEL OLIVERIO-HOFFMAN, University of Maryland
SOHYUN PARK, Johns Hopkins School of Public Health
RUTH PEROT, Summit Health Institute for Research and Education, Inc.
ALYCE RAUCHENSTEIN, Office of Disease Prevention and Health Promotion
KRISTIN ROBERTS, D.C. Hunger Solutions
JOCELYN ROGERS, American Heart Association
ALEXIS ROURK, Academy for Educational Development
RAVI SAWHNEY, Department of Health and Human Services
DANIELLE SCHOR, International Food Information Council
REBECCA SCRITCHFIELD, Elite Nutrition
KAREN SEAVER-HILL, National Association of Children's Hospitals and Related Institutions
MAISHA SIMMONS, The Robert Wood Johnson Foundation
STACEY SNEE, Virginia Tech Dietetic Internship
ANASTASIA SNELLING, American University
JOANNE SPAHN, U.S. Department of Agriculture
DESIREE STAPLEY, Food and Nutrition Information Center
KATHRYN STRONG, Physicians Committee for Responsible Medicine
KATHERINE TALLMADGE, Personalized Nutrition
LINDA THOLSTRUP, Nemours Health and Prevention Services
JULIE THURNAU, Harrisonburg and Rockingham Childhood Obesity Team
ELIZABETH WALKER, National Association of State Boards of Education
JENNIFER WEBER, American Dietetic Association
VICTORIA WELLS, American Cancer Society
LEE WILSON, Department of Health and Human Services/Assistant Secretary for Planning and Evaluation
SARA WILSON, Food and Nutrition Information Center