



HEALTHY WEIGHT Community Outreach Initiative

Strategy Development Workshop Report



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Heart, Lung, and Blood Institute

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Obesity Education Initiative

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Foreword

Overweight and obesity are now primed to overtake smoking as the leading cause of death in the United States. More than 65 percent of U.S. adults are overweight or obese, with nearly 31 percent of adults—more than 61 million people—meeting the criteria for obesity. In just over two decades, after remaining relatively static through the 1980s, prevalence has nearly doubled in adult populations. Overweight and obesity also disproportionately affect racial and ethnic minority populations and those of lower socioeconomic status (SES).

What is perhaps even more alarming is the staggering effect the epidemic has had on children. Over the past 20 years, overweight prevalence rates have nearly doubled for youth and tripled for adolescents. Approximately 16 percent of young people ages 6 through 19 are now overweight. The levels of pediatric overweight have ominous implications for the development of serious diseases, such as type 2 diabetes and cardiovascular disease (CVD), both during youth and adulthood. These rates have directly contributed to the dramatic incidence of type 2 diabetes in children—an illness once considered nonexistent in adolescents that is now estimated to account for up to 45 percent of newly diagnosed diabetes cases in children and adolescents.

Since its inception in January 1991, the National Heart, Lung, and Blood Institute's (NHLBI) Obesity Education Initiative (OEI) has undertaken activities to help bring national attention to this major public health problem. In response to the alarming increase in the prevalence of overweight and obesity in children, the OEI is planning a national public education outreach initiative on body weight—the Healthy Weight Initiative (HWI)—to help reduce the number of children and adolescents who are overweight and obese.

To define the unique niche and program parameters for the new HWI, NHLBI convened this Strategy Development Workshop on February 17-18, 2004, in Bethesda, Maryland. The Workshop brought together more than 70 public health leaders, nutritionists and dietitians, food industry experts, health communicators, youth marketing experts, park and recreation officials, and others from professional societies and constituency groups with a stake in stemming the growing epidemic of overweight and obesity. The Workshop proceedings helped to illuminate the complexity of the issues around weight gain in children, youth, and families; the many environmental and societal influences on the eating and physical activity habits of various population groups; and the community-based strategies that might encourage healthier habits.

We will use the recommendations from this Workshop, together with an examination of the science base and lessons learned from the success of our Hearts N' Parks program, to develop new, targeted strategies for youth and their adult influencers. Strategies will include use of national media and messages, community outreach, and partnership development. We hope that these strategies will be useful to the many communities working hard to help improve the overall health of America's youth.



Barbara Alving, M.D.
Acting Director, NHLBI

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Introduction

The National Heart, Lung, and Blood Institute (NHLBI) convened a 2-day Healthy Weight Community Outreach Initiative (HWI) Strategy Development Workshop on February 17-18, 2004, in Bethesda, Maryland. The Workshop was part of NHLBI's Obesity Education Initiative (OEI). Launched in January 1991, the OEI aims to help reduce the prevalence of overweight, obesity, and physical inactivity in order to lower the risk of, and overall morbidity and mortality from, coronary heart disease (CHD).

The goal of the Workshop was to develop a focused, collaborative, national public education outreach effort to help combat the persistent rise in overweight and obesity in the United States by building on the momentum of NHLBI's Hearts N' Parks initiative and creating synergy among public and private programs with related goals.

The objectives of the Workshop were as follows:

1. Examine community-based obesity best practices.
2. Help determine the unique niche for the new NHLBI HWI.
3. Recommend appropriate and effective program strategies and interventions.
4. Identify potential program partners and partnership opportunities.

The Strategy Development Workshop brought together more than 70 key community-based organizations and coalitions, foundations, trade associations, professional societies, and Federal agencies. Representatives included researchers, public health leaders, nutritionists and dietitians, food industry experts, obesity advocates, health communicators, youth marketing experts, parks and recreation officials, and others from constituency groups that have a stake in curtailng the growing epidemic of overweight and obesity. The Workshop was convened to develop a science-based blueprint for a comprehensive healthy weight education action plan for these constituency groups and the public.

The Workshop's plenary sessions provided: background on the current obesity-prevention landscape with presentations on challenges, obstacles, and strategic considerations; a review of the current evidence; one community's response to the challenge; and the translation of clinical trials into school-based community programs. Other plenary sessions considered youth marketing strategies, public health messaging, and the cultural and societal issues around weight, including environmental factors, weight discrimination, and the need for culturally positive approaches. A presentation in talk-show format featured seven individuals who are involved in State-based obesity coalitions or are implementing the NHLBI-National Recreation and Park Association's (NRPA) Hearts N' Parks program at the local level. These panelists shared their observations about the challenges faced and successes achieved by those working in the field to implement creative and innovative obesity education and prevention initiatives.

Workshop participants were assigned to small groups for an intensive, creative brainstorming session, where they set parameters for strategy development in the areas of defining NHLBI's program niche; refining the target audience; creating strategies, tools, and tactics; and measuring results. A spokesperson from each of the small groups reported to the entire group, and follow-up discussions were held.

The proceedings from the Workshop were captured via a graphic depiction of the 2 days of deliberations. Reproductions of these graphic images are included in this report. Participants were asked to view the pictorial depiction of the deliberations during the meeting breaks and at lunchtime in order to add information that was missing or to modify existing information.

Opening Session

Gregory J. Morosco, Ph.D., M.P.H.;
Karen Donato, S.M., R.D.; and Marian Fitzgibbon, Ph.D., Workshop Chair

The HWI Strategy Development Workshop opened with brief comments about the congressionally mandated responsibility of NHLBI's Office of Prevention, Education, and Control, as well as a description of NHLBI's numerous longstanding national education programs and its newly implemented community outreach programs. The educational program tenets discussed included considering the science base, tailoring education and communication strategies, and involving many national and local partners.

The education programs relate to four major goals of Healthy People 2010: prevention of cardiovascular disease (CVD) risk factor development, detection and treatment of CVD risk factors, early recognition and treatment of acute coronary syndrome, and prevention of the recurrence and complications of CVD. Many of the educational programs, including those under the rubric of the OEI, are part of the current HealthierUS Initiative begun by President George W. Bush. It encourages all Americans to be physically active every day, eat a nutritious diet, get preventive screenings, and make healthy choices. Department of Health and Human Services Secretary Tommy Thompson has responded by putting into action Steps to a HealthierUS, which envisions a healthy, strong United States where diseases are prevented when possible, controlled when necessary, and treated when appropriate.

The HWI Workshop is not the first time NHLBI has convened representatives from a broad range of Government agencies and non-Government organizations prior to launching a new program. The *Heart Truth* campaign and its red dress symbol/pin were presented as an example of an educational outreach initiative that began with a simi-

lar Strategy Development Workshop. The campaign's intent, to raise awareness that heart disease is the #1 killer of women, has evolved into a high-level national effort involving the President and First Lady, as well as many partners, the media, the fashion industry, and others not typically involved in such efforts.

For OEI, NHLBI has adopted a two-pronged strategy for educating professionals and the public about the effect of overweight and physical inactivity on cardiovascular and pulmonary disease: a population-based approach and a high-risk approach. Although both strategies are important in managing overweight and obesity and in promoting physical activity, this Strategy Development Workshop is an attempt to further infuse population-based components into the new HWI.

★ The population-based approach focuses on prevention of overweight, obesity, and physical inactivity in the general population. Since the convening of a Strategy Development Workshop in 1992, various public education strategies and messages have been implemented. Activities have included promoting to elementary school officials and teachers nationwide the physical education and nutrition curriculum developed in the NHLBI-funded Child and Adolescent Trial for Cardiovascular Health (CATCH), materials from the Sports, Play, and Active Recreation for Kids (SPARK) trial, and JumpSTART. Public service announcements on the importance of physical activity as fun for families were developed, as were an after-school booklet called *JumpSTART After School* and an adaptation of CATCH—entitled *CATCH Recreation*—for park and recreation professionals.

A major focus of the population-based approach is Hearts N' Parks, a fun and flexible community-based effort in partnership with NRPA to encourage heart healthy eating and increased physical activity among youth and adults. Hearts N' Parks was launched in 1999. Programs and materials for recreation and park professionals to use in promoting heart healthy eating and increased physical activity are being implemented in summer day camps, after-school programs, senior centers, and community outreach centers in 50 Magnet Center sites and other communities throughout the United States. The Magnet Center sites have committed to implementing heart healthy activities that emphasize the five Ps of Hearts N' Parks: **P**eople, **P**rograms, **P**artners, **P**ublic Visibility, and **P**erformance Measures. Performance results from the Magnet Center sites over 2 years of program implementation show significant improvement from pre- to post-questionnaire in almost all indicators of heart healthy eating and physical activity.

☆ NHLBI's high-risk approach targets individuals who are experiencing, or who are at high risk for, the adverse health effects of and medical complications associated with overweight and obesity. In implementing the high-risk strategy, an expert panel issued *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: Evidence Report* in June 1998. These are the first Federal clinical practice guidelines to deal with overweight and obesity issues using an evidence-based approach. The guidelines provide scientific evidence behind the assessment of weight, CVD risk factors and therapeutic recommendations for weight loss and weight maintenance, and they offer practical strategies for implementing the recommendations. In addition, the clinical guidelines have been adapted to a variety of formats to address the needs of different health care practitioners, including physicians in primary care, nutritionists, nurses, pharmacists, and health maintenance organizations (HMOs), as well as patients and the public.

In response to the alarming increase in the prevalence of overweight and obesity in both children and adults across all age, gender, and race groups, OEI will undertake a national public education outreach initiative on body weight: The HWI. This new program will build on the success of the Hearts N' Parks initiative and will complement current Federal, State, and community efforts to motivate and support healthy choices that reduce the burden of preventable diseases such as obesity.

The HWI will:

- ☆ Engage communities to take an active role in creating hometown environments that promote a healthy weight.
- ☆ Help the public recognize both individual and environmental factors that influence individuals' attempts to achieve and maintain a healthy weight.
- ☆ Motivate health professionals to provide their patients with clear, nonjudgmental, and non-stigmatizing messages about preventing inappropriate weight gain.

The HWI will include:

- ☆ Key messages to specific target audiences;
- ☆ Multiple partners at national, regional, and local levels;
- ☆ National- and community-level resources (broadcast media, print, Internet, etc.); and
- ☆ Outreach efforts to the public, community organizations, and health care providers.

The audiences for the HWI will be children/youth and adult influencers. The rationale for audience selection is based on:

- ☆ Increasing prevalence of overweight and obesity and the associated health consequences;
- ☆ The likelihood that overweight accumulated in childhood will transfer to adulthood;
- ☆ The advantages associated with prevention; and
- ☆ The fact that behaviors learned in childhood are often learned for life.

Population-based strategies may include, but are not restricted to: limiting the availability of energy-dense food; increasing opportunities for physical activity and reducing opportunities for sedentary behavior; and implementing strategies that focus on the individual (knowledge and attitudes) and that deal with environmental factors (including physical, economic, policy, and sociocultural).

The discussion and learning that took place over the 2-day Workshop will inform the strategy and program parameters for this new and exciting initiative.

The Workshop was designed to answer the following questions:

- ☆ Which components of a population-based strategy will have the most impact on preventing obesity (going beyond the individual)?
- ☆ What are the challenges to success and how can they be overcome?
- ☆ How can public, private, and corporate entities synergize approaches?

Objectives of the Workshop:

- ☆ Examine community-based, obesity-related best practices.
- ☆ Determine the unique niche for the NHLBI HWI.
- ☆ Recommend appropriate, specific, and effective strategies and interventions.
- ☆ Identify potential partners.

All of these considerations will help move obesity prevention to the next level.

Obesity: What Are the Challenges, Obstacles, and Strategic Considerations?

Marian Fitzgibbon, Ph.D.

Overweight and obesity are caused by a complex interplay among three factors: genetic predisposition, excess caloric intake, and inadequate physical activity. Over the past two decades, rates of overweight and obesity have increased dramatically. However, given that little has changed *vis-a-vis* genetic predisposition during that period, it appears that the increase may be due more to systemic/environmental factors (excess caloric intake and inadequate physical activity).

According to the latest Centers for Disease Control and Prevention Growth Charts, overweight in children ages 2 through 20 is defined as a body mass index (BMI) of >95th percentile. Research has shown that overweight children are more likely to become overweight adults. At age 4, children who are already overweight have a 20 percent chance of becoming overweight as adults; by adolescence, the chance for overweight rises to 80 percent. Although obesity treatment is more effective with youth than adults, primary prevention of obesity is critical.

Data from the National Health and Nutrition Examination Surveys have shown that from 1963 to 2000, the prevalence of excess weight among children and adolescents increased dramatically—it more than tripled for youth ages 6 through 19. As children age from 2 to 19 years, a rise in excess weight is seen among non-Hispanic white, non-Hispanic black, and Mexican American youngsters, with the latter two racial/ethnic groups showing the greatest increases.

Television viewing often is considered a leading systemic cause of youth overweight and obesity. Data from the National Household Education Surveys and the National Longitudinal Survey of Youth show a positive association between the number of hours of television watched per day and the prevalence of obesity.

Systemic influences often have been ignored, due in part to the continued belief that obese individuals fail to make the right choices. Prejudice against obese individuals may be the last socially acceptable form of prejudice. In our current culture, however, making the right choices may not be realistic or feasible given numerous influences related to diet and physical activity, including:

- ☆ Diet: eating out/fast food, prevalence of school vending machines, increased portion sizes, and the proliferation of television advertising related to food and beverages.
- ☆ Physical activity: television viewing, use of automobiles for transportation, decreased occupational activity, prevalence of home computers, scarcity of and lack of access to safe recreational space, and reduction of daily physical education classes in schools.

To be effective, efforts to prevent and control overweight and obesity must expand beyond the individual to families, schools, and the community. Each of these plays an important role in both diet and physical activity factors related to obesity prevention.

Systemic factors that can be addressed by the family include:

- ☆ Diet: healthier food choices (e.g., milk versus sweetened beverages, fruits and vegetables versus fast food), food preparation, and food portion size.
- ☆ Physical activity: activity choices (e.g., sedentary versus active), access to activity, and participation in organized sports.

Family television-viewing habits may affect both dietary intake and physical activity.

The school also can encourage more healthful options:

- ☆ Diet: healthier food choices (salad bars versus fast foods), food preparation, vending machines, and incentives to choose healthier options (e.g., price controls).
- ☆ Physical activity: physical education classes, safety of surrounding communities, unstructured time for physical activity, health promotion programs for teachers, attention to mastery and confidence in physical activity participation (versus competitive sport format), and links between school and community resources.

Within the community, the following factors might be considered:

- ☆ Diet: strict labeling of foods and caloric content in both restaurants and fast food outlets, changing food preparation, halting some forms of food advertising, taxing certain foods, and creating incentives for making healthful choices.
- ☆ Physical activity: promoting walking on a community level through city planning (e.g., sidewalks), providing incentives to employers who offer access to activity options for employees, creating no-car-traffic areas, and encouraging stairway use in the workplace.

Corporate America also has a responsibility in overweight and obesity prevention. Several major food companies are now supporting an initiative to persuade consumers that eating too much of their

products may be harmful to one's health. Others are examining their product lines and considering such changes as caps on portion sizes of single-serving packages, guidelines for the nutritional content of all products (even on products for which content is not mandated), and plans to improve existing products (e.g., by creating versions that are lower in fat and/or calories).

The marketing practices of companies could be modified to eliminate all in-school marketing, to assess the healthfulness of products sold in school vending machines, and to create clear guidelines for all advertising and marketing of consumer products to children.

Corporations also can assume an important advocacy role by supporting public policies that encourage schools and communities to improve fitness and nutrition and by increasing dialog with key stakeholders who can help guide a company's continuing response to the obesity issue.

The challenge for a society that is now plagued with an epidemic affecting all segments of the population is to identify which strategies will help shift physical activity, healthy dietary patterns, and weight control to a cultural norm.

The Basic (Care and) Feeding of Homo Sapiens: Are We Truly Clueless About Weight Control?

David L. Katz, M.D., M.P.H., FACPM, FACP

The prevalence of obesity has skyrocketed during the past two decades, and overweight and obesity have arguably become the gravest public health threat in the United States because of the chronic diseases affiliated with these conditions. Today, more than 65 percent of adults in the United States are considered either overweight or obese (defined as a BMI ≥ 25).

The trends of obesity (defined as a BMI ≥ 30) in adults by State, derived from the Behavioral Risk Factor Surveillance System (BRFSS) data from 1985 to 2001, have dramatically increased. In 1985, few States reported 10–14 percent of their adult population as obese. By 2001, most States reported adult obesity levels of 20–24 percent, with one State reporting levels of more than 25 percent.

Using the BRFSS data to consider diabetes trends among adults, including gestational diabetes, it appears that diabetes trends follow the same pattern of increased BMI. In 2001, many more States reported an increase in the number of adults with diabetes than in 1990. The diabetes projections suggest that matters will continue to worsen for both adults and children. In addition, other health conditions that are associated with obesity are likely to rise, including cancer, osteoporosis, hypertension, cerebrovascular disease, renal function disorders, gastrointestinal disorders, and mental health disorders.

Each year, 300,000 to 400,000 deaths are attributed to obesity. Complacency about this issue must be overcome. The public health community

and the public have the power to change the situation. After decades of decline in CVD, a reversal likely will be seen if overweight and obesity rates continue to rise.

For children, the future looks ominous. In a period of 20 years, adult-onset (type 2) diabetes—which previously affected only the middle-age population—has become a pediatric scourge. Given the strong association between diabetes and heart disease, this generation is destined to have adolescent heart disease. CVD may soon become a routine pediatric problem. Children are more harmed by the adverse effects of poor diet and lack of physical activity than by alcohol, tobacco, and illicit drug use combined. Today's children may experience a shorter life expectancy than their parents in addition to serious psychological sequelae.

Americans are obese because of a food-centered culture and an environment that makes it possible. Physiologically, the body is designed to absorb and retain calories. Our Stone Age physiology makes it extremely difficult not to gain weight in the modern world, where a sea of available calories makes weight gain easy. However, individuals vary markedly in their susceptibility to weight gain. Genetic factors and the different types of obesity may play a role. Yet the formula for weight control is the same for everyone: balance calories consumed and calories burned.

The concept of a healthier weight needs to be communicated and promoted not only to those individuals who are obese, but also to children and youth before they become obese. There are

far too many inaccurate weight-loss messages that the public must muddle through. Current fads include the numerous diets advocating a reduction in carbohydrates as well as foods with a low glycemic index. Many people are fixated on the quick fix regardless of the consequences.

The public health community must take what its members already know about healthful eating and physical activity and make the information accessible to all individuals through environmental change in schools, at the worksite, and in the community. A recent review of the scientific evidence due to be published in 2004 in the Community Guide for Preventive Services shows the following strategies as having merit.

In schools:

- ☆ Provide education in healthful nutrition.
- ☆ Implement routine physical activity during the school day using creative approaches, such as 5 to 7 minutes of fun physical activity at the start of every class session.
- ☆ Focus on reduced television viewing.
- ☆ Ban vending machine sodas and calorie-dense snacks.
- ☆ Offer in-season fruits and vegetables.
- ☆ Cultivate a culture of healthful eating.
- ☆ Capture height and weight measures on a routine basis.

At worksites:

- ☆ Offer structured physical activity, either via onsite facilities or through incentives for employees.
- ☆ Promote use of stairs instead of elevators.
- ☆ Offer healthful nutrition choices.
- ☆ Provide practical nutrition education/self-help materials.
- ☆ Establish and promote a culture of commitment to healthful practices.

In communities:

- ☆ Involve families in health promotion.
- ☆ Include sidewalks and parks in urban plans.
- ☆ Provide nutrition information in restaurants, particularly in fast food establishments.
- ☆ Promote and subsidize farmers' markets.
- ☆ Offer on-site education in supermarkets.
- ☆ Offer routine clinical counseling about weight control.

While working for these environmental changes, it is imperative that individuals also be empowered to safeguard their weight and that of their family members. Combating the epidemic of obesity can begin one family at a time. Because there is abundant evidence as to what constitutes a healthful dietary pattern, less time and fewer resources should be devoted to debates about different diets, and more should be devoted to how to adopt and sustain the basic dietary pattern—rich in vegetables, fruits, and whole grains—known to promote both health and weight control. Educating the public about unknown challenges, such as sensory-specific satiety and how to contend with it, can make portion control far more feasible. Empowered with the right kinds of knowledge, families can create safe nutritional environments in their own homes at the same time our nation engages in a society-wide effort to create a safer nutritional environment for us all.

CardioVision 2020:

A Community Responds to the Obesity Epidemic

Thomas E. Kottke, M.D., M.S.P.H.

CardioVision 2020 is a comprehensive, community-based CVD-prevention program established in 1996, in Olmsted County, Minnesota. The program's aim is to make the county the healthiest in the United States by the year 2020 by helping individuals reduce their risk of CVD by making informed choices that lead to sustained changes in personal behavior.

Program funders include the Mayo Clinic, which is located in the county, and an array of community partners.

CardioVision 2020 was developed in response to signs of a new epidemic that organizers believe is influenced by “the lifestyle syndrome”—too many calories taken in, too few burned, too little physical activity, and tobacco use or exposure. The lifestyle syndrome is believed to lead to another syndrome, “the metabolic syndrome,” which includes a cluster of conditions, including hypertension, hyperlipidemia, and obesity, that may play a role in coronary heart disease (CHD) and stroke. Diseases of the lifestyle syndrome include heart disease, stroke, cancer, diabetes, chronic obstructive lung disease, osteoarthritis, and depression.

The philosophy behind the program comes from the North Karelia Project, a highly successful comprehensive CVD-prevention program organized in Finland in 1972. Over a period of 25 years, the North Karelia Project was associated with a 75 percent decline in CVD mortality rates and an increase in life expectancy of 6 years. The motto of the project was “We Participate”—meaning that everyone in the community, regardless of their risk factors, could help improve the lives of their fellow community members.

The mission of CardioVision 2020 is to bring together clinicians and community organizations to develop information systems, environments, skills, and the encouragement needed to help individuals make informed choices and behavior changes that can lead to primary and secondary prevention of CVD. Because this personal behavior change is easier to sustain if people are surrounded by a supportive physical and social environment, program planners host complementary programs to modify the environment and brief campaigns to encourage people to sample the new behavior.

CardioVision 2020 focuses on behaviors, not diseases. The rationale for this is twofold. First, while there is a seemingly endless list of diseases affected by lifestyle, only a handful of behaviors affect how well and how long people live—lifestyles are choices, while diseases are not. Second, focusing on lifestyle permits all disease-oriented advocacy groups, such as those focused on heart disease, stroke, diabetes, dementia, and cancer, to join forces with a common message to the public.

CardioVision 2020 advocates five goal behaviors that residents of Olmsted County can adopt to improve their health. These goals are consistent with Healthy People 2010:

- ★ Living tobacco-free and having zero exposure to environmental tobacco smoke.
- ★ Consuming five servings of fruits and vegetables each day and only lean/extra-lean meats and lowfat/fat-free dairy products.

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- ☆ Maintaining total serum cholesterol <200 mg/dL (low density lipoprotein <100 mg/dL for individuals with CHD).
 - ☆ Keeping blood pressure below 130/85 mmHg.
 - ☆ Engaging in 30 minutes of physical activity on most, if not all, days of week.

Given that lifestyles are a product of a community's social and physical environment, the CardioVision team has defined a vision for the community that focuses on four broad areas: tobacco, nutrition, physical activity, and clinical care systems for secondary prevention. All of the CardioVision 2020 programs aimed at changing the social and physical environment are centered around achieving the vision.

The program's community vision for tobacco by the year 2020 is that all public areas are smoke-free, that there is no advertising or promotion of tobacco products, and that youth are not able to purchase tobacco products in the community.

The program's community vision for nutrition by the year 2020 is that: all restaurants provide patrons with meal analyses; all grocery stores provide product analyses of total fat, saturated fat, cholesterol, and sodium; school lunch programs offer and promote healthy foods and beverages that meet Healthy People 2010 recommendations; and goal (healthy) foods cost less per calorie than foods that are high in saturated fat, sodium, or sugar.

The program's community vision for physical activity by the year 2020 is that: all county residents can travel throughout the community on foot or bicycle, all residents have access to affordable and safe opportunities for physical activity, affordable and attractive youth activity programs are available to all children and adolescents, and elementary and secondary school curricula include daily physical activity at all levels.

The program also has a community vision for secondary prevention by the year 2020: that all residents of Olmsted County with CHD, congestive heart failure, or critical risk factors for these two

conditions have access to a case management system so they can experience the full benefit of the medical technologies available to treat these conditions.

CardioVision 2020 is implemented through various activities and community partners. These include collaborating with restaurants that feature the program logo on menus to indicate healthy meal choices, working with food service providers in workplaces to offer healthier choices and to raise the cost of foods with high amounts of saturated fat, joining the park and recreation department in promoting multiple-use trails for physical activity, working with schools to implement physical education curricula, offering healthy food preparation demonstrations at bookstores, and more. CardioVision 2020 has found that these vital environmental changes are not possible without a great deal of time-consuming hard work by community outreach workers.

Convenience is key. The program offerings have been most successful when they "go where the people are" or are situated between where people are and where they are going.

CardioVision 2020 experimented with a number of intervention formats before learning that people were more likely to try or sample the goal behaviors if they were promoted via 60- to 90-day campaigns. Key to these campaigns are events that kick off or boost the effort or that announce prizewinners or recognize accomplishments. Each campaign, while focusing on a single behavior change such as smoking cessation or exercise, also creates a feeling of newness and accomplishment around the lifestyle change. To add an element of timeliness, campaigns may tie in with seasons (e.g., Walk & Win) or with good nutrition during the holidays (e.g., Weigh & Win).

The short-term campaigns also encourage the concept of "trial-ability." Those who try the behavior during a campaign are more likely to do so if they know they can stop or end it in a relatively brief period of time and don't feel a long-term obligation to continue. Brief campaigns also allow new community groups the opportunity to jump on the CardioVision 2020 bandwagon at numerous

times throughout the year, rather than having to wait until the end of the year to join in a campaign.

CardioVision 2020 is evaluated through an annual community survey that documents whether the program is reaching people, whether these individuals are changing their behavior as a result of the program, and whether risk-factor levels and disease rates are changing in the community. In addition to the survey, CardioVision 2020 is tracking use of health services and procedures, disease incidence and prevalence rates, and death rates in the community.

The program is making an impact: Nearly 10 percent of survey respondents report changing their behavior because of CardioVision 2020, and 95 percent of those surveyed rank the program as good, very good, or excellent.

To date, numerous lessons have been learned through program implementation:

- ☆ Risk patterns and risk distribution are the same in Olmsted County as in the rest of the United States—no matter how community members may have originally thought they differed from those in other communities.
 - ☆ Identity of the messenger is a key component of the message being delivered: Lifestyle is a very personal choice that is often modeled after that of opinion leaders.
 - ☆ Community members need to be able to try a program for a limited period of time so that they can then accept or decline the lifestyle changes.
 - ☆ If the timeline is realistic, significant changes can be accomplished (as seen in the North Karelia Project in Finland).
 - ☆ Improvement in health requires continuous community effort, resources, leadership, and marketing.
 - ☆ The program needs to be convenient and located where the people are; it will be less successful if people have to go to or find it.
- ☆ Data are essential in making the case that CardioVision 2020 is needed, demonstrating that it is achieving its goals, and helping to guide it.
 - ☆ Self-care is important: People who take care of themselves, their families, their friends, and their coworkers will save money and, possibly, their own lives.

From Clinical Trial to Public Health Practice: Translation and Dissemination of the Coordinated Approach to Child Health (CATCH)

Deanna M. Hoelscher, Ph.D., R.D., L.D., C.N.S., and Peter Cribb, M.Ed.

The Child and Adolescent Trial for Cardiovascular Health was a major randomized intervention trial funded by NHLBI. The trial was unique in that it was one of the largest controlled school health education interventions ever conducted; its design set a new standard for school health intervention research. It involved 3,714 children in nearly 100 ethnically and racially diverse elementary schools. CATCH reduced total and saturated fat content of school lunches, increased moderate-to-vigorous physical activity during physical education classes, and improved students' self-reported eating and physical activity behaviors—changes that persisted among the target population for 3 years (into early adolescence) following implementation. It included four components: health education (classroom curriculum), physical activity and education, nutrition services (school food service), and family and community involvement.

The Center for Health Promotion and Prevention Research at the University of Texas Health Science Center translated and disseminated CATCH as a coordinated school health program across the State. Implementation of CATCH in Texas represented a significant effort to apply diffusion theory to health behavior change. This program was unique because it illustrated that adoption of an innovation (translating research to practice) is possible in a large geographic area with a diverse population. The ability to successfully translate research to practice is influenced by many factors, including understanding; evaluation; acceptance; social, economic, and political constraints; versatility in adaptation to specific situations; time; funding; and the use of change agents.

Certain innovation characteristics (relative advantage, compatibility, reduced complexity, trial-ability, and operability) were emphasized in the dissemination of CATCH in Texas in order to improve the chance that the innovation would be adopted by new schools. For instance, CATCH's relative advantage over existing practices and initiatives was demonstrated by underscoring that the program was based on sound intervention strategies and that the program had shown positive effects: it was doable and affordable; numerous timetables and blueprints existed; flexibility was critical; user-friendly tools existed; and, finally, CATCH training and materials were carefully designed to be fun and teacher friendly. With its unanimous approval of CATCH for use as part of the State school health curriculum, the Texas Board of Education sent a clear message that the program was compatible with State physical activity guidelines and U.S. Department of Agriculture school meal guidelines.

Another key to the successful dissemination of CATCH in Texas was the use of diverse partners and change agents to reach and engage new communities. Emphasis was placed on identifying persons who held leadership or other influential roles in State health or education agencies, as well as State and national organizations. The efforts of these individuals were critical in helping ensure effective communication of CATCH promotion messages to school administrators, teachers, and others in the education system.

Some of the key partners included:

- ☆ Centers for Disease Control and Prevention, Prevention Research Centers
- ☆ Paso del Norte Health Foundation
- ☆ American Heart Association
- ☆ American Cancer Society
- ☆ Texas Medical Association
- ☆ Texas Pediatric Society
- ☆ Texas Parent-Teacher Association
- ☆ Bexar County Community Health Collaborative

- ☆ Texas Department of Agriculture
- ☆ Texas Association for Health, Physical Education, Recreation, and Dance

- ☆ Texas Area Health Education Centers
- ☆ Texas Regional Education Service Centers
- ☆ Texas Education Agency

The CATCH/Texas team identified four simple truths about school-based interventions designed to change the nutrition and physical activity environment:

- ☆ If children are encouraged to eat healthful foods through classroom lessons, healthful foods must be available in the school cafeteria.
- ☆ If children are encouraged to be physically active every day, they should be given opportunities to be active every day at school.
- ☆ If you expect environmental changes in the school to carry over into children's homes, you must educate and involve the parents in the process.
- ☆ When everybody starts communicating and using the same language, sustainable environmental change is possible.

Evaluation of the CATCH/Texas effort included assessment of the program's reach (number of schools that purchased the program and number of schools that have participated in training), follow-up surveys with staff, and observational data. Evaluation has shown that training and ongoing support for coordinated school health is essential to the successful implementation of CATCH, that elements of CATCH have been widely and effectively disseminated among elementary schools in Texas, that participation by staff in training increased the likelihood of adoption, and, ultimately, that implementation of CATCH resulted in increased levels of moderate-to-vigorous physical activity.

Youth Marketing and Public Health Messaging

Peter Zollo and Richard Ellis

The luncheon session featured two youth research and marketing experts who provided a snapshot of teens and factors to consider when creating marketing campaigns for them.

Although teenagers may seem like a fairly homogeneous group, many are actually more different than similar. For public health and other marketing messages to resonate with them, communications must be tailored by type of teen:

- ☆ **Edge teens:** at-risk, avant-garde, first to try new things, disdain for what is possible (approximately 11 percent of teen population).
- ☆ **Influencers:** “cool” but mainstream, promote trends, often physically enviable (approximately 13 percent of teen population).
- ☆ **Conformers:** want to move up the “aspirational ladder,” second in almost everything, largest group of teens (approximately 41 percent of teen population).
- ☆ **Passives:** struggling with life situation, do not feel encouraged (approximately 36 percent of teen population); obese teens tend to be members of this group.

Two teen traits that are particularly important are aspiration and “coolness.” All teens aspire to be older than they are. Younger teens have a larger gap between actual and aspired age than do older teens, with most teens of any age aspiring to be between 17 and 20 years old. A teen is considered cool when he/she looks good, is funny, and is outgoing; however, trying to be cool is not simple and may backfire.

Effective marketing recognizes that communication to teens needs to meet them where they

congregate (home, school, theatres, malls, coffee houses, parks). Teens live in a fast-moving media environment (Internet, radio, television), and communication with them needs to be perceived as relevant, needs to jump on trends, and must move fast. For all teens—even young ones—seven key types of marketing positionings resonate: individuality, rebelliousness, irreverence, excellence, sociability, fun, and sex.

Qualitative marketing research shows that teens are savvy about nutrition and physical activity. When asked about behavior, blame, and personal choice related to overweight and obesity, teens showed some understanding of the issues. Although they do not report treating obese teens any differently from other teens, they note that they have seen others make mean comments. They acknowledge that it must be tough to be overweight. They believe that those who are overweight, not the food manufacturers, are responsible for what they put in their mouths. Most teens are well aware of their diets, and, if necessary, they are willing to change to lose weight. Girls often are on diets. In terms of who is responsible for obesity, teens believe that it arises from a combination of genetics, food choice, and laziness. Teens who are overweight need to compensate for it in other areas of their lives (e.g., by being funny). Romance is the area that makes being overweight tough. Most realize that there is no silver bullet for dealing with overweight and obesity.

When it comes to their own behaviors, teens do not really know what to do, they do not really know what will work for them, and they will do the behavior later, when they “really need to.”

The implications for messaging to teens include the following:

- ☆ Teens are smart; make sure they know that you know that.
- ☆ Tell teens what to do and what to do next.
- ☆ Suggest an aspirational ladder from passive to influencer in a certain number of viable steps.
- ☆ Be clear: It's about food; give them the benefits of not overeating (fitting in, participating in sports or other activities, being successful with the opposite sex).
- ☆ Make healthy eating decisions immediate, courageous, personal, and empowering. For example: "Managing your weight is something that you do for yourself, right now." "Decide to be healthy. Do it again."
- ☆ Consider branding communication and messaging in order to leverage efforts. Brands help teens to express who they are, broadcast what they stand for, and gain entry into a desired group.
- ☆ Be aware that teen behavior is as much about emotions as intellect.

Talk-Show Session: Feedback From the Field

Moderator: *William A. Smith, Ed.D.*

Panelists: *Ezra D. Alexander III; Lisa Bailey-Davis, M.A., R.D., L.D.N.; Kathy Burkhardt; Monica Dixon, Ph.D., R.D.; Kristy Hansen, M.Ed., CHES; Molly M. Michelman, M.S., R.D.; and Anita Pesses*

This presentation in talk-show format featured four individuals from the Hearts N' Parks Magnet Center sites who described the target audience and challenges of each of their programs and offered their perspectives on the successes and lessons learned in the first 2 years of the Hearts N' Parks program. Three individuals who represented the State-based obesity coalitions in Pennsylvania, Washington, and Texas provided an update on activities currently underway in three different regions of the country.

Ezra D. Alexander III
City of Gary Park Department
(Hearts N' Parks Magnet Center)

The challenge in Gary, Indiana, is changing the mindset of parents and transforming intent to change into behavior change. Site staff members realize that change is slow. The site's initiatives reach out to senior citizens and children. Young people indicate they want to do better in terms of physical activity and nutrition but can't because their parents control the purse strings. Seniors often are in the same situation—someone else is in control (caregivers, service agencies, etc.). To encourage children and senior citizens to buy healthier foods, the park department offered prizes to those who brought in their own healthy snacks.

Molly M. Michelman
University of Nevada, Las Vegas
(Hearts N' Parks partner)

Through a nutrition science class (formerly called "Hearts N' Parks," now called "Field Experience and Nutrition") she teaches at the University of Nevada/Las Vegas, her students worked with ele-

mentary schools and children participating in the Hearts N' Parks program to teach them nutrition and physical activity lessons from an existing curriculum. Over three semesters, the class conducted pre-testing, nutrition-based lessons, fitness activities, and post-testing. The program is expanding to middle school students at five schools.

Anita Pesses
The Maryland-National Capital Park and Planning Commission, Department of Parks and Recreation, Prince George's County, Maryland (Hearts N' Parks Magnet Center)

A fitness program at a well-funded and recognized park facility in a largely minority, lower-income area in Prince George's County, Maryland, has increased participation in its walking program from 30 to 300 people. The sports and learning facility contains numerous resources, including a year-round indoor track that offers free admission from 6:00 a.m. to 10:00 a.m. The "Morning Milers" walking program, which relocated to the facility from a recently closed shopping mall, includes many senior citizens. The initiative has been augmented through an educational component that includes healthy breakfasts served monthly, educational sessions with representatives from the local health department, a cardiac rehabilitation program, and partnerships with local medical associations.

An additional benefit of this initiative, which was created without any additional grant monies, was staff rejuvenation. Young college students were hired on a part-time basis to facilitate the program. They brought a new energy and excitement to

staff members and older participants alike. Because the goal of a park and recreation agency in any community is to increase community health and provide opportunities for fun, their participation in this initiative brought fun and revitalization to staff—not to mention their combined loss of 1,143 pounds.

Lisa Bailey-Davis
Pennsylvania Department of Health
(State coalition)

In 2003, the State Department of Health released a plan to prevent obesity. Because it was comprehensive and stakeholder-driven, rather than agency-driven, the Pennsylvania Advocates for Nutrition and Activity (PANA) coalition was formed to build statewide capacity for plan implementation. PANA grew from 30 to 80 leadership team members within a year, including numerous State agencies, academic partners, and volunteer and professional organizations. The State plan and PANA's leadership team have three focus areas: health care, active community environments, and youth and families. The leadership teams translate the plan into community strategies and tools, which are disseminated through more than 400 PANA community members. PANA's first public campaign, the Keystone Healthy Zone, launches in March 2004. It is the first phase of a multiyear plan to create healthier school environments in Pennsylvania. The Keystone Healthy Zone campaign cost \$400,000 in year one; 10 percent of that came from the Centers for Disease Control and Prevention, with the remainder from partners.

Through Ms. Bailey-Davis's efforts, Pennsylvania's youth tobacco surveillance survey now includes questions regarding nutrition and physical activity. Coupled with data from State screening programs that will record the height and weight of children in kindergarten through third grade in schools in the 2004–2005 school year (and K-12 by the 2007–2008 school year), this information will guide future efforts.

Monica Dixon
Washington State Department of Health
(State coalition)

The Washington State Department of Health's Nutrition and Physical Activity program has a pilot project in Moses Lake (population: 18,000), an isolated, remote, high-desert, agrarian area 200 miles from Olympia with a large Hispanic and small African American population. The project focuses on trails, breastfeeding, and community garden projects. Ms. Dixon developed a 20-member youth wellness team of 16- to 22-year-old local teens from the Job Corps who had an average BMI of 33. Two of them have type 2 diabetes. The empowered team has created a logo, tee shirts, a pedometer challenge, and a dorm challenge (the youth are dormitory residents) and has appeared before the city council, school board, and elsewhere to influence others. Other activities included constructing gardens at dorms and working with food service staff to improve nutrition.

Kristy Hansen
Texas Department of Health
(State coalition)

The Texas Department of Health (TDH) Public Health Nutrition program focuses on providing technical assistance to small, rural, or underserved communities that do not have the same resources as do major metropolitan cities. A great challenge is the geographic vastness of the State. A staff of only eight regional nutritionists covers more than 250 counties, with populations representing vastly different socioeconomic status (SES) levels and many cultures. However, numerous community coalitions are creating solutions.

The TDH provided competitive minigrants (approximately \$5,000 each) to 10 communities to develop community walking trails or improve existing trails. The grantees were urged to think creatively, and the results were remarkable. In one example, an elementary school principal used the grant to create a campus walking trail for students and the community; local groups pulled together in-kind support (staff, skills, and funds) from community- and youth-serving organizations such as the Kiwanis, Lions Clubs, and Boy

Scouts, ensuring that the project became a community reality that even a hurricane's destruction did not stop. Because the interventions had to be evaluated, many communities asked health and physical education students from nearby colleges and universities to assist with tracking participation, conducting surveys, and providing pre- and post-evaluation reports. The initiative demonstrated that communities need to work with accessible resources in order to put together successful coalitions and interventions.

Kathy Burkhardt
City of Las Vegas—Leisure Services
(Hearts N' Parks Magnet Center)

With funding tight, the Las Vegas Leisure Services Department looked at existing programming to determine what could be tweaked to improve community health. Several ideas were implemented: existing cooking classes for youth were lengthened, and a nutrition and physical activity component was added at only slightly increased cost; physical activity and nutrition instruction and "fun fit days" were added to summer camp programs; at year-round schools, unhealthy snacks were replaced with healthy ones, and children were expected to spend a daily minimum of 2 hours outside; and an adaptive recreation program was established with activities for people with disabilities in which participants were taught physical activities and nutrition concepts within the scope of their mental capacities. Ms. Burkhardt recommends that others "go home and look at what you already offer and figure out how to change it just enough to offer more bang for your buck."

In addition to sharing personal experiences, all panelists commented on one thing they had heard at the Workshop that they will take back and try to put into practice immediately:

- ☆ Pool resources and work together.
- ☆ Use increased understanding of teen culture to reach out to youth more effectively.
- ☆ Involve youth in developing campaigns for peers.

- ☆ Award minigrants to schools and other groups to examine the relationship between increased activity and academic performance.
- ☆ Find money in unexpected places; use existing materials to extend resources.
- ☆ Use closed armories and other facilities (while military personnel are overseas) as family intervention sites for exercise and learning.
- ☆ Publicize data and information showing that the obesity epidemic is serious, not cosmetic.

Other themes that the seven panelists raised during the presentation in connection with scaling up activities and making them bigger were:

- ☆ The importance of creating community leaders who can develop mini stakeholder groups that develop plans, present them, and then become recognized. When these groups already exist, they can be mobilized and programs can be expanded quickly.
- ☆ The need to focus on building statewide capacity to facilitate a plan. Hire staff members with backgrounds in marketing and sales to ensure that the products being offered are tailored to peoples' needs and to get the message out.
- ☆ The benefits of partnering with other groups—other community centers or neighboring communities—to increase scale.
- ☆ The difficulties in changing cultural mind frames. Many African Americans think being overweight is acceptable. How can we help them think otherwise? Do income levels have anything to do with the weight phenomenon?
- ☆ The importance of outreach, including articles, signs, and promotional materials at multiple locations.
- ☆ The importance of understanding the legislative process to affect policy decisions.
- ☆ The need to agree on what the message is or should be.
- ☆ The benefits of keeping the big picture in mind, even when developing local programs.

Carousel Brainstorming: Facilitated Small-Group Sessions

During the carousel brainstorming sessions, participants provided input on four topics: define the program niche for the HWI; refine the target audience; create strategies, tools, and tactics; and measure results. After approximately 20 minutes of group discussion, participants rotated into another group to consider the previous group's ideas and recommendations, which were noted on flip charts. This model allowed for many ideas to be generated, discussed, and augmented. Following the carousel sessions, participants returned to the breakout rooms and prioritized the ideas, affixing stickers next to the favored topics recorded on the flip charts during the brainstorming sessions. Participants were given a total of 20 stickers, 5 for each brainstorm topic. The summary below represents the participants' self-identified, most promising ideas by each of the four topics and questions.

Red Group: Define the Program Niche for the HWI

Session Goal: Identify a programmatic niche for the HWI that will have the greatest impact and contribute to advancing the field of obesity prevention.

Given the current environment of national, State, and local activity and attention to obesity prevention, what unique role can NHLBI play to advance the field and support community outreach efforts?

Participants began brainstorming a unique role for NHLBI in obesity prevention by thinking through organizational assets that the Institute could bring to bear on the epidemic. Among these were

NHLBI's credibility in heart disease prevention, its strong link with the medical community, and its ability to set national standards.

Several possibilities for a unique NHLBI role flowed from these strengths:

- ☆ Provide a unifying national voice for obesity prevention by identifying effective interventions and developing clear messages.
- ☆ Forge national partnerships to create and gather resources and to foster local relationships.
- ☆ Strengthen health care providers' abilities to address obesity in their local communities.

In providing a national voice, it was suggested that NHLBI take the lead in identifying valuable interventions and in simplifying messages for consumers. Because NHLBI is an organization grounded and effective in interpreting science, it could play a role in culling science to test, review, and recommend interventions and best practices. Participants also suggested that the Institute provide more effective messages—ones that give audiences simple and clear strategies for obesity prevention. Participants were quick to note that given the complexity of the problem, the overwhelming number of recommendations given, and the scarcity of resources available, national leadership from NHLBI could provide an effective foundation for moving forward.

Partnership development was seen as another critical role that NHLBI could play in preventing obesity. Citing a reputation of forging national relationships, participants noted that NHLBI could create partnerships that develop and leverage existing resources. These partnerships could create professionally and culturally appropriate mate-

rials and could act as effective channels for disseminating the information. Participants also noted that strong national relationships would provide fertile ground for developing effective local partnerships. They were particularly enthusiastic about this possibility, given the potential that exists in stepping beyond traditional public health boundaries to address obesity prevention.

A final series of recommendations focused on an NHLBI role in enhancing physicians' prevention efforts. Participants—many of whom were physicians—noted that the clinical community often is reticent to counsel patients on obesity prevention and is frequently unaware of local community resources accessible to patients. They stressed that community prevention efforts would benefit from the strong link between NHLBI and providers to encourage more effective patient counseling by physicians. A number of participants also noted additional audiences that they felt were worthy of consideration, including parents and urban community groups.

How can NHLBI efforts serve to complement other, ongoing initiatives? How should NHLBI build on the successes of previous and/or existing national and community programs?

Participants recommended that NHLBI complement ongoing initiatives by providing unifying, motivating, and clear messages that inspire change. In doing so, they suggested that NHLBI systematically review other efforts and identify gaps and areas of confusion. They also suggested that NHLBI work to raise awareness of programming tools that already are in place to prevent obesity and study successes of previous campaigns such as the “Know Your Number” effort to emphasize the importance of having cholesterol measured.

Blue Group: Refine the Target Audience

Session Goal: Determine if NHLBI should focus its resources on specific audience segments or subgroups and, if so, identify these key segments within the primary and secondary audiences.

Within the primary audience of children and youth and the secondary audience of adult influencers, are there subgroups that NHLBI should target to maximize program impact? What criteria should be used?

Most participants supported the proposed focus on children and youth as the primary audience and the focus on adult influencers (parents, pediatricians, etc.) as the secondary audience. There were suggestions for further audience refinement, but no clear consensus emerged. Many felt that targeting preschool youth was important because of the need to emphasize prevention and to start early. Others said that it would be more appropriate to target school-age youth through preteens because of the ability to reach and influence them through multiple channels and secondary audiences (schools, parents, families, physicians). Participants pointed out that teens should not be the primary audience because of the many competing issues this group faces.

Participants recommended the use of important adult influencers such as parents, guardians, teachers and other school personnel, and primary care physicians. They noted some research indicating that mothers are a key influence on nutritional choices of children and that fathers are a key influence on physical activity choices.

Several participants suggested that it would be important to target low SES youth and families and minority audiences because of the greater need for resources in these communities.

A small but vocal group of participants said that NHLBI should not identify a specific target audience but should support a broad, population-

based approach and address messages and programs to the general population.

What is the rationale for focusing on these audience subgroups?

The importance of starting prevention messages and interventions early in life was identified as the key rationale for targeting children and youth. The rationale for targeting low-income and minority youth included the high prevalence of obesity in these groups coupled with the lack of resources.

How could the HWI best target its resources to specific audience segments or subgroups, while still allowing and encouraging local choice and diversity?

NHLBI should partner with existing national, regional, and local groups that have an infrastructure able to reach the target populations. NHLBI can give national visibility to these organizational and community efforts. By providing an umbrella theme, materials, and support, NHLBI enables these organizations to tailor programs to their specific audiences and organizational needs. The key advice to NHLBI was “Keep it simple!”

Yellow Group: Create Strategies, Tools, and Tactics

Session Goal: Identify national and community support strategies, tools, and tactics that will best advance the goals of the HWI.

What national promotions and strategies will be most effective in developing partnerships, collaboration, and participation?

Much of the group’s discussion focused on the lack of national leadership on the obesity issue. While many organizations and Government agencies are creating their own programs and initiatives, there is virtually no coordination or synergy among programs. Many participants realized the opportunity lost by not having a unified voice on this front. Most expressed that because of NHLBI’s grounding in research and science, the

Institute is well positioned to convene a national team that could pull the threads together to build a more cohesive national strategy. Pulling these national programs together not only will help facilitate the sharing of best practices from each program, but also will create a cohesive national message that would amplify, not compete with, existing messages.

Each brainstorming group independently conveyed that this campaign needs to communicate one strong theme or brand that acts as a very simple national message that could be adapted locally. In doing so, the campaign would truly serve as the umbrella to unify and align the efforts of other programs.

A few participants pointed out the need for partnerships and third-party alliances to help extend messages as broadly as possible through existing communication infrastructures, as well as the need for the campaign to be measurable. Creating evaluation metrics at the beginning of the program will keep efforts focused and results oriented.

How can NHLBI best support State and community efforts? What national resources would be most helpful to the community initiatives?

Without a doubt, the most popular form of support for State and local programs included program funding, including grants programs. This kind of assistance allows local programs the flexibility to institute programs that are appropriate to their own communities and facilitates growth in the fastest, most effective ways.

One suggestion that generated interest and excitement was a national seal of approval. Much like the “Good Housekeeping Seal of Approval,” NHLBI would create the gold standard seal or accreditation for national and local obesity programs that meet certain criteria (to be determined) in communicating about the obesity issue and creating related programs. Organizations and programs could apply for this coveted designation and would use the seal to indicate that they were proud participants in the national program. However, participants noted that creating

the criteria and monitoring that process could become cumbersome.

There was much discussion about coalitions. While building a coalition seems like a good idea in creating a national strategy that involves many groups, numerous coalitions already exist. Many people expressed frustration with the pressure of serving on too many, and noted that some coalitions are not tremendously effective. All agreed, however, on the importance of cross-agency coordination and collaboration. The best way to create that collaboration—if not a coalition—should be decided at a later date.

Additional ideas that received enthusiastic support included an online clearinghouse to share best practices, resources, telephone numbers, and other information, plus flexible tools (in a toolkit) that could be customized and adapted to local environments and situations.

Green Group: Measure Results

Session Goal: Identify practical means for community organizations and coalitions to assess their progress.

Given the current state of the science in obesity prevention that we heard about during the “Current Obesity-Prevention Landscape” plenary session, on what factors should communities focus to assess program progress? What measures?

Participants noted that funders and policy makers increasingly hold communities and local programs accountable. Participants recommended a range of simple process and outcome measures suitable for basic community-level program evaluation. Participants differentiated between short-term and long-term measures and advocated for realistic time frames for achieving either. Several suggested that communities focus on positive measures (the do’s, rather than the don’t’s).

The availability of resources for evaluation would dictate the type of evaluation any community could actually undertake.

Process measures included: tracking aggregate persons served, number and types of partners (including academic institutions), physician referrals to community programs, coalitions established, the nature of food industry and restaurant offerings and portion size offerings in restaurants, and simple measures of population energy expenditure.

Outcome measures included: changes in population knowledge, awareness, and reported behaviors; structural changes; environmental changes; policies in place; program and/or brand awareness; sustainability (continued implementation); TV hours watched; and BMI.

How can national efforts such as the HWI support communities to measure and assess their progress?

NHLBI can greatly aid community-level evaluations by establishing and communicating a clear set of measures and standards for program achievement; developing simple tools for community data collection, analysis, and reporting; establishing reasonable timelines for accomplishing and assessing desired objectives; and providing adequate resources to support evaluation. The data collection required should be appropriate for each setting. For example, medical or clinical measures may not be required in community settings. Evaluation requirements should be developed with sensitivity to dealing with issues of overweight for children and should not add to their embarrassment or humiliation. Measures should track positive changes.

How should NHLBI measure success at the national level?

The group appealed to NHLBI to develop clear program objectives, an overarching logic model for the program design, and specific measures to track progress in meeting the objectives. Participants suggested that the model outline a reasonable time frame and differentiate between

immediate and long-term outcomes. Some suggested measures to be tracked included: the number of Federal agencies engaged in or promoting the program; number and types of supportive policies (or policy changes); involvement of insurance companies and HMOs; and numbers, types, and contributions of other partners. One of NHLBI's program objectives should be to work across Federal agencies and to support development of a universal voice at the national level.



When Obesity Is More Common Than Not: Developing a Culturally Positive Approach

Shiriki Kumanyika, Ph.D., M.P.H.

Programs developed to address obesity and overweight should have positive messages. Because the obesity epidemic is a mainstream issue, messages about obesity will invariably relate to factors that are central to our culture and ways of living: food and eating, aspects of daily activities, and concepts of attractiveness. Many attitudes about obesity are negative, but negative promotions about core cultural variables will be counterproductive in the long term. In addition, a positive focus will help to ensure that efforts to combat obesity do not have adverse side effects such as increasing cycles of futile dieting, increasing discrimination against obese individuals, or playing into negative stereotypes of minority populations with a high prevalence of obesity. The need for positive messages may seem obvious, but it is a key challenge and, to some extent, will require reversing current cultural norms.

It is essential to recognize the influence of culture on weight-related attitudes. Culture shapes norms, values, and expectations shared by a community, as well as ideas of what is acceptable and sensible to that community's members. Culturally influenced attitudes and norms influence weight-loss motivations and the way messages about overweight and obesity are received. It is particularly important to keep this in mind when working with ethnic minority populations, which are the highest risk groups and which are culturally different from the mainstream population in many ways that relate directly to weight control.

Numerous cultural perspectives coexist in our society and for individuals. Cultural perspectives may be defined by the mainstream society,

regional differences, ethnic identification, immigration, SES/social class, and age or generation. Additional concepts to be considered are bicultural orientation and acculturation. Bicultural orientation is the active participation in two not necessarily congruent cultures and can be characterized by the use of more than one language or cultural frame of reference. Acculturation refers to movement toward the cultural perspectives and practices of the dominant culture, such as the United States' mainstream culture.

Cultural perspectives reflect variables that, in connection with obesity, can be roughly grouped into two areas: general and weight-specific. General variables may include world view, beliefs about food and health, activity and fitness, spirituality, concepts of physical attractiveness, family relationships, and status orientation. Cultural influences on food and physical activity may be driven by social and psychological needs and preferences that are independent of weight issues, although the resulting behaviors may influence weight. Cultural perspectives also affect weight-specific attitudes about eating, physical activity, body image, and the perceived relationships among these variables, as well as voluntary weight control practices, such as dieting. There are many ways in which these attitudes manifest themselves.

In some populations, self-acceptance may include weight level, and the link between body weight and self-esteem may be relatively weak. In other populations, being overweight is much more likely to have damaging effects on self-concept. In the African American population, there may be less concern about weight and a greater tolerance for

overweight, that is, a less negative attitude than is observed in whites and in some other minority populations. In addition, obese African American women may not be satisfied with their weight but may fear becoming “too thin”—as body sizes and shapes that are in the overweight or obese range may be considered healthy and attractive by some African Americans.

The effects of excess weight on health may not always be recognized. Perceptions of what constitutes a healthy body size are influenced by the observation that wasting diseases cause thinness, accompanied by the belief that a larger body size symbolizes robustness and strength. In addition, some of the health conditions associated with obesity may not be apparent for many years and may not be attributed to obesity when they do emerge.

Society at large may be more tolerant of overweight in minority populations; expectations may be lowered for groups considered to be disadvantaged, because obesity fits with certain stereotypes, or because overall negative attitudes toward the minority group may cause inattention to specific characteristics, such as whether or not the person is overweight.

Numerous challenges to addressing this issue exist:

- ☆ Obesity, although medically important, is strongly defined and responded to according to culturally influenced attitudes and values.
- ☆ Efforts to promote healthy weight must avoid aggravating deeply entrenched negative attitudes toward obese people or ethnic minority populations with a high obesity prevalence.
- ☆ Efforts to promote healthy weight must work around attitudes about food, activity, or body image that tend to perpetuate obesity.
- ☆ Messages to promote healthy weight must be sustainable for a long time.
- ☆ Promotion of healthy weight offers an opportunity to establish new or reshape existing attitudes about eating and physical activity in a positive direction for society.

- ☆ Eating and physical activity have cultural values that are unrelated to energy balance issues.

To be sensitive to the many complexities of how cultural factors influence obesity-related issues and programs, planning for the HWI needs to take into account numerous concepts, such as cultural lens, cultural imposition, ethnocentrism, cultural relativism, cultural adaptation, and cultural appropriateness.

It is important to determine whether or not mass media messages can and should be targeted to different cultural groups, whether or not messages should mention weight or simply focus on food and physical activity, and whether or not it is possible to target “counteradvertising” to different cultural groups in order to counterbalance the greater allocation of advertising dollars spent on minority consumers than is warranted by their consumption patterns. In addition, program planners will need to determine how members of the population of interest can best have a role in designing programs and how population “insider”/population “outsider” issues, when relevant, will be addressed.

The crucial questions to answer are: how do we want people to think about their body weight and that of family members, friends, and coworkers; and how do we want people to think about overweight and obesity in general? We want these attitudes to counteract the potential for obesity while remaining positive in other respects. Achieving this balance will be a key challenge in designing a HWI.

Environmental Factors:

Disparities in Access to Healthy Foods and Active Living

Jeane Ann Grisso, M.D., M.Sc.

The Robert Wood Johnson Foundation (RWJF) has made obesity a central focus of its programming for the next decade. To battle America's obesity epidemic, the Foundation is working to create activity-friendly communities, promote more physical activity and better nutrition in schools, and conduct research to determine which policies and programs are most effective in helping families make healthier choices.

Obesity and overweight do not equally affect all population groups, and addressing health disparities among racial and ethnic groups is a major component of the RWJF initiative. Among women, the prevalence of obesity is 50 percent higher in Mexican American and African American women compared with non-Hispanic white women. Among children, the prevalence of obesity is two to four times greater in Latino and African American children compared with non-Hispanic white children. Perhaps most alarming is the rate of increase in obesity prevalence. According to the National Longitudinal Survey of Youth, among low-SES African American and Latino boys, obesity increased by a staggering 400 percent in the 12-year period between 1986 and 1998. The rate of increase among high-SES non-Hispanic girls during that same time frame was much less.

One of the Foundation's visions for dealing with this public health problem is to slow the obesity epidemic among high-risk children. To accomplish this goal, RWJF will support an environmental approach encompassing change in physical environments to promote active living and change

in the food environments to foster healthy diets. Active living environments include those with parks, community centers and other sports facilities, walking/biking trails, and transportation options other than automobiles. In low-SES versus high-SES census tracts, significantly fewer resources for physical activity exist. High-SES areas were found to have more than twice the number of physical activity resources than low-SES areas. In addition, low-SES neighborhood playgrounds have significantly more hazards per play area than those in high-SES areas.

Although media reports seem to indicate that urban sprawl and factors such as greater reliance on the automobile are behind the Nation's obesity problem, RWJF's review of available data indicated that the correlation between sprawl and increased BMI is weak. The real public health problem is in urban areas—where the burden of higher BMI and obesity rests.

Food environments also play a crucial role in fostering healthy diets. Food environments are often viewed through the four Ps of marketing:

Place: whether healthy food is accessible. With a significant gap between the number of supermarkets in high-SES versus low-SES neighborhoods, most low-income families do not live within walking distance of a supermarket. There are 30 percent fewer supermarkets in low-income versus high-income neighborhoods, despite the fact that 92 percent of people living in the U.S. purchase their fresh produce at supermarkets. Predominantly white neighborhoods have approximately

four times the number of supermarkets than do predominantly non-white areas, and only 8 percent of African American residents live in a census tract with more than one supermarket. Public transportation systems are generally set up for commuting, not for transportation to supermarkets. As a result, low-SES families tend to visit supermarkets only once per month and patronize neighborhood corner stores more often.

Product: caloric density and food quality. Foods found in lower income neighborhoods are of lower quality and are more likely to be packaged. Also, less overall variety is available. Neighborhood corner stores stock few types of fresh fruits and vegetables and generally carry only those vegetables that have long shelf lives. Studies are mixed on whether low-SES communities have a greater number of fast food outlets than do high-SES neighborhoods. Low-SES communities, however, generally have a paucity of healthful food outlets. Even if these neighborhoods have equal numbers of fast food and other food outlets, the reduced overall number of food outlets means that food options are still limited.

Promotion: food marketing and packaging. More food advertisements (which often are aimed at urban populations) are aired during prime time programs targeting African American viewers compared with programs targeting general viewers.

Price: cost variance by SES. Prices charged in neighborhood stores commonly found in low-income neighborhoods can exceed those of chain supermarkets by 48 percent.

Although additional study is needed, RWJF's examination found six community-based solutions to reducing obesity rate disparities that should be examined for potential dissemination and application:

- ☆ First, bring supermarkets back to urban neighborhoods. Successful efforts in Newark, NJ, and other areas indicate it may be possible to do this via community advocacy and policy initiatives.
- ☆ Second, ensure that inner-city residents have access to shuttles or other transportation to

supermarkets where they will have a wide variety of fresh produce and other food choices, including the fruits and vegetables to which they are culturally accustomed and know how to prepare.

- ☆ Third, establish farmers' markets in low-income neighborhoods to provide easy access to competitively priced produce for low-SES urban residents (Philadelphia was named as an example).
- ☆ Fourth, create school environments that promote healthy eating and active living, and keep schools open beyond school hours to make safe indoor physical activity facilities accessible to all.
- ☆ Fifth, create environments and community infrastructures that promote increased physical activity.
- ☆ Sixth, create and promote recreational programs with fun activities for all age and fitness levels.

These are some of many community-solution models that have shown results or promise in changing environmental factors to reduce racial/ethnic and SES disparities in obesity. With assistance from NHLBI and others, these models can be more systematically evaluated and can become part of comprehensive obesity prevention programs.

Is Increased Weight Discrimination Acceptable Collateral Damage in the War on Obesity?

Lynn McAfee

There is a long history of studies showing unequivocally that there is bias against fat people. This bias, demonstrated in both subtle and obvious ways, is part of everyday life for people who are obese. Some specific areas in which bias exists are outlined below.

Bias in Employment

Studies have found that in employment, larger applicants are significantly less likely to be recommended for hiring and are judged as significantly less neat, productive, ambitious, disciplined, and determined. These stereotypes can affect wages, promotions, and termination. Large people have lower promotional prospects than do average-weight people. Obese men may choose certain occupations over others, believing that their employment opportunities and salary levels may be lower in managerial and professional occupations than those who are not obese; perhaps, as a result, overweight men are overrepresented in transportation occupations.

Bias in Health Care

An article in the October 2001 *International Journal of Obesity*—"Implicit anti-fat bias among health professionals: Is anyone immune?"—reported on an Implicit Attitude Test given to health professionals who specialize in obesity. Although these specialists showed somewhat less bias than did the control group, even those health care specialists who care for the obese believe them to be "bad" and "lazy."

Negative attitudes exist in the nursing profession as well: 48 percent of nurses agreed that they felt uncomfortable caring for obese patients;

31 percent preferred not to care for an obese patient at all. Another study of nurses showed that 24 percent of nurses agreed or strongly agreed that caring for an obese patient repulsed them.

In a study of female health care workers, 32 percent of those mildly overweight and 55 percent of those with grade 2 obesity delayed or avoided doctor appointments solely on the basis of the embarrassment they felt about their weight. Another study showed that fat women were less likely than thin women to use preventive health care services and screenings such as Pap smears and gynecological exams. This may contribute to the higher rate of gynecological cancers experienced by larger women.

Bias Among Children and Adolescents

In the early 1960s a study of school-age children showed that prejudice is well established in grammar school. Anti-fat attitudes may be held by children as young as 3 years of age. Junior and high school teachers have also been found to have negative attitudes toward obese students.

The 1994 *Report on Discrimination Due to Physical Size* by the National Education Association stated that "for fat students, the school experience is one of ongoing prejudice, unnoticed discrimination, and almost constant harassment" and that "from nursery school through college, fat students experience ostracism, discouragement, and sometimes violence."

Bias in the Media

In selected highly rated prime time programming on six commercial networks in the 1999–2000 season, only 3 of every 100 major television characters were obese, compared with 1 of every 4 people in real life. In those same programs, unemployed characters were larger than employed characters, larger characters were less likely to be perceived as attractive, and overweight male and female characters were less likely to have romantic partners than their thinner counterparts.

The bias illustrated by these studies must be recognized prior to development of any weight-related initiatives. Because weight- and size-related recommendations can easily become judgmental and insulting, any program must be sensitive to the feelings and interests of large people. In order for an initiative to be successful, it must not be seen as or positioned as a war on the obese and how they look, or even a war on obesity. It must be positioned as a focus on healthy behaviors that all people can adopt. A program that focuses on weight loss implies that one can tell a person's exercise and eating patterns by looking at them, increasing the stereo-typing that those who are overweight must suffer.

Finally, prevention and treatment of obesity need to be separated, because those who are not fat (prevention) have a different mindset/perspective/biology than those who are obese (treatment). As yet, no truly effective program for either prevention or treatment has been found, so the emphasis must be on making a hospitable environment for health-inducing behaviors by making changes to the obesogenic environment and removing barriers to healthy eating and exercise. Each person has his/her individual potential for health, and programs should be developed that will help empower people to improve their position on their personal continuum of health, whether or not weight loss occurs.

Closing Session:

Workshop Wrap-Up and Next Steps

*Marian Fitzgibbon, Ph.D., Workshop Chair, and
Karen Donato, S.M., R.D.*

The Strategy Development Workshop helped to identify and define key elements that should be associated with a unique niche for the HWI.

At the conclusion of the Workshop, Dr. Fitzgibbon summarized these elements. The HWI should do the following:

- ☆ Capitalize on NHLBI's credibility in heart disease prevention, its science base, and its ability to set national standards to provide a unifying national voice in obesity prevention.
- ☆ Capitalize on the success of Hearts N' Parks in developing the program's community outreach effort.
- ☆ Focus on 5- to 13-year-old youth and adult influencers (parents, guardians, teachers and other school personnel, and primary care physicians) as primary audiences.
- ☆ Consider messages that are unified, well defined, and simple, even though the complex interplay between nutrition and physical activity among individuals is anything but simple. Keep the messages positive; weight discrimination is a reality and messages must not stigmatize.
- ☆ Mobilize the many organizations interested in and willing to partner in this important initiative.

As the meeting neared conclusion, Ms. Donato acknowledged the important work taking place in communities around the country, as was evidenced during the Workshop by both the presenters and participants, whose involvement in the obesity issue was critical in shaping the small-group brainstorming session outcomes. She thanked attendees for participating in the first of many discussions about the HWI and urged participants to keep NHLBI apprised about what they are doing in the field, what they hope to do in the future, and how the Institute can help them in these efforts.

The Workshop is the starting point for the 3-year HWI program. This report and the illustrative graphic facilitation materials created during the Workshop will be provided to each participant and made available to the public at large.

The information offered through the presentations, as well as the ideas developed throughout the 2-day Workshop, will be reviewed and will inform the development of strategy and programmatic elements of the HWI. It is the hope that strategy, messages, tools, and partnerships will be developed during Year One. Year Two activity will concentrate on dissemination and implementation. Evaluation will take place in Year Three, and NHLBI hopes to continue the program into future years.

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Appendix B: Strategy Development Workshop Agenda

NHLBI HEALTHY WEIGHT COMMUNITY OUTREACH INITIATIVE STRATEGY DEVELOPMENT WORKSHOP

TUESDAY, FEBRUARY 17, 2004

8:30–9:15	Opening Session	
	☆ Welcome and Introductions	Dr. Barbara Alving Dr. Gregory Morosco
	☆ What Is the NHLBI Healthy Weight Community Outreach Initiative?	Ms. Karen Donato
	☆ Purpose of the Workshop: What We Need to Make Happen	Dr. Marian Fitzgibbon
9:15–10:30	Plenary Session: The Current Obesity-Prevention Landscape <i>Panel</i>	
	☆ Obesity: What Are the Challenges, Obstacles, and Strategic Considerations?	Dr. Marian Fitzgibbon
	☆ The Basic (Care and) Feeding of Homo Sapiens: Are We Truly Clueless About Weight Control?	Dr. David Katz
10:30–11:00	Break and View Graphic Documentation	
11:00–12:00	Plenary Session: The Current Obesity-Prevention Landscape (continued) <i>Panel</i>	
	☆ CardioVision 2020: A Community Responds to the Obesity Epidemic	Dr. Thomas Kottke
	☆ From Clinical Trial to Public Health Practice: Translation and Dissemination of the Coordinated Approach to Child Health (CATCH)	Dr. Deanna Hoelscher Mr. Peter Cribb
12:00–1:30	Lunch With Keynote Speakers Youth Marketing and Public Health Messaging	Mr. Peter Zollo Mr. Richard Ellis
1:30–2:30	Talk Show: Feedback From the Field Moderator <i>Talk Show Panel</i>	Dr. William Smith Mr. Ezra D. Alexander Ms. Lisa Bailey-Davis Ms. Kathy Burkhardt Dr. Monica Dixon Ms. Kristy Hansen Ms. Molly M. Michelman Ms. Anita Pesses

TUESDAY, FEBRUARY 17, 2004 (CONTINUED)

- 2:30–2:40 **Moving Forward: Carousel Brainstorming**
- Introduction and Explanation of Process Dr. Marian Fitzgibbon
- 2:40–3:50 **Carousel Brainstorming: Facilitated Small-Group Sessions**
- ✧ Red Group: Define the Program Niche (begin in Room C1)
 - ✧ Blue Group: Refine the Target Audience (begin in Room C2)
 - ✧ Yellow Group: Create Strategies, Tools, and Tactics
(begin in Room G1)
 - ✧ Green Group: Measure Results (begin in Room G2)
- 3:50–4:20 **Priority Setting** All Participants
- 4:20–4:50 **Reports From Carousel Brainstorming Sessions**
Facilitator Reports
- ✧ Red Group
 - ✧ Blue Group
 - ✧ Yellow Group
 - ✧ Green Group
- 4:50–5:00 **Summary and Closing: What Lies Ahead?** Dr. Marian Fitzgibbon
- 5:00 **Adjourn**

WEDNESDAY, FEBRUARY 18, 2004

8:30–8:45	Greetings and Day One Summary	Dr. Marian Fitzgibbon Ms. Karen Donato
8:45–10:15	Plenary Session: Cultural and Societal Perspectives on Designing the Healthy Weight Community Outreach Initiative <i>Panel</i>	
	✧ When Obesity Is More Common Than Not: Developing a Culturally Positive Approach	Dr. Shiriki Kumanyika
	✧ Environmental Factors: Disparities in Access to Healthy Foods and Active Living	Dr. Jeane Ann Grisso
	✧ Is Increased Weight Discrimination Acceptable Collateral Damage in the War on Obesity?	Ms. Lynn McAfee
10:15–10:45	Break and View Graphic Documentation	
10:45–11:45	Sharing the Vision of the Healthy Weight Community Outreach Initiative	Dr. Marian Fitzgibbon
11:45–12:00	Closing: What Lies Ahead?	Dr. Marian Fitzgibbon Ms. Karen Donato
12:00	Adjourn	

Appendix C: Participant Guidelines for Small-Group Carousel Brainstorming

At 2:30 p.m., you will begin the small-group brainstorming sessions. The colored dot on the back of your name badge indicates your group and the topic where you will start. You will spend approximately 20 minutes with each topic and then, with your fellow participants, move through each of the other topics. With each new topic, you will build on the previous groups' ideas and comments.

During the priority-setting time on the agenda, you will get a chance to review the work of all the groups and indicate your opinions as to the priority issues and ideas that NHLBI should address in its HWI. The results of this priority setting will then be reported to the full group.

HWI Parameters for Strategy Development

1. The HWI is part of the NHLBI OEI's population-based strategy.
2. The HWI will support national and community-based strategies to encourage all Americans to maintain a healthy weight.
3. The primary target audience for the HWI will be children and youth; the secondary audience will be key adult influencers.

Small-Group Sessions and Questions

1. Define the program niche for the HWI (RED group).

Session Goal: Identify a programmatic niche for the HWI that will have the greatest impact and contribute to advancing the field of obesity prevention.

- ☆ Given the current environment of national, State, and local activity and attention to obesity prevention, what unique role can NHLBI play to advance the field and support community outreach efforts?
- ☆ How can NHLBI efforts serve to complement other, ongoing initiatives?
- ☆ How should NHLBI build on the successes of previous and/or existing national and community programs?

2. Refine the target audience (BLUE group).

Session Goal: Determine if NHLBI should focus its resources on specific audience segments or subgroups and, if so, identify these key segments within the primary and secondary audiences.

- ☆ Within the primary audience of children and youth and the secondary audience of adult influencers, are there subgroups that NHLBI should target to maximize program impact?
- ☆ What criteria should be used to determine these subgroups (age, ethnicity, behavior, settings, geographic location, other)?
- ☆ What is the rationale for focusing on these audience subgroups?
- ☆ How could the HWI best target its resources to specific audience segments or subgroups, while still allowing and encouraging local choice and diversity?

3. Create strategies, tools, and tactics (YELLOW group).

Session Goal: Identify national and community support strategies, tools, and tactics that will best advance the goals of the HWI.

- ☆ What national promotions and strategies will be most effective in developing partnerships, collaboration, and participation?
- ☆ How can NHLBI best support State and community efforts?
- ☆ What national resources would be most helpful to the community interventions?

4. Measure results (GREEN group).

Session Goal: Identify practical means for community organizations or coalitions to assess their progress.

- ☆ Given the current state of the science in obesity prevention that we heard about this morning, what should communities focus on to assess program progress? What measures should they be looking at?
- ☆ How can a national effort such as the HWI support communities to measure and assess their progress?
- ☆ How should NHLBI measure success from the national level?

For More Information

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