

Be Our Voice

a project of **NICHQ**

Guide for Health Care Professionals to Partner with Community Based Organizations



Combating the Childhood Obesity Epidemic

Be Our Voice is a program of the National Initiative for Children's Healthcare Quality (NICHQ), in cooperation with:



**Robert Wood Johnson Foundation
Center to Prevent Childhood Obesity**

Sponsored by the Robert Wood Johnson Foundation.

Be Our Voice Overview

About the Project: The National Initiative for Children’s Healthcare Quality (NICHQ) has been awarded a grant from the Robert Wood Johnson Foundation (RWJF) to reverse the childhood obesity epidemic trend across the nation by training, supporting and providing technical assistance to Healthcare Professionals in becoming advocates for change within their communities. As part of the grant, NICHQ is partnering with the American Academy of Pediatrics (AAP), the California Medical Association (CMA) Foundation and the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity (the Center) to facilitate Healthcare Professionals becoming community advocates for local change, and to build an online network serving as the “go to resource” for healthcare providers looking for solutions to the childhood obesity epidemic.

About the Partners: About NICHQ: Founded in 1999, the National Initiative for Children’s Healthcare Quality (NICHQ) is an action-oriented organization dedicated to achieving a world in which all children receive the healthcare they *need*. Led by experienced pediatric Healthcare Professional, NICHQ’s mission is to improve children’s health by improving the systems responsible for the delivery of children’s healthcare. For more information, visit www.nichq.org.

About the American Academy of Pediatrics: The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well being of infants, children, adolescents and young adults. *The AAP achieves its mission through advocacy, education, policy development, research and service. As such, the AAP and its 59 US chapters and members regularly advocate on behalf of children and pediatricians at the federal, state and local level.* For more information, visit www.aap.org.

About the CMA Foundation: The CMA Foundation is a nonprofit organization that serves as a link between physicians and their communities. The CMA Foundation has developed a cutting edge Physician Champion program that can serve as a template for national programs. This innovative approach to obesity prevention has been cited as a “best practice” in the 2006 Institute of Medicine Preventing Childhood Obesity report. For more information about the CMA Foundation, visit www.thecmafoundation.org.

The Robert Wood Johnson Foundation Center to Prevent Childhood Obesity: The Robert Wood Johnson Foundation Center to Prevent Childhood Obesity is a leading voice in the national movement to reverse the epidemic by 2015. Through policy analysis, leadership development, and communications with a broad network of advocates, the center is working to enable children of all races, ethnicities and geographic locations to eat healthy, be physically active and avoid obesity. For more information, visit <http://www.reversechildhoodobesity.org>.

About the Robert Wood Johnson Foundation: The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For more information, visit www.rwjf.org.

Acknowledgements

The National Initiative for Children's Healthcare Quality (NICHQ) and the CMA Foundation would like to thank the following organizations individuals who shared their insights and experiences as part of **Be Our Voice** to help make this Guide a strong resource for healthcare professional advocates involved in efforts to reverse the childhood obesity epidemic who are reaching out and partnering with groups and organizations to initiate critical advocacy efforts.

Alabama AAP Chapter	Cabarrus Health Alliance	Mississippi AAP Chapter	Texas Pediatric Society (The AAP Texas Chapter)
Arkansas AAP Chapter on behalf of the Arkansas Coalition for Obesity Prevention (ArCOP)	Kentucky AAP Chapter	Envision New Mexico	Wake Med Health & Hospitals, Advocates for Health in Action

We also wish to thank the healthcare professional advocates below for their time to review this Guide, sharing their insights and experiences as healthcare professional advocates.

Christopher Bolling, MD, FAAP Kentucky Pediatric Society, KY Chapter/AAP	Eric Ramos, MD, FAAFP California AFP Physician Champion
Kimberly Edwards, MD, FAAP Texas AAP Chapter	Frank Stagers, MD Past President, National Medical Association (NMA)
Dexter Louie, MD, JD National Council of Asian Pacific Islander Physicians	Christine Wood, MD, FAAP San Diego Childhood Obesity Initiative

Your patients, clients and their families are depending on you! Children cannot vote. They need your help to tell their story. Through partnership in community advocacy, you can increase the chances that decision makers are not simply recognizing children's health and well being as an important issue, but that they are actively working to improve their health, their lives and their communities.

We wish to thank the CMA Foundation for their leadership in creating this Guide.

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Section 1 - Overview

Why This Guide Was Written & Who It is For

Many of you, as healthcare professionals see on a daily basis the medical and social complications of overweight and obesity in children. You see that even when children and their families want to make healthy choices, those choices are not always available to them based on the resources in their community. The communities our children live in have a profound impact on the foods they eat and the amount of physical activity they get. A lack of access to full-service grocery stores, increased costs of healthy foods compared to the lower cost of unhealthy foods and lack of access to safe places to play and be physically active all contribute to the increase in obesity rates.

Healthcare Professionals come from a variety of disciplines that interact and have an impact and interest in children's health. They include physicians, nurses, including nurse practitioners and school nurses, dentists, pharmacists, physician assistants, registered dietitians, nutritionists, health educators and other related clinicians.

As a result, more and more healthcare professionals are taking action to improve the health of children and their families through efforts to increase access to healthy foods and opportunities for physical activity through community and environmental change.

To maximize these efforts, healthcare professionals will be most effective working in partnership with other individuals and organizations who share your passion to improve the health of children through improving the health of their communities.

This Guide is designed for healthcare professional advocates already engaged in or starting their involvement in community advocacy efforts to bring about change. This Guide is designed to equip you as healthcare professional advocates to effectively connect and partner with local and state organizations involved in community based education and advocacy efforts to maximize your efforts to reverse the childhood obesity epidemic.

Objectives for the Guide

Healthcare Professional Advocates will -

1. Grow in their understanding of the connection between community influences and the health of children, particularly addressing access to affordable healthy food and physical activity.
2. Be aware of evidence based approaches to improve the health of their community.
3. Understand the importance of working in collaborative approaches to reverse the childhood obesity epidemic.
4. Understand how collaborative processes work and describe tips for working effectively in this type of process.
5. Articulate the value they bring to a collaborative or partnership effort to reverse the childhood obesity epidemic.
6. Recognize the importance of checking in and sharing their advocacy activities with their partner organization.
7. Identify organizations working at the state and local levels that might serve as partners to reverse the childhood obesity epidemic.

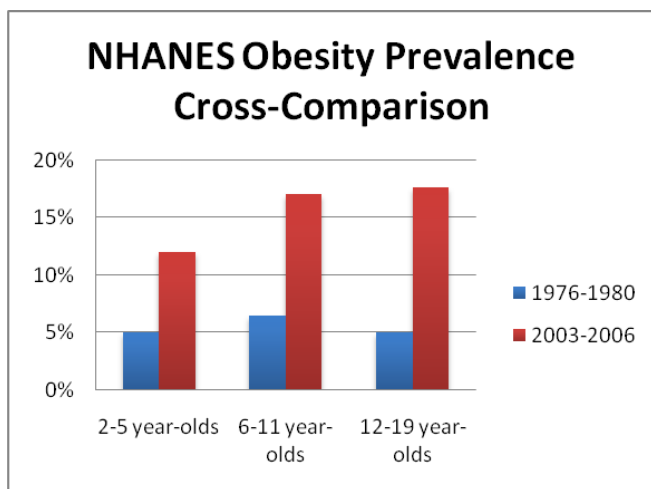
Trends in Overweight & Obesity in Children

The overweight designation in children is defined as 85th-95th percentile BMI while the obese designation is defined as 95th-100th percentile BMI.ⁱ Roughly 32% of all children in the US are overweight or obese, placing them at risk for a number of chronic diseases and cancer, according to *F as in Fat: How Obesity Threatens America's Future 2010*, a report released by the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF).ⁱⁱ

The percentage of overweight or obese children is at or above 30 percent in 30 states. According to the report, nine of the 10 states with the highest childhood obesity rates are located in the South with Mississippi ranking highest for childhood obesity at 21.9%.

Data from NHANES surveys (1976–1980 and 2003–2006) also show that the prevalence of obesity has increased over the past three decades.ⁱⁱⁱ

- For children aged 2–5 years, prevalence has increased from 5.0% to 12.4%.
- For those aged 6–11 years, prevalence has increased from 6.5% to 17.0%.
- For those aged 12–19 years, prevalence has increased from 5.0% to 17.6%.
- The rates of obesity among children ages 2-19 have more than tripled since 1980.



Latino and African Americans disproportionately live in communities with more limited healthy food choices and with fewer resources for physical activity. These communities often have many more fast food outlets and small convenience stores with limited fresh produce and lack of safe areas for children to play and be active. Within equivalent levels of socioeconomic status, race still serves as a determinant of health. Children as a subgroup, are more racially and ethnically diverse than the nation's population as a whole, and overweight and obesity prevalence rates are highest among children and adolescents of color.

- Mexican-American and African American children ages 6 to 11 are more likely to be obese or overweight than White children. Almost 43% of Mexican-American children and almost 37% of African-American children are obese or overweight, compared to 32% of White children.
- Studies among Native American children ages 5 to 17 in North and South Dakota, Nebraska and Iowa found that 48% of males and 46% of females were obese or overweight.

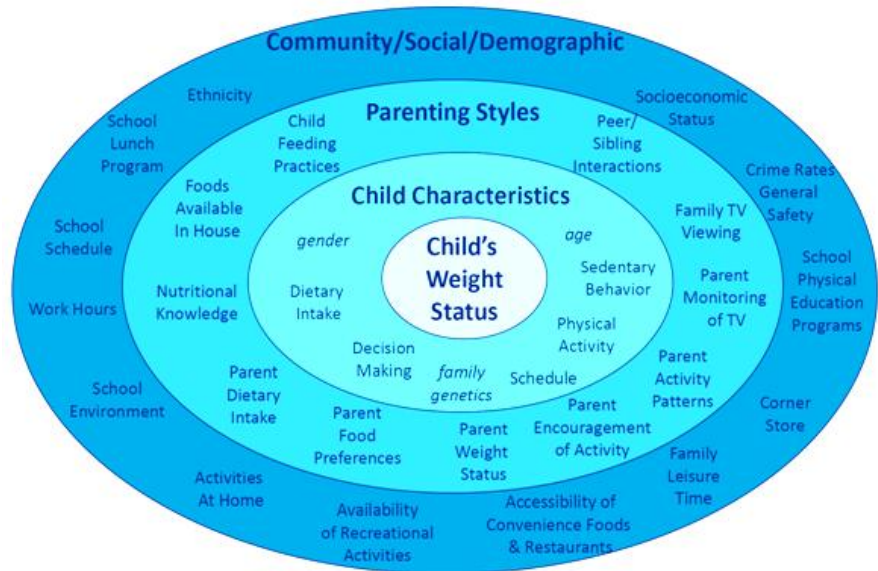
The high prevalence of obesity among all racial/ethnic groups highlights the importance of engaging in community efforts to impact childhood obesity.

Linking Community Advocacy with Clinical Practice

Factors that influence a child's ability to achieve and maintain a healthy weight come from a number of sources. The diagram at the right shows the link between the child's genetic influences, individual behaviors, parent and family influences and influences found at the community or environmental level that can influence a child's health.

As we move from the center of the grid, to its furthest ring, the opportunities for change move from an individual to a systems and policy focus.

It is therefore essential to identify community based approaches with a payoff to reverse this epidemic among our nation's children and youth. The following policy priorities as reported by the RWJF have been identified that demonstrate the greatest and most long lasting impact on children and their families:^{iv}



1. Ensure that all foods and beverages served and sold in schools meet or exceed the most recent Dietary Guidelines for Americans.
2. Increase access to high-quality, affordable foods through new or improved grocery stores and healthier corner stores and bodegas.
3. Increase the time, intensity and duration of physical activity during the school day and out-of-school programs.
4. Increase physical activity by improving the Built Environment in communities.
5. Use pricing strategies – both incentives and disincentives – to promote the purchase of healthier foods.
6. Reduce youth exposure to unhealthy food marketing through regulation, policy and effective industry self-regulation.

The AAP created its Prevention of Obesity Policy Opportunities Tool for those healthcare professionals who have not been exposed to these community policy initiatives, and may not readily see the link between what they encounter with patients and clients each day and these policy approaches. (Appendix A)

When you make this connection, you become empowered to share powerful stories of the negative impacts of policy inaction among your patients and clients, and becoming a strong partner to address policy change to reverse the childhood obesity epidemic. This Guide will help you to partner with others to maximize the chance for community change.

Section 2 - Partnership for Community Change

Why Partnership is Important

There are four key reasons why working in partnership to reverse the childhood obesity epidemic is critical:

- More can be done by individuals and groups together than can be done alone.
- You don't have to know everything about an issue.
- When you participate in a partnership, you will grow and learn from those with whom you partner.
- Roles and responsibilities are shared. Others are available to help you connect with the audiences you are trying to reach.

More can be done by individuals and groups together than can be done alone.

The beauty of a partnership or coalition is that a diverse, broad range of individuals and groups come together to address an issue of shared concern. When this happens, many more resources are brought to bear collectively than could ever happen by a single advocate.

The partnership captures and harnesses the passion of many, which provides the energy and opportunity for a stronger impact. There are many voices, hands and feet seated at the table to collectively move the agenda. There will be those in the group with the expertise to gather the background information to support the group's advocacy focus. Others will coordinate the development of materials and resources for the coalition. Still others will take the lead in outreach and focusing the advocacy agenda. And, there will be those who take the lead in organizing the work of the partnership, keeping track of what is taking place and making sure the logistical support for the team happens.

The reciprocal benefit also happens. Not only is the partnership made stronger by the connection and synergy among its members, each participating organization and individual grows as well. Each participant is able to share with his or her constituents the resources developed by the coalition. Coming together to form the partnership results in the growth of the total group, made greater than the sum of its parts. And, each of its contributing parts, its member individuals and organizations, grows stronger through their participation.

By joining the Be Our Voice Project, Sharon Notah-White grew in her understanding of critical factors that were influencing childhood obesity. Sharon works as a health educator with Molina Healthcare of New Mexico, serving vulnerable populations.

She was able to bring that knowledge and tools from Be Our Voice back to her programs to better support healthcare providers working with children in need.

The benefit of the partnership was mutual. Molina Healthcare's involvement made Be Our Voice stronger, and their healthcare providers grew in their capacity to better serve children at greatest risk for obesity through partnership in Be Our Voice.

New Mexico
Be Our Voice Project

You don't have to know everything!

You don't need to be an expert in all of the technicalities of the issue that you are advocating for. You only need to be an expert in your story—how the problem affects your patients or clients and their community and how the proposed solution can bring about meaningful impact and positive change. Many of you who are engaged in community advocacy acknowledge that you will often play a lead role in the clinical and scientific understanding of the childhood obesity issue with others taking the lead on different issues that are part of the advocacy campaign. The partnership allows its members to maximize and contribute their strengths to the success of the group.

You will learn from those with whom you partner.

Many healthcare professional advocates will acknowledge that it is leaders from the community itself who bring knowledge the greatest knowledge of what is happening in their community and what will or will not work to bring about change. By working together, each group of advocates learns through a sharing of different perspectives, making the advocacy effort stronger in its potential impact.

Each brings something valuable to their advocacy. For some of you already working in the community to bring about change, this is seen as an extension of your professional role, as part of a realization that you cannot break the cycle of overweight and obesity one child at a time. By working with community members, the business community and others, the opportunity is greater to bring about needed change. When you as healthcare professionals reach out to community organizations to learn with them, it conveys that you, too, have something to learn.

Roles and Responsibilities are Shared. Others are available to help you connect with the audiences you are trying to reach.

Working in a partnership with others also means there is a sharing of responsibility to move the education and advocacy campaign forward. This can be particularly valuable to those healthcare professionals who spend their days seeing patients and clients, leaving little time to organize the work of an advocacy campaign or manage the logistics to support it.

A key factor sometimes identified as a valuable resource for healthcare professional advocates is having a supportive group to work with. Healthcare professional advocates who are passionate about the advocacy work they are doing may describe it as difficult, sometimes frustrating work. To have an encouraging group to provide a foundation and support is often what is needed to get through the tough times, and keep going.

Connecting Your Interest with the Partner Organization

As you consider partnering with an organization to reverse the childhood obesity epidemic, do your homework about your advocacy issue and the priorities of the organization you are considering partnering with.

- Spend the time upfront to determine the link and synergy between your advocacy issue and the organization's interests.



- Do the interests match?
- Be sure to invest time to learn what motivates the members of the organization you may wish to work with on your advocacy campaign.

Convey why your advocacy issue is important to you and why you would like to join the group and be part of their team. Let them know how you feel you can be a resource to the organization and what help you will need from them. Be as concrete as possible when describing the help you will need. Be clear about the time parameters you have to work in and what you feel you can offer within that amount of time.

Key Elements of Partnership & Collaborative Approaches

Partnerships and coalitions are typically formed to address an important issue. They offer the opportunity to pool resources and bring together individuals and groups with differing backgrounds and experiences that share a concern for the same issue. The group may be organized in a more formalized in structure, operating under the direction of a government agency or nonprofit organization, with specific goals and expectations, timelines and requirements for action and outcomes.

Partnerships or coalitions may also be more informal in nature with a group of individuals and organizations coming together to address an issue of shared concern. As you begin to explore the value and opportunities to engage in partnership to carry out your childhood obesity advocacy activities, be sure to find out how a partnership or coalition is organized, as this will influence how work is conducted and decisions are reached.

Partnerships and coalitions that follow a collaborative model have the goal of creating a safe environment for involvement, so participants can work together to identify and solve problems, make decisions, resolve conflicts if they arise and move forward. Collaboration, in a nutshell, is the act of people working together to get something done. In childhood obesity prevention, that might focus on increasing physical activity on school campuses, or increasing access to healthy foods in neighborhood markets. Members share and build knowledge and relationships while they work to achieve their goals, bringing different types of data and resources to bear on their advocacy issue.

Participation in a partnership or coalition is usually structured around the amount of time each team member has available and their areas of interest and expertise. This can run the gamut from being involved in writing letters to policy makers about a key issue or participating in a letter-to-the-editor campaign when less time is available to the highest level involvement which usually includes serving on the group's leadership board to help shape its policy and priorities.

Irrespective of how a partnership is organized, participants work with one another to address areas of shared interest, taking actions to achieve their goals. Advocacy efforts by the group will be more likely to succeed if advocates have listened well to one another, heard each other's expressed needs and have reached consensus on goals and approaches to address their advocacy issue. More information about creating and maintaining a coalition or partnership can be found at The Community Toolbox at:

http://ctb.ku.edu/en/dothework/tools_tk_content_page_71.aspx.

Consensus Decision Making Process

Many partnerships using a collaborative model to carry out their work use a consensus process to make decisions. In this decision making model, participants focus on creating win-win solutions to achieve their goals, recognizing the importance of give and take and compromise. When working in a collaborative model, it is often impossible for everyone to always have their interests prevail. So compromise is imperative when collaborative skills are put to use.

Some healthcare professionals and many physicians are often used to being in leadership roles of groups of which they are a member, or being asked for their opinions by policy makers. They have had experiences throughout their training and work life where others ask their opinion and recommend them for leadership. Many who have served in these types of leadership roles have not been exposed to, or trained in, a consensus decision making model. As a result, they may expect meetings to utilize more of a voting based decision making process rather than the consensus decision making process. If healthcare professionals, particularly those with more of a clinical background, become involved in community partnerships that use consensus decision making, it will be critical to gain background on how this process is conducted and perhaps participate in training to allow the healthcare professionals to more easily fit with the group’s decision making approach.

Identifying Possible Partner Organizations

Successful collaboration must be a partnership. The first step in a successful partnership is to identify those who share a passion for your childhood obesity prevention issue. Identifying allies does not have to take a lot of time.

- *First, be clear about the issue or issues that focus your interest and passion.*
- *Second, identify the locale where you will focus your efforts.*
 - Will you be working at the community level, focusing on schools or the community?
 - Will you focus your efforts more at the state level to bring about change?

Once you have answered these questions, you can begin to identify potential partner organizations already working to address your advocacy issue. These might include local health departments, cities, schools and organizations such as the YMCA. Both the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation (RWJF) are funding a number of projects in states and communities to address community advocacy. Through its Healthy Communities Program, the CDC has provided funding for 23 states to engage in efforts to reduce overweight in children and adolescents. These programs are addressing policy and community change that focuses on:

Increased Physical Activity	Consumption of Fruits & Vegetables
Breastfeeding	Decreased Television Watching
Decreased Consumption of Sugar Sweetened Beverages and High Energy, Dense Foods	

RWJF has provided support to a number of partnerships throughout the nation as well. Through the Healthy Kids, Healthy Communities Initiative, 50 grantees are working on policy change efforts to improve access to healthy foods and increase physical activity within their communities. The RWJF Center to Prevent Childhood Obesity also supports 17 Network partners in their efforts to reverse childhood obesity. The *Be Our Voice Campaign* is one of those partners. Appendix B includes the background information on these partnerships.

Many state health departments also are involved in Obesity Prevention Programs. If your interest is more in line with statewide advocacy efforts, be sure to check with your state health department to identify any statewide activities underway.

In 2003, Arkansas was among the first states to pass sweeping legislation to combat childhood obesity. Arkansas Act 12120 to Reduce Childhood Obesity gained national attention. Since the law's implementation, school districts have increasingly adopted nutrition and physical activity policies. Evaluations of the law's impact show that schools have become healthier environments for students and staff alike.

The State Health Department has played a lead role in helping to organize this statewide campaign to reduce childhood obesity. Arkansas is divided into five public health regions and within each region a Growing Healthy Communities team is in place. These teams include the local mayor, and community decision makers. It is through these networks that healthcare professional advocates have been recruited, trained and supported.

Arkansas Be Our Voice Project

Section 3 – Strengthening the Partnership

What Healthcare Professionals Bring to Community Advocacy Partnership

As healthcare professionals, you bring a number of assets to a partnership to reverse the childhood obesity epidemic.

- First, you have high credibility with policy makers, the media and others. When you engage in community advocacy, you are viewed as someone working for a higher, unbiased goal, to improve the health of your patients or clients and their communities.
- You have the scientific grounding on the issues surrounding childhood obesity and can speak about these with great conviction and clarity. As a healthcare professional, better than anyone else, you can speak with conviction about how your patients or clients are impacted by the actions needed that will lead to greater access to healthy food choices and physical activity.
- More than any other advocate involved in childhood obesity prevention, you can bring a face to the work being done. Again, through your patients or clients and their families, you can make the issues and statistics real.
- Through your professional organizations, you may have access to data and information about the impact of advocacy campaigns and work others are doing to reverse the childhood obesity epidemic. This can be shared with your partner organization. Appendix C provides a list of Key Data Resources available to address childhood obesity.

Challenges that May Arise

Many healthcare professionals may not have been exposed to or experienced collaborative partnership models and consensus decision making. As a result, there may not be awareness about how these processes work and the foundation's on which they are built, particularly the focus on ensuring the time for relationship building.

- This lack of exposure and understanding may, at times, result in impatience when meeting agendas are focused more on discussion rather than decision making, creating what seems like a longer time to reach a conclusion.
- Because these models are built on a framework of shared responsibility, a variety of members of the advocacy team may be in leadership positions. It is not assumed that healthcare professional advocates will be the ones leading the advocacy partnership.

A key issue that often arises in advocacy partnerships is that members of the team may speak “different languages”.

- Community advocates may use jargon to describe work they are doing to address their issue, using phrases like **Eating Occasion** to describe a single meal or snack, or **Food**

Desert to mean an area in the United States with limited access to affordable and nutritious food. (See Appendix D for the complete Advocacy Glossary of Terms.)

- Healthcare professional advocates may use medical terminology not familiar to their community partners, using a term like **adipocytes** to refer to fat cells and **Obesogenic** to refer to the environmental factors that may promote obesity and encourage the expression of a genetic predisposition to gain weight.^v Just as community advocates need to be cognizant of speaking in a way that others understand their advocacy focus, healthcare professionals need to speak about the health impacts associated with childhood obesity in ways that nonclinicians can understand.

“When working with new advocacy recruits, I tell them that when my patients are in my office, they will have to learn the words I use to describe their health or illness. But, when I go into the community, I’m in their office and I need to understand what they are saying and what it means.”

Frank Staggers Sr., MD
Pas President, NMA
Oakland California

As healthcare professionals, many of you are very busy with your schedules.

- You may be difficult to reach because you are seeing patients and clients each day, and sometimes into the evening.
- As a result, members of your advocacy team may find it difficult to reach you in a timely manner to ask your involvement in some type of campaign activity.
- You may also not respond to requests by your partner organization’s leadership team both to participate in an advocacy activity for follow-up to check in on the advocacy work you are completing.
- Because of your limited time availability, you may find it difficult to participate in the organization’s leadership or team meetings, having to focus your time more on completing specific advocacy tasks.

Working Through the Challenges

Although some challenges may exist for healthcare professionals to successfully partner with organizations to address childhood obesity, with forethought and planning healthcare professionals can help to resolve and move through these challenges.

- Those of you who have not participated in collaborative approaches to community partnership have an opportunity to learn more about this approach and the value it places in building relationships among team members.
- Team members will learn from each other by sharing different experiences and different points of view. This will make the advocacy campaign stronger.
- When you attend organizational meetings and decisions aren’t always made, recommend to the group to establish a procedure to make at least one decision at each meeting, even if it is a small one. This gives a sense of forward movement and accomplishment.

- If it is a new experience to work in partnership, listen, observe and learn. Don't expect to be the "instant" leader because you have the most training and education on the team. Remember that in a partnership environment many different experiences are reflected and valued. By listening to others, you will grow in your understanding of the challenges faced by the community you are serving.
- As a team member, if your involvement does not include attending team meetings and you are primarily carrying out specific action items because of your time availability, remember to make time to respond to requests to check in and share what you are doing. This is how the partnership is able to track its efforts and their impact.
- To be a healthcare professional advocate does not have to require large amounts of time. Chose advocacy activities that fit your availability. Irrespective of the time you have available, you can make an impact.

Examples of Advocacy Activities Matched with Available Time

Activity	< 1 Hour a Month	1 Hour a Month	>1 Hour a Month
Vote	X	X	X
Call, email or write a letter to a decision maker addressing your advocacy issue.	X	X	X
Contribute to a nonprofit advocacy organization that focuses on your advocacy issue.	X	X	X
Sign up for 1 or 2 email lists that are related to your advocacy issue.	X	X	X
Patronize businesses that donate a percentage of their profits to health issues related to preventing overweight and obesity in children.	X	X	X
Cultivate long-term relationships with a public official or other decision maker in your community who can impact your advocacy issue.		X	X
Write a letter to the editor of your local newspaper about your advocacy issue.		X	X
Talk to other healthcare professionals and parents that you come into contact with about the advocacy issue you care about. Encourage them to get involved.		X	X
Submit an article on your advocacy issue to your professional association's newsletter or website.		X	X
Attend community forums and events sponsored by decision makers who may have a say on your advocacy issue.		X	X
Testify before the state legislature or participate in community forums about your advocacy issue.			X
Apply for community advocacy grants.			X
Set up a booth in your professional setting that explains the issue you are working on that provides information to and resources for getting involved.			X
Serve as a spokesperson for a local issue or community based organization that is also addressing your advocacy issue.			X
Volunteer as a board member of a health organization working that is supportive of your advocacy issue.			X

Section 5 - What Organizational Partners Need from You

In order to create and sustain a successful relationship with healthcare professional advocates, organizational partners will need input and information in a number of areas. Organizational partners will need to know:

- Your background and experience in advocacy in general and as it relates to childhood obesity, including experience with other coalitions and partnerships, media advocacy and providing testimony to policy makers. In this way, they can be a stronger support to you in your advocacy efforts.
- The type of help you will need from them, for example, logistical support, training, background and resource materials.
- The time you have available to support the partnership.
- Ideas you have about how to use this time. With this background information, you and the organization can most effectively target your advocacy involvement.
- Times of the day and evening you are available to be part of the advocacy team.
- The languages you speak and your experience working with diverse and underserved communities.
- Groups and organizations in the community you belong to that will help identify opportunities to share your advocacy message.
- Your work on advisory committees and leadership boards.
- Background and experience with different types of group decision making models, including consensus decision making process.
- Professional organizations you belong to and what these organizations are doing to address the childhood obesity epidemic.
- Stories you can share that paint a picture of the impact of limited access to healthy food choices and physical activity on children and their families.

Partner organizations will need you to share with them the advocacy work you are doing in your community as part of their campaign. They will need help from you to navigate through your communication infrastructure so that you both can connect. For those of you who are clinicians, this may mean letting your office manager know to forward messages on to you, providing them with your email address and back office line. They need your commitment to share your advocacy activities and stay connected.

Section 6 – Putting It All Together

Lessons Learned from Healthcare Professional Advocates in the Field

What follows are a set of lessons learned compiled by healthcare professional advocates working in partnership to reverse the childhood obesity epidemic.

- ***By Definition, We Are a Very Diverse Group.***

- We have many different backgrounds and types of training and interests. Some of us work for schools, public health agencies and other healthcare organizations. Some of us are clinicians by training, seeing patients and clients throughout our work day. We may work in at risk and underserved communities seeing the impact of policy inaction in a very up close and personal way. Others of us may not.
- Some of us may have more time during the day available to attend meetings. Because of where we work, some of us may be limited in the types of advocacy work we can do.
- We have different experiences and exposure related to childhood obesity. Some of us are involved in developing campaigns for the organizations where we work. Our focus is more on data gathering and development of programs to address childhood obesity.
- Others of us see the impacts of childhood obesity each day in a very personal way with our patients and clients. We have stories to share about programs needing to be developed and policy needing to change.
- Many of us do not directly work with children. Still we are drawn to this issue and have great interest and desire to be involved in efforts to bring about positive change.

Organizations most successful in partnering with healthcare professional advocates understand this variety and have taken the time and steps to match their interests and needs with healthcare professionals who share their passion and fit with the type of partnership they need.

- ***Most of Us Will Need Help & Support to Carry out Our Advocacy Efforts.***

- Many healthcare professionals involved in advocacy campaigns have stated that one of the greatest areas of assistance they can receive is help in connecting with groups they would like to reach with their education and advocacy message. Having this done for them is often described as a godsend!
- Others have shared that they appreciate receiving updates and new information that can be incorporated into their advocacy efforts. (See Appendix E for Online *Be Our Voice* Resources.)

- Training and educational updates are also valued by healthcare professional advocates. When the training is conducted by the partner organization, it makes it all the easier to be there, participate and learn.

As you are considering partnering with an organization or coalition to engage in your advocacy efforts, check to see what type of support they can provide you to link with community organizations. Find out if they have a mechanism to share data and resources and whether they provide training for their advocates or help to link advocates with other training resources in the community.

- ***We Get Busy Seeing Our Patients and Clients and Don't Follow-up Routinely with Our Organizational Partners.***

- Those healthcare professional advocates who spend their days seeing patients and clients can be very hard to reach.
- Many of you do not check email routinely. Calls to your office are taken by the office manager or front office staff member and may not make it to you on a timely basis.
- While partner organizations may have staff or volunteers who can dedicate some time to follow up with their advocates to track community activity, they can only do so much.
- The reports advocates provide shows policy makers, the media, other advocates and community leaders that energy is in the campaign, that it is moving forward and having an impact. This information is critical for the success of the advocacy partnership.

As you are considering partnering with an organization or coalition to engage in your advocacy efforts, check to see what type of support they can provide you to link with community organizations. Find out if they have a mechanism to share data and resources and whether they provide training for their advocates or help to link advocates with other training resources in the community.

- ***We May Lack the Experience in Working in a Collaborative Process.***

- We can get frustrated with meetings where lots of talking takes place, no decisions get made and everyone goes home.
- We have often been in positions of responsibility and come into a collaborative and are on equal footing with others. This can be challenging. When we open ourselves to this, or others help us to see the value of this approach, we learn from the other team members.

We may not have experienced the value of relationship building and then when we do, we get plugged in and will respond differently to those reaching out to us.

- **We Like Acknowledgement, But That Isn't Why We Do This.**

- Our energy to engage in childhood obesity prevention is the kids themselves. Whether we see children in our work every day, or not, each of us can likely bring the face of a child to mind who serves as our catalyst for change.
- For some of us, the motivation to engage in community advocacy to reverse the childhood obesity epidemic is focused on our desire to prevent the trauma that would face these children if they became obese and started down the path to diabetes or cardiovascular diseases.
- We do appreciate the thank yous and acknowledgement we receive, don't get us wrong. What keeps us going, though, is knowing that we are making a difference, that some change is happening. We like to hear what others are doing that is making an impact. And, if there is data that shows some impact or change that is resulting from our work or the work of other advocates, that will provide a boost and energy to keep going.

"As a father of a seven year-old, Baker sees first-hand the environment in which children are growing up today and it motivates him to get involved. "I asked my son one day what he was doing in gym, and he said, 'What's gym?'" Baker met with the principal and teachers to talk about increasing the time during the school day for physical activity and has gotten other parents to do the same. "Kids are our future and I want our communities to know that it is our job to keep them healthy."

Alphonzo Baker, Sr. RN
University of Arkansas for Medical Sciences Center
Arkansas Be Our Voice Project

We can be difficult to reach. Our schedules do not always make for easy connections. When we are part of a coalition or advocacy group, we do want them to reach out to us, and share the results of the work we are engaging in. That is a motivator for us to keep going. Sharing available data shows us that our approaches, and those of others, are having an impact to help the children in our community. This is the greatest thank you we can receive.

- **Even With Limited Time Availability, We Will Get Involved.**

- There is that smaller group of us who are taking the lead and raising the visibility of healthcare professional advocates. Most of us, however, do not have lots of extra time to engage in community advocacy activities.
- Most of us, though, have only a few hours a month to bring to the advocacy we do. We want to be involved and work to improve the health of the children in our communities. When others help us to see the small action steps we can take and we have a way to plug into campaigns taking place, it is easier to be involved than if we try to do this on our own.

Be clear about how much time you have to give and find those small steps to take to engage as a community advocate. Check to see how your partner organization can get you plugged in.

What Success Can Look Like

When healthcare professional advocates and organizations successfully partner to reverse the childhood obesity epidemic a number of success factors emerge. It is critical to capture these factors both from the perspective of organizations working with healthcare professional advocates and from the advocate's themselves.

Organizations working successfully with healthcare professionals –

- Acknowledge that working successfully means building a relationship that has value.
- Invest the time for discussion and learning so that each grows in the other's perspective.
- Learn the interests and passions of healthcare professional advocates and take steps to respond.
- Break down advocacy opportunities into “bitable chunks” so that no matter what amount of time advocates have available, opportunity to advocate happens.
- Respond to targets of opportunity for healthcare professional advocates to engage.
- Take steps to reach, communicate and engage busy healthcare professional advocates to keep them abreast of the childhood obesity advocacy campaign.
- Periodically assess their support and engagement efforts and respond as their relationship with their healthcare professional advocates changes and grows.

In Cabarrus County, the leaders of the Be Our Voice Team have been collecting a long list of initiatives developed by their healthcare professional advocates through feedback provided by their healthcare professional advocates.

Advocates have created and led classroom presentations, created a Breakfast is Best program, organized an exercise club for non-athletes, spoken to the local PTA about the nutritional value of school lunches and created a Nutrition Advisory Club.

Knowing about these initiatives has allowed the project's leaders to share these with the local media, policy makers and business leaders in Cabarrus County, raising the visibility and value of the work they are all engaged in.

Cabarrus County North Carolina
Be Our Voice Project

Healthcare professional advocates working successfully with organizations in community advocacy campaigns –

- Participate in learning and training opportunities and take steps to grow in their understanding of community change and its value.
- Share with the organization their time availability and work together to find ways to advocate in a meaningful way in that time.
- Learn how the organization works to maximize their participation and contributions.

- Share with the organization the advocacy work they are doing in the community.
- Make a commitment to engage.
- Identify their community advocacy targets and plans and share these with the organization.

“In Tyler Texas, the Be Our Voice Advocacy team moved from smaller pockets of people who are interested in health to a larger group of people. We now have a coalition called Fit City Tyler that is focused on reducing obesity, and leaders from across the community are involved.”

*Valerie Smith, MD
Texas Be Our Voice Project*

- Expand their advocacy work from initial action steps and focus to larger sets of activities and a larger focus.
- Grow in their understanding of the policy decision making process for their advocacy issue.
- Offer to connect with new healthcare professional advocates and share the “Rules of the Road” for the community advocacy process.

Getting Started – Tips to Initiate Your Partnership

1. Know why you want to be part of a larger partnership effort to reverse the childhood obesity epidemic.
2. Research which organizations are available for partnership and match your interests with their mission and advocacy focus.
3. Be clear about the time you have available to dedicate to your advocacy efforts and match your time with advocacy opportunities.
4. When you meet with the leaders of the partnership organization with whom you would like to work, listen as they describe how they conduct their business and if they have worked with healthcare professional advocates.
5. Let the group know the time you have available and agree on some initial action steps you can take as part of the advocacy team.
6. Complete one small advocacy action step such as writing a letter to the editor or calling, emailing or writing a letter to a decision maker addressing your advocacy issue.
7. Close the loop and share with the partnership organization the action step you took!

As you begin to form your advocacy partnership, consider completing the Partnership Checklist found in Appendix F.

Section 7 – Appendices

**Appendix A - Prevention of Obesity Policy Opportunities
Tool**

**Appendix B - CDC & RWJF Childhood Obesity Prevention
Sponsored Projects**

**Appendix C - Key Data Resources to Address Childhood
Obesity**

Appendix D - Glossary of Obesity Terms

Appendix E - *Be Our Voice* Online Resources

Appendix F - Partnership Checklist

Appendix A

PREVENTION OF OBESITY POLICY OPPORTUNITIES TOOL (POPOT)

The American Academy of Pediatrics (AAP) is pleased to announce the release of the **Prevention of Obesity Policy Opportunities Tool (POPOT)**. The POPOT is a dynamic Web-based tool created for healthcare professionals (HCPs) who have experience in advocacy and are interested in focusing their advocacy efforts on obesity prevention. This tool provides actionable policy strategies and associated resources to prevent obesity. Specific strategies and resources are presented for implementation at the practice, community, school, state, and federal levels.

The POPOT is available at http://www.aap.org/obesity/matrix_1.html.

Top Level of POPOT tool: Showcases high level strategies to support healthy nutrition (row labeled 5 for 5 fruits and vegetables/day), reduced screen time (row labeled 2 for 2 hours of screen time or less/day), increased physical activity (row labeled 1 for 1 hour of physical activity/day), limiting unhealthy foods (row labeled 0 for 0 sugar-sweetened beverages per day), breastfeeding (row labeled BF) and BMI screening (row labeled BMI) at various levels (pediatric practice/hospital, community, school, state, and Federal).

	Practice	Community	Schools	State	Federal
5	<ul style="list-style-type: none"> Increased Access to Healthy Food Limited Access to Unhealthy Foods Point of Purchase Media Campaigns 	<ul style="list-style-type: none"> Increased Access to Healthy Food Limited Access to Unhealthy Foods Point of Purchase Media Campaigns Change Relative Pricing 	<ul style="list-style-type: none"> Increased Access to Healthy Food Limited Access to Unhealthy Foods Point of Purchase Media Campaigns Change Relative Pricing 	<ul style="list-style-type: none"> Increased Access to Healthy Food Limited Access to Unhealthy Foods Point of Purchase Media Campaigns Change Relative Pricing 	<ul style="list-style-type: none"> Increased Access to Healthy Food Limited Access to Unhealthy Foods Point of Purchase Media Campaigns Change Relative Pricing
2	<ul style="list-style-type: none"> Restrict Screen Time 	<ul style="list-style-type: none"> Restrict Screen Time 	<ul style="list-style-type: none"> Restrict Screen Time 	<ul style="list-style-type: none"> Restrict Screen Time 	<ul style="list-style-type: none"> Restrict Screen Time
1	<ul style="list-style-type: none"> Increased access for safe and attractive places for Physical Activity Increase Physical Activity 	<ul style="list-style-type: none"> Increased access for safe and attractive places for Physical Activity Increase Physical Activity 	<ul style="list-style-type: none"> Increased access for safe and attractive places for Physical Activity Increase Physical Activity 	<ul style="list-style-type: none"> Increased access for safe and attractive places for Physical Activity Increase Physical Activity 	<ul style="list-style-type: none"> Increased access for safe and attractive places for Physical Activity Increase Physical Activity
0	<ul style="list-style-type: none"> Access to Healthy Beverages Limit Access to Unhealthy Beverages 	<ul style="list-style-type: none"> Access to Healthy Beverages Limit Access to Unhealthy Beverages Point of Purchase Change Relative Price Media Campaigns 	<ul style="list-style-type: none"> Access to Healthy Beverages Limit Access to Unhealthy Beverages Point of Purchase Change Relative Price Media Campaigns 	<ul style="list-style-type: none"> Access to Healthy Beverages Limit Access to Unhealthy Beverages Point of Purchase Change Relative Price Media Campaigns 	<ul style="list-style-type: none"> Access to Healthy Beverages Limit Access to Unhealthy Beverages Point of Purchase Change Relative Price Media Campaigns Taxes

To learn more about the strategies identified to improve nutrition within the community click on this cell. See page 2 for next level of information.

BF	• Breastfeeding Friendly Environments	• Breastfeeding Friendly Environments	• Breastfeeding Friendly Environments	• Breastfeeding Friendly Environments	• Breastfeeding Friendly Environments
BMI	• Payment	• BMI Screening	• Payment	• Payment • BMI Screening	• Payment

Key:

- 5= Fruits and vegetables/day
- 2= Less than 2 hours of screen time/day
- 1= Hour of physical activity/day
- 0= Sugared beverages/day
- BF= Encourage and support breastfeeding
- BMI= Body mass index screening

[Obesity Advocacy Glossary](#)

Special Feature: An obesity advocacy glossary is included to help HCP's learn related advocacy terms.

Level 2 of POPOT tool: Showcases the various policy actions steps for each hi-level strategy (based on Centers for Disease Control and Prevention's MAPPs strategies) defined in the first layer of the tool.

Sample Level 2: Improved Nutrition at the Community Level

Increased Access to Healthy Food
Action steps to increase access to healthy food in the community include:

- Communities should improve geographic availability of supermarkets via a variety of strategies such as incentives, relaxing zoning requirements, and/or small business programs.
- Encourage farmers' markets, farm stands, mobile markets, community gardens, and youth-focused gardens in your community by offering incentives and/or modified land use policies/zoning regulations.
- Encourage farmers' markets to accept WIC and SNAP.
- Create incentive programs for markets and other food vendors to carry healthier foods.
- Increase availability of healthy food in public venues.
- Enhance accessibility to existing grocery stores through public safety efforts and through increased public transportation routes.

CLICK ON THE GREEN HEADER TO REVEAL

Limit Unhealthy Foods
Action steps to limit unhealthy foods in the community include:

- Implement zoning and/or establish ordinances designed to limit the number of fast food establishments and mobile vending in the community.
- Communities should restrict availability of less healthy foods in public service venues.

CLICK ON THE GREEN HEADER TO REVEAL

Point of Purchase
Action steps for point of purchase in the community include:

- Require menu labeling in restaurants to provide consumers with calorie information on menus and menu boards.
- Regulate smaller portion size, low-fat, low-calorie options be available and clearly labeled as such in public service venues.
- Offer incentives to restaurants that promote healthier options.
- Encourage or incentivize food vendors to adopt family-friendly policies that promote healthy products and limit unhealthy marketing.
- Encourage purveyors of vending machines to create healthy vending guidelines and labeling.

[Scroll back to the top](#)

CLICK ON THE GREEN HEADER TO REVEAL

Media Campaigns
Action steps to develop media campaigns in the community include:

- Develop media campaigns to promote healthy choices and counteract media messaging of unhealthy choices.

[Scroll back to the top](#)

CLICK ON THE GREEN HEADER TO REVEAL

Change Relative Pricing
Action steps to change relative pricing in the community include:

- Develop and implement a tax strategy to discourage consumption of food and beverages with minimal nutritional value.

After clicking on a cell in the top layer of matrix, various **policy action steps** to implement the high level strategies are highlighted. The example to the left showcases actions steps to improve nutrition at the community level (the cell circled on the previous page). To learn more about one of these action steps, simply click on the action step to reveal the 3rd level of content (see page 3 for example).

Sample Level 3: Detailed information on Policy Action Step: Describes details about each policy action step, what organizations recommended this strategy, and provides links to reports and resources. The example below showcases what one would find if they selected one of the action steps in layer 2.

Sample Level 3: Communities should improve geographic availability of supermarkets

Action steps to increase access to healthy food in the community include:

A. Communities should improve geographic availability of supermarkets via a variety of strategies such as incentives, relaxing zoning requirements, and/or small business programs.
 People cannot consume a healthy diet unless healthy foods are available, affordable, and convenient. Research suggests that neighborhood residents who have better access to supermarkets and grocery stores tend to have healthier diets and lower levels of obesity. Unfortunately, many communities across the U.S. lack access to healthy food options. Communities without supermarkets should explore incentives such as grants and loan programs, small business development programs and tax incentives that encourage grocery stores to locate in underserved areas. Localities and local zoning boards can also relax zoning requirements that make it difficult for supermarkets to move into densely populated urban areas and rural communities, provide parking subsidies and implement policies that encourage that recently closed grocery stores can be replaced by another one as quickly as possible.

Recommended by:

- ▶ [Centers for Disease Control and Prevention \(CDC\): Recommended Community Strategies and Measurements to Prevent Obesity in the United States](#)
- ▶ [Institute of Medicine \(IOM\) Report: Local Government Actions to Prevent Childhood Obesity](#)
- ▶ [Robert Wood Johnson Foundation \(RWJF\): Action Strategies Toolkit – A Guide for Local And State Leaders Working to Create Healthy Communities And Prevent Childhood Obesity](#)

For more information:

- ▶ [The Food Trust](#)
- ▶ Public Health Law and Policy: [Getting to Grocery: Tools for Attracting Healthy Food Retail to Underserved Neighborhoods](#) and [Zoning Talking Points](#)
- ▶ The Rudd Center: [Access to Healthy Foods in Low-Income Neighborhoods](#)
- ▶ International City/County Managers Association (ICMA): [Community Food Access – The Local Government Role](#)

This section provides a brief description of the policy action step (highlighted in yellow) that was selected in layer 2.

This section showcases the various organizations recommending this policy action and provides direct links to each organization’s corresponding report. See box below for featured reports.

This section provides links for more information on sample briefs, model policy, other important reports and/or organizations focused on the cause.

- Reports Featured Include:**
- Relevant American Academy of Pediatrics Policy Statements
 - Recommended Community Strategies and Measurements to Prevent Obesity in the United States (Centers for Disease Control and Prevention)
 - Local Government Actions to Prevent Childhood Obesity (Institute of Medicine)
 - Action Strategies Toolkit – A Guide for Local and State Leaders Working to Create Healthy Communities and Prevent Childhood Obesity (Robert Wood Johnson Foundations)
 - Successful State Strategies to Prevent Childhood Obesity (National Governor’s Association)

Appendix B

CDC & RWJF Childhood Obesity Prevention Sponsored Projects

Robert Wood Johnson Foundation (RWJF) Childhood Obesity Prevention Sponsored Projects

The organizations and programs listed below are among those currently funded by the RWJF to help reverse the childhood obesity epidemic. <http://www.reversechildhoodobesity.org/content/network>

Active Living Research

African American Collaborative Obesity Research Network

Alliance for a Healthier Generation

Bridging the Gap

Communities Creating Healthy Environments

Healthy Eating Active Living Convergence Partnership

Healthy Eating Research

Healthy Kids, Healthy Communities

Leadership for Healthy Communities

National Initiative for Children's Healthcare Quality (NICHQ)

National Policy and Legal Analysis Network to Prevent Childhood Obesity

The NJ Partnership for Healthy Kids

Safe Routes to School National Partnership

Salud America! The RWJF Research Network to Prevent Obesity Among Latino Children

Save the Children: Campaign for Healthy Kids

Yale University Rudd Center for Food Policy and Obesity

YMCA of the USA: Pioneering Healthy Communities

CDC's Healthy Communities Program- List of All Funded Communities

This list shows, in parentheses, the funding model and month/year that participation began in CDC's Healthy Communities Program. <http://www.cdc.gov/healthycommunitiesprogram/communities/index.htm>

View map of all communities at

<http://www.cdc.gov/healthycommunitiesprogram/communities/overallmap.htm>

As of February 2011

ALABAMA

Birmingham (PHC 10/08)
Birmingham (REACH 10/07)
Dallas County (SAH 10/08)
Jefferson County (CPPW 3/10)
Mobile County (CPPW 9/10)
Montgomery (ACHIEVE 3/09)
Perry County (SAH 10/08)
River Region (Steps 10/04)
Southeast Alabama (Steps 10/04)
Sumter County (SAH 10/08)

ALASKA

SouthEast Alaska Regional Health Consortium (tribal health consortium of 18 Alaska Native communities) (Steps 10/04)
Wrangell (ACHIEVE 2/10)

ARIZONA

Cochise County (Steps 10/03)
Phoenix (REACH 9/10)
Pima County (CPPW 3/10)
Santa Cruz County (Steps 10/03)
Tohono O'odham Nation (Steps 10/03)
Tucson (PHC 10/05)
Tucson (REACH 10/07)
Yuma County (Steps 10/03)

ARKANSAS

Hot Springs (PHC 10/08)
Independence County (CPPW 9/10)
North Little Rock (CPPW 9/10)
statewide (PHC 10/05)

CALIFORNIA

Anaheim (ACHIEVE 3/09)
Garden Grove (REACH 10/07)

Grass Valley (ACHIEVE 2/11)
Hayward (PHC 10/08)
Inglewood (REACH 10/07)
La Mirada (ACHIEVE 3/09)
Lompoc (PHC 10/09)
Long Beach (PHC 10/09)
Los Angeles (REACH 9/10)
Los Angeles (REACH 10/07)
Los Angeles County (CPPW 3/10)
Monterey County – Salinas (Steps 10/03)
Oakland (REACH 10/07)
Ontario (PHC 10/09)
Orange County (PHC 10/05)
Sacramento (ACHIEVE 3/09)
San Diego County (CPPW 3/10)
San Francisco County (REACH 9/10)
San Francisco (PHC 10/07)
Santa Clara County (CPPW 9/10)
Santa Clara County (CPPW 3/10)
Santa Clara County (Steps 10/04)
San Jose (REACH 10/07)
Santa Clara and South San Mateo Counties (PHC 10/04)
Shasta County (PHC 10/06)
Ukiah (ACHIEVE 2/11)
Whittier (ACHIEVE 2/11)
Yuba City (ACHIEVE 2/11)

COLORADO

Adams/Arapahoe/Douglas Counties (CPPW 3/10)
Aurora (ACHIEVE 2/10)
Aurora (REACH 10/07)
Boulder (PHC 10/04)
Colorado Springs (PHC 10/07)
Fort Collins (ACHIEVE 2/10)
Longmont (PHC 10/07)
Mesa County (Steps 10/03)

Pueblo County (Steps 10/03)
Teller County (Steps 10/03)
Weld County (Steps 10/03)

CONNECTICUT

Danbury Area (ACHIEVE 2/11)
Brookfield (ACHIEVE 2/11)
Central Connecticut Coast (PHC 10/06)
Eastern Highlands (ACHIEVE 3/09)
New London (ACHIEVE 3/09)
Northeast District (ACHIEVE 3/09)
West Hartford (REACH 10/07)

DELAWARE

Statewide (PHC 10/04)
Seaford (ACHIEVE 2/11)

FLORIDA

Clearwater (PHC 10/05)
Daytona Beach (ACHIEVE 2/11)
Fort Lauderdale (PHC 2/11)
Hillsborough County – Tampa (SAH 10/09)
Hillsborough County – Tampa (Steps 10/04)
Jacksonville (ACHIEVE 2/11)
Manatee County (ACHIEVE 2/10)
Miami-Dade County (CPPW 3/10)
North Miami (ACHIEVE 3/09)
Orange County (CPPW 3/10)
Palm Beach County (ACHIEVE 3/09)
Pinellas County (CPPW 9/10)
Pinellas County – St. Petersburg (Steps 10/03)
Tallahassee (ACHIEVE 2/10)
Tampa (PHC 10/04)
Venice (ACHIEVE 3/09)
Winter Park (ACHIEVE 2/10)

GEORGIA

Atlanta (REACH 10/07)
Augusta (ACHIEVE 2/11)
Dalton (ACHIEVE 2/11)
DeKalb County (CPPW 9/10)
DeKalb County (CPPW 3/10)
DeKalb County (Steps 10/04)
DeKalb County – Atlanta (SAH 10/08)
Moultrie (PHC 10/09)
Savannah (PHC 10/08)

HAWAII

Honolulu (PHC 10/09)
Honolulu (REACH 10/07)
Kauai (CPPW 3/10)
Maui (CPPW 3/10)
Waianae (REACH 10/07)
Wailuku (PHC 2/11)

IDAHO

Boise (PHC 10/04)

ILLINOIS

Bloomington (ACHIEVE 2/10)
Chicago (CPPW 9/10)
Chicago (CPPW 3/10)
Chicago (ACHIEVE 3/09)
Chicago (REACH 10/07)
Cook County (CPPW 3/10)
Cook County (ACHIEVE 3/09)
DeKalb (PHC 2/11)
Elgin (PHC 10/06)
Quad Cities in IL & IA (PHC 10/06)
Rock Island (PHC 2/11)
Rockford (PHC 10/07)
St. Clair County (PHC 10/08)

INDIANA

Bartholomew County (CPPW 3/10)
Bloomington (ACHIEVE 3/09)
East Chicago (REACH 10/07)
Evansville (PHC 10/09)
Fort Wayne (PHC 10/06)
Frankfort (ACHIEVE 2/11)
Lawrence (Indianapolis) (PHC 10/08)
Noble County (PHC 10/09)
Vanderburgh County (CPPW 3/10)

IOWA

Black Hawk County (ACHIEVE 1/08)
Davenport (ACHIEVE 3/09)
Des Moines (PHC 10/04)
Des Moines County (PHC 2/11)
Linn County (CPPW 3/10)
Marshalltown (PHC 10/05)
Quad Cities in IA & IL (PHC 10/06)
Ringgold County (CPPW 3/10)

KANSAS

Lawrence (REACH 9/10)
Topeka (PHC 10/08)
Wichita (ACHIEVE 1/08)

KENTUCKY

Ashland (ACHIEVE 2/10)
Frankfort (ACHIEVE 2/11)
Greater Louisville (PHC 10/06)
Hopkinsville (ACHIEVE 2/11)
Jefferson County – Louisville (CPPW 3/10)
Lexington (PHC 10/05)
Manchester (ACHIEVE 2/11)

LOUISIANA

New Orleans (REACH 9/10)
New Orleans (Steps 10/03)
Shreveport (PHC 10/05)

MAINE

Casco Bay (ACHIEVE 2/10)
Hancock County (ACHIEVE 1/08)
Healthy Lakes (CPPW 3/10)
Mid Coast Maine (PHC 10/06)
Penobscot Bay (ACHIEVE 2/10)
Portland (CPPW 3/10)

MARYLAND

Annapolis (ACHIEVE 2/11)
Greenbelt (ACHIEVE 2/11)
Mid-Delmarva (PHC 10/06)

MASSACHUSETTS

Attleboro (PHC 10/05)
Boston (CPPW 3/10)
Boston (REACH 10/07)
Boston (SAH 10/09)
Boston (Steps 10/03)
Brockton (PHC 2/11)
Chelsea (ACHIEVE 2/10)
Dorchester (REACH 10/07)
Hockomock Region (PHC 10/07)
Lawrence (REACH 10/07)
New Bedford (ACHIEVE 3/09)
Springfield (ACHIEVE 2/10)
Worcester (PHC 10/08)

MICHIGAN

Ann Arbor (PHC 10/07)
Augusta (PHC 2/11)
Battle Creek (PHC 10/07)
Belleville (ACHIEVE 2/11)
Calhoun County (PHC 2/11)
Delta and Menominee Counties (ACHIEVE 2/10)
Flint (REACH 10/07)
Greater Cadillac Area (PHC 10/09)
Greater Kalamazoo Area (PHC 10/09)
Ingham County (ACHIEVE 2/10)
Inter-Tribal Council of Michigan (consortium of Michigan's federally recognized tribes) (REACH 10/07)
Inter-Tribal Council of Michigan (Steps 10/03)
Marquette County (ACHIEVE 2/10)
Muskegon (ACHIEVE 3/09)
Okemos (REACH 9/10)
Saginaw (ACHIEVE 3/09)
Sault Sainte Marie Tribe of Chippewa Indians (SAH 10/08)
West Michigan (Grand Rapids) (PHC 10/05)

MINNESOTA

Albert Lea (PHC 10/09)
Duluth (PHC 10/09)
Itasca County (PHC 10/07)
Marshall (PHC 10/05)
Minneapolis (REACH 9/10)
Minneapolis (CPPW 3/10)
Minneapolis (Steps 10/04)
Moorhead (and Fargo, ND) (PHC 10/07)
Olmstead County (CPPW 3/10)
Olmsted County – Rochester (Steps 10/04)
Pipestone (ACHIEVE 2/10)
Ramsey County – St. Paul (Steps 10/04)
Red Wing (PHC 10/08)
Willmar (ACHIEVE 2/10)
Willmar (Steps 10/04)

MISSISSIPPI

Forrest and Lamar Counties (ACHIEVE 3/09)

MISSOURI

Fulton (PHC 10/09)
Greene County – Springfield (PHC 10/05)
Kahoka (ACHIEVE 2/11)

Neosho (PHC 10/08)
O'Fallon (ACHIEVE 3/09)
Putnam County (ACHIEVE 2/10)
St. Joseph (PHC 10/09)
St. Louis (REACH 9/10)
St. Louis (PHC 10/04)
St. Louis County (CPPW 3/10)

MONTANA

Helena (ACHIEVE 2/11)
Yellowstone County (ACHIEVE 3/09)

NEBRASKA

Douglas County (CPPW 3/10)
Hastings (ACHIEVE 2/10)
Lincoln (PHC 10/05)
Omaha (PHC 10/07)

NEVADA

Clark County (CPPW 9/10)
Clark County (CPPW 3/10)
Washoe County (ACHIEVE 2/10)

NEW HAMPSHIRE

Concord (ACHIEVE 2/11)

NEW JERSEY

Burlington County (PHC 10/09)
Flemington (PHC 10/09)
Morristown (ACHIEVE 2/10)
Rahway (PHC 10/06)
Summit (ACHIEVE 2/11)
Sussex County (PHC 10/08)
Ocean County (ACHIEVE 2/11)
Woodbridge (PHC 10/07)

NEW MEXICO

Albuquerque (ACHIEVE 1/08)
Lordsburg (REACH 10/07)
Pueblo of Jemez (CPPW 3/10)

NEW YORK

Albany County (SAH 10/08)
Brooklyn (PHC 2/11)
Brooklyn (REACH 10/07)
Broome County (SAH 10/08)
Broome County (Steps 10/03)

Chautauqua County (Steps 10/03)
Clinton County (ACHIEVE 3/09)
East Harlem (PHC 10/07)
Jefferson County (Steps 10/03)
Mt. Morris (ACHIEVE 2/11)
New York City (CPPW 3/10)
New York City (REACH 10/07)
New York City (SAH 10/08)
Orange County (SAH 10/08)
Rochester (PHC 10/04)
Rockland County (ACHIEVE 3/09)
Rockland County (Steps 10/03)
Rye (PHC 10/05)
Salamanca (ACHIEVE 1/08)
Schenectady County (REACH 9/10)
Schenectady County (SAH 10/08)
Syracuse (ACHIEVE 2/10)

NORTH CAROLINA

Alleghany/Ashe/Watauga Counties (CPPW 9/10)
Asheville Area (PHC 10/07)
Belmont (ACHIEVE 3/09)
Cabarrus County (ACHIEVE 2/10)
Charlotte (PHC 10/05)
Cleveland County (ACHIEVE 1/08)
Columbus (ACHIEVE 2/10)
Eastern Band of Cherokee Indians (REACH 10/07)
Goldsboro (PHC 2/11)
Guilford County (PHC 10/09)
Hickory (ACHIEVE 2/11)
Lexington (ACHIEVE 2/11)
Mecklenburg County (ACHIEVE 3/09)
Pitt County (CPPW 9/10)
Raleigh (REACH 9/10)
Shiloh (PHC 2/11)
Winston-Salem (PHC 10/08)

NORTH DAKOTA

Bismarck (ACHIEVE 2/11)
Fargo (and Moorhead, MN) (PHC 10/07)
Grand Forks (ACHIEVE 2/11)
Valley City (ACHIEVE 2/10)

OHIO

Butler County (ACHIEVE 3/09)
Champaign County (PHC 10/06)
Cincinnati (PHC 10/08)

Cleveland (PHC 10/06)
 Cleveland (REACH 10/07)
 Cleveland (Steps 10/04)
 Columbus (ACHIEVE 2/11)
 Defiance (PHC 10/09)
 Delaware (ACHIEVE 2/11)
 Hamilton County (CPPW 3/10)
 Hamilton County – Cincinnati (SAH 10/08)
 Lake County (ACHIEVE 3/09)
 Lima (PHC 2/11)
 Marietta (PHC 10/08)
 Miamisburg (ACHIEVE 2/11)
 Stark County (ACHIEVE 1/08)

OKLAHOMA

Cherokee Nation (CPPW 3/10)
 Cherokee Nation (SAH 10/08)
 Cherokee Nation (Steps 10/04)
 Choctaw Nation (REACH 10/07)
 Oklahoma City (PHC 10/09)
 Oklahoma City (REACH 10/07)
 Tulsa (ACHIEVE 2/10)
 Tulsa (PHC 10/05)

OREGON

Columbia County (ACHIEVE 3/09)
 Eugene (ACHIEVE 2/11)
 Grants Pass (PHC 10/09)
 Jefferson County (ACHIEVE 3/09)
 Multnomah County (CPPW 3/10)
 Multnomah County (ACHIEVE 3/09)

PENNSYLVANIA

Allentown (ACHIEVE 1/08)
 Chester County – Brandywine Valley (PHC 10/05)
 Fayette County (Steps 10/04)
 Luzerne County (Steps 10/04)
 Philadelphia (CPPW 3/10)
 Philadelphia (PHC 10/09)
 Philadelphia (REACH 10/07)
 Philadelphia (Steps 10/03)
 Pittsburgh (ACHIEVE 2/10)
 Pittsburgh (PHC 10/04)
 Tioga County (Steps 10/04)
 Uniontown (ACHIEVE 3/09)
 Wilkes-Barre (ACHIEVE 3/09)
 York (ACHIEVE 2/10)

PUERTO RICO

Coamo (ACHIEVE 2/10)

RHODE ISLAND

Newport (ACHIEVE 2/10)
 Providence (CPPW 3/10)
 Providence (PHC 10/07)
 South Providence (PHC 2/11)

SOUTH CAROLINA

Charleston (REACH 10/07)
 Chesterfield/Darlington/Hartsville (PHC 10/07)
 Columbia (ACHIEVE 3/09)
 Florence County (CPPW 3/10)
 Greater Greenville (PHC 10/05)
 Greenville County (ACHIEVE 3/09)
 Horry County (CPPW 3/10)
 Kershaw County (ACHIEVE 3/09)
 North Charleston (ACHIEVE 2/10)
 Rock Hill (ACHIEVE 2/11)
 Spartanburg (ACHIEVE 2/11)
 statewide (CPPW 9/10)

SOUTH DAKOTA

Pierre (ACHIEVE 3/09)
 Rapid City (PHC 10/05)

TENNESSEE

Davidson County – Nashville (CPPW 3/10)
 Jackson (ACHIEVE 2/10)
 Knoxville (PHC 2/11)
 McMinnville (ACHIEVE 2/10)
 Memphis (PHC 10/06)
 Milan (ACHIEVE 2/11)
 Nashville (PHC 10/08)

TEXAS

Bexar County – San Antonio (Steps 10/04)
 Corpus Christi (ACHIEVE 2/11)
 Dallas (PHC 10/04)
 El Paso (ACHIEVE 2/10)
 Harris County – Aldine (ACHIEVE 1/08)
 Nacogdoches (ACHIEVE 3/09)
 San Antonio (CPPW 3/10)
 Tarrant County – Fort Worth (PHC 10/05)
 Travis County – Austin (CPPW 3/10)

Travis County – Austin (Steps 10/03)
Williamson County (ACHIEVE 3/09)

UTAH

Salt Lake City (PHC 2/11)
St. George (ACHIEVE 2/10)

VERMONT

Burlington (PHC 10/08)
Rutland (ACHIEVE 2/11)
Windham County (PHC 10/09)

VIRGINIA

Accomack County (ACHIEVE 2/10)
Alexandria (ACHIEVE 3/09)
Arlington (ACHIEVE 2/10)
Lynchburg (ACHIEVE 2/11)
Portsmouth (ACHIEVE 2/10)
Richmond (REACH 10/07)

WASHINGTON

Chelan/Douglas/Okanogan Counties (Steps 10/03)
Clark County (Steps 10/03)
Colville Confederated Tribes (Steps 10/03)
Island County (ACHIEVE 3/09)
King County – Seattle (CPPW 3/10)
King County – Seattle (Steps 10/03)
Klickitat County (ACHIEVE 3/09)
Longview (ACHIEVE 3/09)
Lynnwood (ACHIEVE 3/09)
Marysville (PHC 10/07)
Pierce County – Tacoma (ACHIEVE 1/08)

Olympic Peninsula (ACHIEVE 2/11)
Seattle (PHC 10/04)
Seattle (REACH 10/07)
Shelton (ACHIEVE 2/11)
Spokane (PHC 10/07)
Thurston County (Steps 10/03)
Union Gap (ACHIEVE 2/11)
Whatcom County (ACHIEVE 3/09)

WASHINGTON, D.C.

(CPPW 3/10)

WEST VIRGINIA

Charleston (REACH 10/07)
Mid-Ohio Valley (CPPW 3/10)
Statewide (PHC 10/04)

WISCONSIN

Dane County – Madison (PHC 10/05)
Eau Claire (ACHIEVE 2/10)
Fox Cities (PHC 10/06)
Great Lakes Inter-Tribal Council (CPPW 3/10)
LaCrosse County (CPPW 3/10)
LaCrosse (PHC 10/07)
Milwaukee (PHC 10/04)
Polk County (ACHIEVE 2/10)
West Bend (PHC 10/08)
Wood County (CPPW 3/10)

WYOMING

Casper (ACHIEVE 2/10)
Northern Arapaho Tribe (REACH 10/07)

Appendix C

Key Data Resources

The section below outlines the key data resources available to you as you begin shaping and bolstering your policy recommendations and messages with data. Please note there are many resources available. Feel free to contact us for assistance in navigating through the different sources.

In outlining available data on childhood obesity, it is worthwhile to first consult two of the most comprehensive resources for childhood obesity data: the National Survey of Children’s Health (NSCH) and the Youth Risk Behavior Survey (YRBS). Beyond data on obesity prevalence, as measured by BMI, the NSCH and YRBS provide rich data on many domains related to risk factors, impacts of obesity, and local responses. Similar data is available in other resources, and there are many additional contextual variables not available in the NSCH or YRBS. However, reviewing this list (Table 1) will help you recognize the “core” data for obesity assessment and advocacy.

Descriptions of these datasets and indicators are below. A major limitation of these data is that they are generally not available below the state level, e.g. at the level of your city, county, or community. For additional data sources and sources below the state level, proceed to the “Additional data resources” section.

National Survey of Children’s Health (NSCH)

The NSCH was sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration and administered by the National Center for Health Statistics at the CDC. The NSCH is a national survey which collected information on nearly 100,000 children in both 2003 and 2007. The survey examined the physical and emotional health of children ages 0-17. Although information is available through other surveys on the physical and emotional health, the purpose of this survey was to collect data on the target population, as well as obtain both sufficient national and state-level sample sizes so that data could be meaningfully compared nationally and across states. Special emphasis was placed on factors that may relate to children’s well-being, including family interactions, parental health, school and after-school experiences, and safe neighborhoods. Where possible, questions from existing surveys were used to allow for comparisons across databases. Data were collected through telephone interviews with a parent of a child selected from the household between the ages of 0-17. Details regarding the data definitions and parameters are included below:

- o **BMI:** Self-reported height and weight.
- o **Nutrition:** Breastfeeding, family eating habits, receive free or reduced-price school breakfast or lunch, concerns about eating disorders, food stamps, WIC, TANF/ADC/AFDC.
- o **Physical Activity:** Participation in heavy and light physical activities (i.e., bike, scooter, skateboard, roller skates, roller blades), participation in physical activities for at least 20 minutes, computer/video game usage and television watching habits, family rules about TV watching.
- o **Geocode:** State
- o **Fact sheet:** NICHQ (CPRC + CAHMI)
http://www.nichq.org/online_communities/coan/document_download.html
- o **Drill-down data:** (Data Resource Center) <http://www.childhealthdata.org/content/Default.aspx>

Youth Risk Behavior Survey (YRBS)

The CDC developed the cross-sectional school-based YRBS in 1990 in order to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth in the United States as well as monitor the progress toward achieving the Healthy People 2010 objectives and other program indicators. These behaviors include dietary behaviors; physical activity; tobacco, alcohol, and drug use; sexual behaviors; and violence. The YRBS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students. These surveys are conducted every two years (starting in 1991), usually during the spring semester. The state and local surveys, conducted by departments of health and education, provide data representative of public and private high school students in each state or local school district. The YRBS also includes additional national surveys conducted by CDC, such as The Youth Risk Behavior Survey, conducted in 1992 as a follow up to the National Health Interview Survey among nearly 11,000 persons aged 12–21 years old. Not all states participate. For example, in 2005, California, Louisiana, Minnesota, Pennsylvania, Virginia, and Washington did not participate. The YRBS contains basic questions regarding the frequency of consumption of fruit, vegetables, and milk. However, these questions were added in varying years and, therefore, do not allow for the examination of consistent trends over time. Full details regarding data parameters and measures are included below:

- **BMI:** Self-reported height and weight.
- **Nutrition:** Frequency of consumption of fruit, vegetables, and milk, dietary behaviors.
- **Physical activity:** Physical activity (level and amount spent on vigorous/moderate PA), participation in physical education classes and sports teams, strength exercises, exercises to lose/maintain weight.
- **Geocode:** Public use: state for schools.
- **Fact sheet:** Focus on students and schools + School Health Policies and Programs Study
<http://www.cdc.gov/HealthyYouth/obesity/facts.htm>
- **Drill down data:** (Youth Online) <http://apps.nccd.cdc.gov/yrbss/>

State and Large Urban School District Fact Sheets from the CDC are quickly available reports which synthesize findings from multiple data sources. These fact sheets combine results from the 2007 state and district YRBS and 2008 state and district profiles to identify the percent of high school students who are obese, engage in unhealthy dietary behaviors, or are physically inactive. They also describe state and local characteristics of health education, physical education, opportunities for physical activity, and the school environment among middle and high schools that may help address the problem.

Table 1. Key Indicators in the NSCH and YRBS

Risk	Impact	Response
Physical Activity	Physical Health	Education
PA 20 min	Chronic illnesses	Afterschool participation
TV/Video 0-5 y/o	Asthma	PE 3 days
TV/Video 6-17 y/o	Diabetes (national only)	PE 40 min
Sports teams	Mental Health	Healthcare
PA 60 min	Mental/emotional conditions	Preventive medical care
TV viewing	Socio-emotional difficulties	Provider spent enough time
Video games	Feel sad	Coordination of care
Nutrition	Difficulty concentrating, getting along	Access to care (qualitative)
Breastfeeding	Youth risk behaviors	BMI as clinical tool (qualitative)
Soda, Milk, Fruit-vegetables, Snacks	Perceptions of body weight	Provider training in obesity (qualitative)
Family	Youth trying to lose weight	
Single headed households	Exercise and diet to lose weight	
O/O and family stress, parental difficulty, family relationships, conflict	Extreme weight loss methods	
Frequency of family meals	Stigma of obesity (qualitative)	
Parent PA	Hidden aspect of obesity (qualitative)	
Need for parent education and inclusion in programs (qualitative)	Youth suicide	
Community	School performance	
Feel safe in your community or neighborhood		
Feel safe at school		Color Key
Sidewalks or walking paths		National Survey of Children's Health
Park or playground area		Youth Risk Behavior Survey
Safe neighborhoods		Both NSCH and YRBS
Recreation center, community center, or boys' or girls' club		

ADDITIONAL DATA RESOURCES

There are well over 50 different existing national datasets which could provide relevant information for childhood obesity advocacy. However, many of these data allow for only nationally-representative estimates, have limited direct and actionable measures of obesity, nutrition and physical activity, have no recent data available, or are not freely and publically available. As well, there are many resources unique to individual states and jurisdictions, such as state-sponsored surveys. Table 2 lists those data which provide at least state-level estimates for most if not all states, have some direct and actionable measures related to obesity, and are freely and publically available. The datasets are evaluated based on the quantity and quality of indicators available.

Each resource listed in table 2 offers unique parameters for advocating against obesity. For example, CDC's Diabetes Indicators and Data Sources Internet Tool allows point-and-click county-level mapping of (adult) obesity prevalence. Walkscore.com provides a score of neighborhood walkability, accounting for proximity to neighborhood amenities including food stores and public transit. Table 3 provides links to the resources

and comments on important features. All of these resources are readily and freely available in some form on the Internet.

TABLE 2. ADDITIONAL DATA RESOURCES FOR CHILDHOOD OBESITY ADVOCACY

Data source	Smallest geo-level	Indicators			Most recent year
		Obesity prevalence	Nutrition	Physical Activity	
Food Environment Atlas	County-MSA	+	+++	+++	Varies
PedNSS	County	+	+		2007
PNSS	State		+		2007
School Health Profiles	State		+++	+++	2008
ACS	City, School District		+	+	2008
Walkscore.com	Address		+	+	2010
NHTS	Census tract			++	2009
CDC-DIDIT	County	+	+	+	2007
FARS	County			+	2008

Ratings are as based on the quantity and quality of indicators.

+++ Estimates with standard deviation and confidence intervals, direct nutrition and physical activity measures

++ Direct or proxy measures of risk factors and outcomes

+ Indirect measures, environmental risk factors or outcomes

PedNSS=Pediatric Nutrition Surveillance System, PNSS=Pregnancy Nutrition Surveillance System, ACS=American Community Survey NHTS=National Household Transportation Survey, CDC=Centers for Disease Control, FARS=Fatality Analysis Reporting System

TABLE 3. ADDITIONAL DATA RESOURCES, LINKS

Data source	Link
Food Environment Atlas	http://maps.ers.usda.gov/FoodAtlas/
PedNSS	http://www.cdc.gov/PEDNSS/
PNSS	http://www.cdc.gov/PEDNSS/
School Health Profiles	http://www.cdc.gov/healthyYouth/profiles/
ACS	http://www.census.gov/acs/www/
Walkscore.com	http://www.walkscore.com/
NHTS	http://nhts.ornl.gov/
CDC-DIDIT	http://apps.nccd.cdc.gov/ddtstrs/
FARS	http://www-fars.nhtsa.dot.gov/Main/index.aspx

COUNTY HEALTH RANKINGS

The *County Health Rankings by Mobilizing Action Toward Community Health (MATCH)* shows us that where we live matters to our health. The health of a community depends on many different factors – ranging from individual health behaviors, education and jobs, to quality of health care, to the environment. This first-of-its-kind collection of 50 reports – one per state – helps community leaders see that where we live, learn, work, and play influences how healthy we are and how long we live. The state rankings were developed by Robert Wood Johnson Foundation in collaboration with the University of Wisconsin Population Health Institute to develop these Rankings for each state’s counties. For more information, visit:

<http://www.countyhealthrankings.org/>

FOOD ENVIRONMENT ATLAS

The Atlas assembles statistics on three broad categories of food environment factors:

- Food Choices—Indicators of the community's access to and acquisition of healthy, affordable food, such as: access and proximity to a grocery store; number of food stores and restaurants; expenditures on fast foods; food and nutrition assistance program participation; quantities of foods eaten; food prices; food taxes; and availability of local foods
- Health and Well-Being—Indicators of the community’s success in maintaining healthy diets, such as: food insecurity; diabetes and obesity rates; and physical activity levels
- Community Characteristics—Indicators of community characteristics that might influence the food environment, such as: demographic composition; income and poverty; population loss; metro-nonmetro status; natural amenities; and recreation and fitness centers

The Atlas currently includes 90 indicators of the food environment. The year and geographic level of the indicators vary to better accommodate data from a variety of sources. Some data are from the last Census of Population in 2000 while others are as recent as 2009. Some are at the county level while others are at the State or regional level. The most recent county-level data are used whenever possible.

PEDIATRIC NUTRITION SURVEILLANCE SYSTEM (PEDNSS)

The majority of PedNSS records (83.5%) are from the WIC Program, while other programs include Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT), Title V Maternal and Child Health Program (MCH), and other programs (including Head Start). It uses already available data collected on infants and children who visit public health clinics for routine care, nutrition education, and supplemental foods. These primarily include health, nutrition, and food assistance programs for infants and children, such as the Women, Infants, and Children Supplemental Food Program (WIC); Early Periodic Screening, Diagnosis and Treatment (EPSDT); and clinics funded by Maternal and Child Health Program (MCH) Block Grants. The PedNSS is designed as a child-based public health surveillance system to monitor the nutritional status of low-income infants, children, and women in federally funded maternal and child health and nutrition programs. The surveillance system was initiated in 1973 in five states and by 2006 has expanded to include 40 states, 1 territory, 5 Indian Tribal Organizations, and the District of Columbia collecting information on 7,600,000 children below the age of 5 years old. State health departments that choose to participate in the PedNSS submit data to CDC on a monthly basis. Data are sent to CDC on computer tapes or disks. Monthly reports listing children at high nutritional risk and reported errors are sent back to surveillance participants. Data are collected on socio-demographic variables (ethnicity/race, age, and geographic location), birth weight, anthropometric indices (height/length, weight), iron status (hemoglobin and/or hematocrit), breastfeeding, and health risk behaviors (TV/Video viewing, smoking in the household). PedNSS also provides a framework for tabulating and interpreting state-specific information on the nutritional

characteristics of low-income children. These data can be used to identify prevalent nutrition-related problems; identify high risk groups; monitor trends; target resources for program planning; and evaluate the effectiveness of interventions. These surveillance data also can be used for program planning, management, and evaluation; for the development of health and nutrition interventions; and to monitor progress toward the Healthy People 2010 objectives for the United States. Data details are below:

- **BMI:** Measured height and weight.
- **Nutrition:** Initiation and duration of breastfeeding.
- **PA:** TV/Video viewing.
- **Geocode:** State and county.

PREGNANCY NUTRITION SURVEILLANCE SYSTEM (PNSS)

The PNSS is directed by the CDC. It is a program-based public health surveillance system which is collected annually and is designed to monitor risk factors associated with infant mortality and poor birth outcomes among low-income pregnant women who participate in two federally funded public health programs for nutrition surveillance, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Title V Maternal and Child Health Program (MCH). The PNSS started in 1979 with 5 participating states and 10,000 surveillance records, and has been growing ever since. In 2006, 26 states, 1 U.S. territory, and 5 Indian Tribal Organizations contributed data, representing approximately 1,100,000 women. The data include information on maternal health indicators (pre-pregnancy weight status, maternal weight gain, parity, inter-pregnancy intervals, anemia, diabetes, and hypertension during pregnancy), maternal behavioral indicators (medical care, WIC enrollment, multivitamin consumption, smoking, and drinking), and infant health indicators (birth weight, preterm births, full term low-birth weight, and breastfeeding initiation). One of the limitations of the data is that they are not nationally representative, as contributing states, U.S. territories, and tribal governments participate voluntarily in the PNSS. Similarly, PNSS is not representative of all low-income pregnant women or pregnant women in the general population. Data details are below:

- **BMI:** pre-pregnancy BMI, gestational (i.e. maternal) weight gain, baby's birth weight.
- **Nutrition:** infant feeding, WIC enrollment, multivitamin consumption, smoking and drinking.
- **PA:** n/a.
- **Geocode:** State and county

SCHOOL HEALTH PROFILES

The School Health Profiles (Profiles) is a system of surveys assessing school health policies and practices in states, large urban school districts, territories, and tribal governments. Profiles are conducted biennially by education and health agencies among middle and high school principals and lead health education teachers. Indicators include health education, physical education and activity, healthy and safe school environment, health services, school health coordination, and family and community involvement.

AMERICAN COMMUNITY SURVEY (ACS)

The American Community Survey (ACS) is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered decennial census program. The ACS collects and produces population and housing information every year instead of every ten years. Beginning with the 2005 ACS, and continuing every year thereafter, 1-year estimates of demographic, social, economic and housing characteristics are available for geographic areas with a population of 65,000 or more. This includes the nation, all states and the District of Columbia, all congressional districts, approximately 800 counties, and 500 metropolitan and micropolitan statistical areas, among others. In 2008, the ACS will release its first multiyear estimates based on ACS data collected

from 2005 through 2007. These 3-year estimates of demographic, social, economic and housing characteristics will be available for geographic areas with a population of 20,000 or more, including the nation, all states and the District of Columbia, all congressional districts, approximately 1,800 counties, and 900 metropolitan and micropolitan statistical areas, among others. For areas with a population less than 20,000, 5-year estimates will be available. The first 5-year estimates, based on ACS data collected from 2005 through 2009, will be released in 2010. Data on relevant to obesity include food stamps benefits and journey-to-work.

NATIONAL HOUSEHOLD TRANSPORTATION SURVEY

People in various fields outside of transportation use the NHTS data to connect the role of transportation with other aspects of our lives. Medical researchers use the data to determine crash exposure rates of drivers and passengers, including the elderly, who have heightened morbidity and mortality rates. Safety specialists study the accident risk of school-age children, particularly when they are traveling on their own by walking or biking. Social service agencies need to know more about how low-income households currently meet their travel needs.

The survey is used to examine:

- Travel behavior at the individual and household level
- The characteristics of travel, such as trip chaining, use of the various modes, amount and purpose of travel by time of day and day of week, vehicle occupancy, and a host of other attributes;
- The relationship between demographics and travel; and
- The public's perceptions of the transportation system.

WALKSCORE

Walk Score uses a patent-pending system to measure the walkability of an address. The Walk Score algorithm awards points based on the distance to the closest amenity in each category. If the closest amenity in a category is within .25 miles (or .4 km), we assign the maximum number of points. The number of points declines as the distance approaches 1 mile (or 1.6 km)—no points are awarded for amenities further than 1 mile. Each category is weighted equally and the points are summed and normalized to yield a score from 0–100. The number of nearby amenities is the leading predictor of whether people walk. The Walk Score may change as data sources are updated or the algorithm is improved.

CDC-DIDIT

The Diabetes Indicators and Data Sources Internet Tool (DIDIT) is a user-friendly web-based tool designed to support surveillance, epidemiology, and program evaluation activities of state diabetes control programs. The primary indicator - Age-Adjusted Estimates of the Percentage of Adults Who Are Obese - is automatically mapped Statewide by county. The tool provides data in trends or quartiles since 2004.

FATALITY ANALYSIS REPORTING SYSTEM (FARS)

The Fatality Analysis Reporting System (FARS) database contains a census of fatal crashes within the 50 states, the District of Columbia, and Puerto Rico. FARS data have been collected since 1975 and contain over 100 different data elements that characterize the crash, vehicle and people involved. The data are currently publicly available through 2003. Included in the data is information on accidents involving pedestrians and bicyclists, as well as information on the time and location of the crash. It is administered by the National Highway Traffic Safety Administration (NHTSA) at the US Department of Transportation.

MAKING THE BUSINESS CASE: COST DATA

Datasets such as PedNSS and FARS contain "transaction" data. Rather than surveying a sample of people, households or institutions, these datasets contain all records from a given population participating in a particular program. For example, PedNSS contains records from the Medicaid, Women Infants and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP) programs. The large size and detail in these datasets make them very powerful, especially where cost data is included. Another transaction source to consider is utilization data from clinics and hospitals. As a healthcare provider, you may have institutional access to these data. However, their utility depends on the accuracy of coding for obesity and co-morbid conditions. There are several resources with cost findings, included some in prepared reports. This includes recent resources such as Centers for Disease Control and Prevention *Overweight and Obesity, Economic Consequences* <http://www.cdc.gov/obesity/causes/economics.html> and projected such as *The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses*.^{vi} These reports used both transaction data and survey data such as the Medical Expenditure Panel Survey.

USE DATA FOR CONTEXT

Other resources specific to children can put obesity data into context. For example, KIDS Count (<http://datacenter.kidscount.org/>) has data available below the State level, in an easy to use online format. Though there are generally no measures of obesity, nutrition or physical data, there is a wealth of data on demographics, education, economic well-being, health, and safety and risky behaviors. The American Fact Finder (<http://factfinder.census.gov/home/saff/main.html?lang=en>) can provide much of the same data at a more granular level. The online Fact Finder tool queries data from the census and other large national surveys for population, housing, economic, and geographic data.

GOING LOCAL

Though some of the datasets already mentioned provide statistics below the State level, within States there are many unique data sources which will help in the advocacy effort. Many states and locales have surveys which are unique to their jurisdiction; these are often conducted by partnerships of government and academic institutions. State and Local health departments are the first stop for this sort of information. As well, many Health Departments will have data on schools. For example, in Northern Kentucky, the Health Department collects data on physical activity and nutrition practices in school as part of its annual school tobacco survey. In addition to health departments, school districts, planning agencies, universities and organizations often have access to or knowledge of unique local data.

IDENTIFYING ADDITIONAL RESOURCES

If the resources recommended here and found locally are not sufficient to support your advocacy effort, there are still many additional ones available. The trick is identifying those which are appropriate. There are several reports such as *Assessing Environmental Influences Associated with Diet, Physical Activity and Obesity: An Inventory of Existing Surveillance Systems*,^{vii} which may help.

APPLYING THE FINDINGS

Like datasets, there are many existing resources to help you apply the findings. One of the more practical sites is: Using Data to State Your Case at <http://www.healthpolicyguide.org/advocacy.asp?id=5209>.

DATA RESOURCES FOR PREVENTION OF OBESITY POLICY OPPORTUNITIES TOOL

	Indicators	NSCH	YRBS	FEA	PedNSS	PNSS	SHP	ACS	Walkscore	Other sources
5	5ST1: Increased Access to Healthy Food	consumption & availability of healthy food, education programs								PERSPCS, SNECPCS, SIPP/SPD, NSAF, CE, Nielsen
	5ST2: Limit Unhealthy Foods	consumption & availability of unhealthy foods								PERSPCS, SNECPCS, SIPP/SPD, NSAF, CE, Nielsen
	5ST3: Point of Purchase	availability of nutrition info								
	5ST4: Media Campaigns	presence of food marketing (healthy and unhealthy), contracts								Nielsen
	5ST5: Change Relative Pricing	tax rate on unhealthy foods, relative cost of healthy food, prevalence of mobile vending								Impacteen
2	2ST1: Restrict Screen Time	amount of screen time, availability of alternative activity, screen time in after-school and child care settings								
1	1ST1: Increased Access to Safe and Attractive Places for Physical Activity	amount of physical activity, availability of exercise opportunities, education programs, walkability								SIPP/SPD, NHTS, SRTS
	1ST2: Increase Physical Activity	amount of physical activity, health and wellness programming and marketing								SIPP/SPD, NHTS
0	OST1: Access to Healthy Beverages	consumption & availability of drinking water								PERSPCS, SNECPCS
	OST2: Limit Access to Unhealthy Beverages	consumption & availability of sugar-sweetened beverages								PERSPCS, SNECPCS
	OST3: Point of Purchase	availability of nutrition info								
	OST4: Media Campaigns	presence of beverage marketing (healthy and unhealthy), contracts								Nielsen
	OST5: Change Relative Pricing	tax rate on sugar-sweetened beverages, relative cost of healthy beverages								Impacteen
BF	OBFAST1: Breastfeeding Friendly	proportion breast-feeding, availability of lactation rooms and breaks								
BMI	BMIST1: Payment	reimbursement for monitoring and counseling services								MEPS
	BMIST2: BMI Screening	screening policy								

Appendix D

Glossary of Obesity Advocacy Terms

DISCLAIMER – These terms are provided as a resource to assist you in your advocacy efforts and do not necessarily reflect policy or endorsement of National Initiative for Child Healthcare Quality, American Academy of Pediatrics, or California Medical Association Foundation.

As Of Right: Zoning standards that are determined in advance of development and are self-enforcing. These types of development do not require special approval from a government agency.

Baby Friendly Hospital: A maternity facility can be designated 'baby-friendly' when it does not accept free or low-cost breast milk substitutes, feeding bottles or teats, and has implemented 10 specific steps to support successful breastfeeding. A baby- friendly hospital:

- Maintains a written breastfeeding policy
- Trains all staff in skills needed to implement this policy
- Informs all pregnant women about the benefits and management of breastfeeding
- Helps mothers initiate breastfeeding within one hour of birth
- Shows mothers how to breastfeed even if they are separated from their infants
- Gives infants no food or drink other than breast milk unless medically indicated
- Allows mothers and infants to remain together 24 hours a day
- Encourages unrestricted breastfeeding
- Gives no pacifiers or artificial nipples to breastfeeding infants
- Refers mothers to breastfeeding support groups

Beverage Contracts: Standard contracts, the most common type for schools, are signed between a school or school district and a bottler/distributor for a period of years. A standard contract facilitates the sale and marketing of beverages in schools and lays out the terms for compensation for the school/school district. These contracts are legal arrangements that integrate a school or school district into a beverage company's marketing strategy and, simultaneously, integrate a beverage company into a school/district's fundraising plan. Other contracts include: Request for Responses Contracts and Purchase Order Contracts.

Bike Lanes: As defined by the American Association of State Highway and Transportation Officials, portions of a roadway that have been designated by striping, signing, and pavement markings for the preferential or exclusive use of bicyclists.

Bike Routes: Cycling routes on roads shared with motorized vehicles or on specially marked sidewalks.

Body Mass Index (BMI): One of the most commonly used measures for defining overweight and obesity, calculated as weight in kilograms divided by height in meters squared.

Built Environment: Encompasses all of the man-made elements of the physical environment, including buildings, infrastructure, and other physical elements created or modified by people and the functional use, arrangement in space, and aesthetic qualities of these elements.

Calorie-Dense, Nutrient-Poor Foods: Foods and beverages that contribute few vitamins and minerals to the diet, but contain substantial amounts of fat and/ or sugar and are high in calories. Consumption of these foods, such as sugar-sweetened beverages, candy, and chips, may contribute to excess calorie intake and unwanted weight gain in children.

Child Nutrition Program: The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. The program was established under the National School Lunch Act, signed by President Harry Truman in 1946.

Coalition: A group of persons representing diverse public-or private-sector organizations or constituencies working together to achieve a shared goal through coordinated use of resources, leadership, and action.

Community Gardens: Any piece of land gardened by a group of people. It can be urban, suburban, or rural. It can be one community plot, or can be many individual plots. It can be at a school, hospital, or in a neighborhood. It can also be a series of plots dedicated to "urban agriculture" where the produce is grown for a market.

Competitive Foods and Beverages: All foods and beverages served or sold in schools that are not part of Federal school meal programs, including "à la carte" items sold in cafeterias and items sold in vending machines. As defined by the Institute of Medicine (2005), competitive foods and beverages typically are lower in nutritional quality than those offered by school meal programs.

Competitive Pricing: The principal vendor selection criterion used for cost containment is a competitive pricing standard to exclude high-priced vendors. States with this criterion require that vendors charge a "fair and competitive price." States differ in defining this price and in whether they use a competitive pricing criterion at application or in evaluating redemptions.

Complete Streets: Streets that support all users—motorists, bicyclists, pedestrians, transit users, young, old, and disabled—by featuring safe access along and across the street via sidewalks, bicycle lanes, wide shoulders, crosswalks, and other features. Complete streets enable safe, attractive, and comfortable access and travel.

Conditional Use Permit: A variance granted to a property owner that allows a use otherwise prevented by zoning, through a public hearing process. These permits allow a city or county to consider special uses of land that may be essential or desirable to a particular community but are not allowed as a matter of right within a zoning district. These permits can also control certain uses that could have detrimental effects on a community or neighboring properties. They provide flexibility within a zoning ordinance.

Connectivity: The directness of travel to destinations. Sidewalks and paths that are in good condition and without gaps can promote connectivity.

Counter-Advertising Media: The Recovery Act Communities Putting Prevention to Work- Community Initiative suggests using **media** as a key strategy to:

- Promote healthy foods/drinks and increase activity
- Restrict advertising and employ counter-advertising for unhealthy foods/drinks

Media can be a key element to increase awareness and motivation and can be used to promote healthy eating, portion size awareness, eating fewer calorie-dense, nutrient-poor foods and to raise awareness of weight as a health issue. High-frequency television and radio advertising, as well as signage, may stimulate

improvements in attitudes toward a healthy diet Counter-advertising media promote healthy foods/drinks/lifestyle in an attempt to counteract the barrage of marketing and media messaging for unhealthy products. This technique was used successfully to reach youth in the tobacco and alcohol prevention fields.

Density: Population per unit of area measure.

Dietary Guidelines For Americans: The Dietary Guidelines for Americans have been published jointly every 5 years since 1980 by the Department of Health and Human Services (HHS) and the Department of Agriculture (USDA). The Guidelines provide authoritative advice for people 2 years and older on how good dietary habits can promote health and reduce risk for major chronic diseases. They serve as the basis for federal nutrition assistance and nutrition education programs.

Discretionary Calories: The number of calories in one’s “energy allowance” after one consumes sufficient amounts of foods and beverages to meet one’s daily calorie and nutrient needs while promoting weight maintenance.

Eating Occasion: A single meal or snack.

Energy-Dense Foods: Foods that are high in calories.

Energy Density: The number of calories per gram in weight.

Environmental Change: An alteration or change to physical, social, or economic environments designed to influence people’s practices and behaviors.

Exactions: Requirements placed on developers as a condition of development approval, generally falling into two categories: impact fees (see below) or physical exactions such as dedication of land or provision of infrastructure. Exactions must be related to the expected impacts of a project. For example, new homes create the need for more parks and schools, and an exaction might dedicate land in the developer’s plans for more parks and schools.

Family Friendly Store Displays: When we shop, our purchases are influenced not only by what’s available and affordable, but also by how products are organized and advertised inside the store. The overall layout of the store affects what we buy. When high-sugar cereals are shelved at children’s eye level, parents are more likely to be pestered into choosing them over healthier breakfast options. When fruit and granola bars, rather than candy and chips, are stocked in the check-out lanes, people are much less likely to make an unhealthy, last-minute impulse buy.

Farm Bill: The Farm Bill sets overall U.S. agricultural policy and is usually renewed at 5-year intervals. It encompasses all federal policy related to commodities, price supports for certain crops, conservation, food safety, agricultural disaster assistance and much more.

Farm Stand: Multiple and single vendors that are not part of a licensed farmers market.

Farmer-Day: Any part of a calendar day spent by a farmer (vendor) at a farmers market (excluding craft vendors and prepared food vendors). The total number of annual farmer-days for a given farmers market is

based on the number of days that the farmers market is open in a year multiplied by the number of farm vendors at the market on a given day.

Farm To School: Farm to School brings healthy food from local farms to school children nationwide. The program teaches students about the path from farm to fork, and instills healthy eating habits that can last a lifetime. At the same time, use of local produce in school meals and educational activities provides a new direct market for farmers in the area and mitigates environmental impacts of transporting food long distances.

Farm To Hospital: The farm to hospital approach extends beyond local fruits and vegetables to include other sustainable and health-promoting food purchasing options such a focus on organic food, sustainably raised produce and meats, antibiotic free meat, and rBGH-free (recumbent Bovine Growth Hormone) dairy products. Farmers' markets on hospital grounds and community health promotion activities are also integral components of the farm to hospital model.

Food Access: The extent to which a community can supply people with the food needed for health. Communities with poor food access lack the resources necessary to supply people with the food needed for a healthy lifestyle. Availability of high quality, affordable food and close proximity to food stores increase food access.

Food Desert: "Food desert" means an area in the United States with limited access to affordable and nutritious food. Food deserts often exist in areas composed of predominantly lower-income neighborhoods and communities.

Form-Based Code: A method of regulating development to achieve a specific urban form. Form-based codes create a predictable public realm primarily by controlling physical form, with a lesser focus on land use, through city or county regulations.

Health Disparities: Differences in the incidence and prevalence of health conditions and health status between groups. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the social determinants or conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health.

Health Equity: *When* everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."

Health Inequities: When health disparities are the result of the systematic and unjust distribution of certain critical conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination).

Health Impact Assessment: Health impact assessment (HIA) is commonly defined as "a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population" HIA is

used to evaluate objectively the potential health effects of a project or policy before it is built or implemented.

Healthy Eating Environment: An environment that provides access to and encourages the consumption of healthy foods, as described by the Dietary Guidelines for Americans.

Healthier Foods And Beverages: As defined by Institute of Medicine (2005), foods and beverages with low energy density and low content of calories, sugar, fat, and sodium.

Home Zone: A residential street or group of streets that is designed to operate primarily as a space for social use. The needs of residents take priority over the needs of car drivers. Home zones are designed to be shared by pedestrians, playing children, bicyclists, and low-speed motor vehicles. Traffic-calming methods such as speed humps are avoided in favor of methods that make slower speeds more natural to drivers, rather than an imposition. Home zones encourage children’s play and neighborhood interaction and also increase road safety.

Impact Fee: A monetary exaction placed on developers related to the expected impacts of a project. For example, to lessen the effect of increased traffic at a new shopping center, a developer might be required to pay an impact fee that would be used for construction of a left-turn lane and traffic lights.

Joint Use Agreement: A joint use agreement (JUA) is a formal agreement between two separate government entities—often a school and a city or county—setting forth the terms and conditions for shared use of public property or facilities. JUAs can range in scope from relatively simple (e.g., opening school playgrounds to the public outside of school hours) to complex (allowing community individuals and groups to access all school recreation facilities, and allowing schools to access all city or county recreation facilities).

Largest School District Within a Local Jurisdiction: The school district that serves the largest number of students within a local jurisdiction.

Less Healthy Foods And Beverages: As defined by Institute of Medicine (2005), foods and beverages with a high content of calories, sugar, fat, and sodium, and low content of nutrients, including protein, vitamins A and C, niacin, riboflavin, thiamin, calcium, and iron.

Local Food: Practically speaking, local food production can be thought of in concentric circles that start with growing food at home. The next ring out might be food grown in our immediate community - then state, region, and country. For some parts of the year or for some products that thrive in the local climate, it may be possible to buy closer to home. At other times, or for less common products, an expanded reach may be required.

Local Government Facilities: Facilities owned, leased, or operated by a local government (including facilities that might be owned or leased by a local government but operated by contracted employees). For the purposes of this project, and according to the definition established by ICMA, local government facilities might include facilities in the following categories:

- 24-hour “dormitory-type” facilities: facilities that generally are in operation 24 hours per day, 7 days per week, such as firehouses (and their equipment bays), women’s shelters, men’s shelters, and

group housing facilities for children, seniors, and physically or mentally challenged persons, not including regular public housing;

- administrative/office facilities: general office buildings, court buildings, data processing facilities, sheriff's offices (including detention facilities), 911 centers, social service intake centers, day care/preschool facilities, historical buildings, and other related facilities;
- detention facilities: jails, adult detention centers, juvenile detention centers, and related facilities;
- health care facilities: hospitals, clinics, morgues, and related facilities;
- recreation/community center facilities: senior centers, community centers, gymnasiums, public parks and fields, and other similar recreation centers, including concession stands located at these facilities; and
- other facilities: water treatment plants, airports, schools, and all other facilities that do not explicitly fall into the categories listed above.

Low Energy Dense Foods And Beverages: Foods and beverages with a low calorie-per-gram ratio. Foods with a high water and fiber content are low in energy density, such as fruits, vegetables, and broth-based soups and stews.

Macronutrients: Nutrients needed in relatively large quantities, such as protein, carbohydrates, and fat.

Measure: For the purpose of this project, a measure is defined as a single data element that can be collected through an objective assessment of the physical or policy environment and used to quantify without bias an obesity prevention strategy.

Micronutrients: Nutrients needed in relatively small quantities, such as vitamins and minerals.

Mixed Land Use: A mixed land use development incorporates many sectors of a community, including retail, office, and residential. Communities with a balanced mix of land use give residents the option to walk, bike, or take transit to nearby attractions.

Mixed-Use Development: Zoning that combines residential land use with one or more of the following types of land use: commercial, industrial, or other public use.

Motivational Interviewing: Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

National School Lunch Program: The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. The program was established under the National School Lunch Act, signed by President Harry Truman in 1946.

Network Distance: Shortest distance between two locations by way of the public street network.

No Child Left Behind: The No Child Left Behind Act of 2001 (No Child Left Behind) is a landmark in education reform designed to improve student achievement and change the culture of America's schools. Enacted under President George W. Bush.

With passage of No Child Left Behind, Congress reauthorized the Elementary and Secondary Education Act (ESEA)--the principal federal law affecting education from kindergarten through high school. In amending *ESEA*, the new law represents a sweeping overhaul of federal efforts to support elementary and secondary education in the United States. It is built on four common-sense pillars: accountability for results; an emphasis on doing what works based on scientific research; expanded parental options; and expanded local control and flexibility.

No Child Left Inside: A movement thought to help address the childhood obesity problem by increasing the time students spend learning about nature, both in and outside the classroom.

Nonmotorized Transportation: Any form of transportation that does not involve the use of a motorized vehicle, such as walking and biking.

Nutrient-Dense Foods: Foods that provide substantial amounts of vitamins, minerals, and other health-promoting components such as fiber and relatively few calories. Foods that are low in nutrient density supply calories but no or small amounts of vitamins, minerals, and health-promoting components.

Nutrition Standards: Criteria that determine which foods and beverages may be offered in a particular setting (e.g., schools or local government facilities). Nutrition standards may be defined locally or adopted from national standards.

Obesity And Overweight: Children and adolescents are defined as obese if they have a body mass index (BMI) equal to or greater than the 95th percentile for their age and sex, and overweight if they have a BMI at the 85th percentile to less than the 95th percentile for their age and sex, according to growth charts (<http://www.cdc.gov/growthcharts>).

Partnership: A business-like arrangement that might involve two or more partner organizations.

Physical Activity: Body movement produced by the contraction of muscle that increases energy expenditure above the resting level.

Pocket Park: A small park frequently created on a vacant building lot or on a small, irregular piece of land, sometimes created as a component of the public space requirement of large building projects. Pocket parks provide greenery, a place to sit outdoors, and sometimes playground equipment. They may be created around a monument, historic marker, or art project.

Point Of Purchase Decision Making: Refers to labeling /signage/placement to increase consumption of healthy foods/drinks, and prompt physical activity. Example: Require menu labeling to assist families and individuals in making healthy choices when eating away from home. Another example is replacing unhealthy foods with healthy foods in prominent display areas such as checkout lines.

Policy: Laws, regulations, rules, protocols, and procedures designed to guide or influence behavior. Policies can be either legislative or organizational in nature.

Portion Size: The amount of a single food item served in a single eating occasion (e.g., a meal or a snack). Portion size is the amount (e.g., weight, caloric content, or volume) of food offered to a person in a

restaurant, the amount in the packaging of prepared foods, or the amount a person chooses to put on his or her plate. One portion of food might contain several USDA food servings.

Pricing Strategies: Intentional adjustment to the unit cost of an item (e.g., offering a discount on a food item, selling a food item at a lower profit margin, or banning a surcharge on a food item).

Public Recreation Facility: Facility listed in the local jurisdiction’s facility inventory that has at least one amenity that promotes physical activity (e.g., walking/hiking trail, bicycle trail, or open play field/play area).

Public Recreation Facility Entrance: The point of entry to a facility that permits recreation. For the purposes of this project, geographic information system (GIS) coordinates of the entrance to a recreational facility or the street address of the facility.

Public Service Venue: Facilities and settings open to the public that are managed under the authority of government entities (e.g., schools, child care centers, community recreational facilities, city and county buildings, prisons, and juvenile detention centers).

Public Transit Stop: Point of entrance to a local jurisdiction’s transportation and public street network, such as bus stops, light rail stops, and subway stations.

Quality Physical Education: Appropriate actions must be taken in four main areas to ensure a high quality physical education program: (1) curriculum, (2) policies and environment, (3) instruction, and (4) student assessment (5) healthy school environment; (6) counseling, psychological, and social services; (7) health promotion for staff; and (8) family and community involvement.

Policy and environmental actions that support high quality physical education require the following:

- Adequate instructional time (at least 150 minutes per week for elementary school students and 225 minutes per week for middle and high school students),
- All classes be taught by qualified physical education specialists,
- Reasonable class sizes, and
- Proper equipment and facilities.
- Instructional strategies that support high-quality physical education emphasize the following:
 - The need for inclusion of all students,
 - Adaptations for students with disabilities,
 - Opportunities to be physically active most of the class time,
 - Well-designed lessons,
 - Out-of-school assignments to support learning, and
 - Not using physical activity as punishment.
- Regular student assessment within a high-quality physical education program features the following:
 - The appropriate use of physical activity and fitness assessment tools,
 - Ongoing opportunities for students to conduct self-assessments and practice self-monitoring of physical activity,
 - Communication with students and parents about assessment results, and
 - Clarity concerning the elements used for determining a grading or student proficiency system.

Retrofit: Modification of infrastructure and facilities in existing areas of the community rather than the provision of infrastructure and facilities in new areas of development.

Road Diet: Involves reducing the amount of lanes in a road to include a bike lane and/or sidewalks. Road diets are intended to slow traffic and make the road safer for pedestrians and cyclists.

Safe Communities: According to the Leadership for Healthy Communities: Action Strategies Toolkit, keeping communities safe and free from crime encourage outdoor activity. Parents' perceptions of safety in their neighborhoods, from concerns about traffic to strangers, can determine the level of activity in which their children engage. Strategies identified to combat these issues include: street patrols, neighborhood watch groups, and community design and aesthetics.

Safe Routes to Schools: Communities use many different approaches to make it safer for children to walk and bicycle to school and to increase the number of children doing so. Programs use a combination of education, encouragement, enforcement and engineering activities to help achieve their goals.

School Siting: The process of locating schools and school facilities.

School Wellness Council: Many states require local School Wellness Councils or Health Advisory councils that are usually made up school staff, students, parents and community members and which implement the School Wellness Policy.

School Wellness Councils:

- Advise the school board/district on school/community health issues.
- Identify student/staff health needs.
- Monitor and evaluate implementation of school wellness policies.
- Support the school in developing a healthier school environment.
- Assist with policy development to support a healthy school environment.
- Plan and implement programs for students and staff.
- Tap into funding and resources for student and staff wellness.

School Wellness Policy: Section 204 of Public Law 108 – 265, the Child Nutrition and WIC Reauthorization Act of 2004, requires that every school district receiving funding through the National School Lunch and/or Breakfast Program develop a local wellness policy that promotes the health of students with a particular emphasis on addressing the growing problem of childhood obesity.

Screen (Viewing) Time: Time spent watching television, playing video games, and engaging in non-educational computer activities.

Shared-Use Paths: As defined by the American Association of State Highway and Transportation Officials, bikeways used by cyclists, pedestrians, skaters, wheelchair users, joggers, and other nonmotorized users that are physically separated from motorized vehicular traffic by an open space or barrier and within either the highway right-of-way or an independent right-of-way.

Sidewalk Network: An interconnected system of paved walkways designated for pedestrian use, usually located beside a street or roadway.

Street Network: A system of interconnecting streets and intersections for a given area.

Smart Growth: An approach to urban planning that is more town centered and transit and pedestrian oriented, and has a greater mix of housing, commercial, and retail uses. It also preserves open space and many other environmental amenities.

Social Environment: Includes interactions with family, friends, coworkers, and others in the community. It also encompasses social institutions, such as the workplace, places of worship, and schools. Housing, public transportation, law enforcement, and the presence or absence of violence in the community are among other components of the social environment. The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs; language; and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment (definition from *Healthy People 2010*).

Social Marketing: Using the same marketing principles that are used to sell Products to consumers to “sell” ideas, attitudes, and behaviors. Social marketing is often used to change health behaviors.

Stranger Danger: The perceived danger to children presented by strangers. The phrase is intended to sum up the various concerns associated with the threat presented by unknown adults.

Sugar-Sweetened Beverages: Beverages that contain added caloric sweeteners, primarily sucrose derived from cane, beets, and corn (high-fructose corn syrup), including non-diet carbonated soft drinks, flavored milks, fruit drinks, teas, and sports drinks.

Supermarket: A large, corporate-owned food store with annual sales of at least \$2 million.

Supplemental Nutrition Assistance Program (SNAP): SNAP helps low-income people and families buy the food they need for good health. You apply for benefits by completing a State application form. Benefits are provided on an electronic card that is used like an ATM card and accepted at most grocery stores. Through nutrition education partners, SNAP helps clients learn to make healthy eating and active lifestyle choices.

Traffic Calming: Measures that attempt to slow traffic speeds and increase pedestrian and bicycle traffic through physical devices designed to be self-enforcing. These include speed humps and bumps, raised intersections, road narrowing, bends and deviations in a road, medians, central islands, and traffic circle.

Transportation Equity Act: Every five to seven years, Congress updates and renews federal transportation policies. This legislation encompasses road-building and related improvements; airline, ship, and rail transportation issues; safety measures; transit and community design; and a range of other aspects of transportation policy.

Underserved Census Tract: Within metropolitan areas, a census tract that is characterized by one of the following criteria: (i) a median income at or below 120% of the median income of the metropolitan area and a minority population of 30% or greater; or (ii) a median income at or below 90% of median income of the metropolitan area. In rural, nonmetropolitan areas, the following criteria should be used instead: (i) a median income at or below 120% of the greater of the State nonmetropolitan median income or the nationwide non-metropolitan median income and a minority population of 30% or greater; or (ii) a median income at or below 95% of the greater of the State nonmetropolitan median income or nationwide nonmetropolitan median income (Department of Housing and Urban Development, 1995).

United States Federal Communications Commission (FCC): The FCC is charged with the regulation of broadcast television and has the authority to make rules “to assure that broadcasters operate in the public interest.” Special FCC rules designed to protect children require that broadcasters limit the amount of advertising shown during children’s programming (to no more than 10.5 minutes/hour on weekends and no more than 12 minutes/hour on weekdays); clearly separate program content from commercial messages; and distinguish when a program will transition to a commercial.

VERB Campaign: A national, multicultural, social marketing campaign to increase and maintain physical activity among tweens. It was coordinated by the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention and ran from 2002 to 2006.

Violent Crime: A legal offense that involves force or threat of force. According to the Federal Bureau of Investigation’s Uniform Crime Reporting (UCR) Program, violent crime includes murder, forcible rape, robbery, and aggravated assault http://www.fbi.gov/ucr/cius2007/offenses/violent_crime/index.html.

Walking School Bus: A walking school bus is a group of children walking to school with one or more adults.

Women Infants Children Program (WIC): WIC provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

Appendix E

Be Our Voice Online Resources

Obesity Fact Sheets

These Factsheets are a resource that makes relevant data more readily available to local advocates and decision makers. NICHQ's Obesity Factsheets provide the most recent national, state, and county-based data regarding childhood overweight and obesity prevalence and the environmental and behavioral factors that influence health. There are two kinds of Factsheets available: State Factsheets and County Factsheets (categorized by state).

http://www.nichq.org/advocacy/obesity_resources/obesity_rates_map.html

Resource Guide for Healthcare Professionals Interested in Advocating for Children's Health

The [Advocacy Resource Guide](#) (PDF) and [Advocacy Toolbox](#) (PDF) are designed to assist healthcare professionals to take a stand in their communities and workplaces to advocate for healthy eating and active living for children and their families. Whatever your level of time commitment, know that every effort you make is improving the health and wellbeing of children and families in your local area.

http://www.nichq.org/advocacy/obesity_resources/toolkit.html

Be Our Advocacy Training Curriculum

Hold a training to get other healthcare professionals involved in advocating for community change to impact the reversal of childhood obesity. By training others and building a coalition, your voice to advocate for children can be strengthened.

http://www.nichq.org/advocacy/advocate_training/hostatraining.html

Be Our Voice Self Study Resources and webinars

Self-study resources and webinars were developed through the BOV technical assistance calls from the sites. Choose the resources that best fit the needs in your community.

http://www.nichq.org/advocacy/advocate_training/selfstudy.html

View specific Web pages for each Be Our Voice site

The pages contain background information about each site's initiative, policy focus and a link to its customized Advocacy Resource Guide. To select the site use the left-hand navigation menu.

<http://www.nichq.org/advocacy/about/index.html>

Appendix F

Partnership Checklist

Structuring a successful partnership with other advocates and organizations rests on a number of key steps. As you begin or renew your work as a healthcare professional advocate, follow this check list to get you started.

- Match your interests with those of the partner organization you may work with. Make sure there is a fit between your interests and those of your partner organization.
- Be clear with your partner organization how much time you have available to do your advocacy work so that you can use the time wisely and for the greatest benefit.
- Share with the partner organization early on what you would like to see accomplished through your participation with the group.
- Ask the leaders of the organization how you can help them to achieve their goals and let them know the help and support you will need from them.
- Budget time to learn how your partner organization conducts its business so that you will know how decisions are made and can participate in an appropriate way.
- Let the organization know how best to reach you so they can communicate what the group is doing and reach out to you to check-in.
- Share your advocacy work and its importance with your staff and colleagues so that when requests to connect with you come to your office, the request gets to you.
- Respond to requests to learn what you are doing. This helps the group –
 - Keep track of its progress, including this information in reports to policy makers and others.
 - Evaluate its efforts and accomplishments.
 - Know how best to structure and target its advocacy focus.
- Don't wait to hear from the group. Share with them the advocacy steps you are taking on behalf of the organization.

Section 8 - References & Resources

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California Medical Association Foundation
3835 N. Freeway Blvd., Suite 100
Sacramento, CA 95834
(916) 779-6620
<http://thecmafoundation.org/>

**Robert Wood Johnson Foundation
Center to Prevent Childhood Obesity**

Robert Wood Johnson Foundation
Center to Prevent Childhood Obesity
Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543
(877) 843-RWJF (7953)
www.rwjf.org