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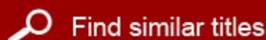

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CROSS-SECTOR RESPONSES TO OBESITY: MODELS FOR CHANGE

Steve Olson, *Rapporteur*

Roundtable on Obesity Solutions

Food and Nutrition Board

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

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

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PLANNING COMMITTEE ON CROSS-SECTOR WORK ON OBESITY PREVENTION, TREATMENT, AND WEIGHT MAINTENANCE: MODELS FOR CHANGE[1]

NICOLAS P. PRONK (*Chair*), HealthPartners, Inc., Minneapolis, Minnesota
DEBBIE I. CHANG, Nemours Foundation, Newark, Delaware
DAVID D. FUKUZAWA, The Kresge Foundation, Troy, Michigan
LISEL LOY, Bipartisan Policy Center, Washington, DC
AMELIE G. RAMIREZ, Salud America!, San Antonio, Texas
SYLVIA ROWE, SR Strategy, LLC, Washington, DC

IOM Staff

LYNN PARKER, Scholar
LESLIE J. SIM, Senior Program Officer
HEATHER DEL VALLE COOK, Program Officer
SARAH ZIEGENHORN, Research Associate
SARAH SIEGEL, Program Coordinator

Consultant

WILLIAM H. DIETZ, George Washington University, Washington, DC

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ROUNDTABLE ON OBESITY SOLUTIONS[1]

BILL PURCELL III (*Chair*), Jones Hawkins & Farmer, PLC, Nashville, Tennessee
RUSSELL R. PATE (*Vice Chair*), University of South Carolina, Columbia
MARY T. STORY (*Vice Chair*), Duke University, Durham, North Carolina
SHARON ADAMS-TAYLOR, American Association of School Administrators, Alexandria, Virginia
NELSON G. ALMEIDA, Kellogg Company, Battle Creek, Michigan
SHAVON ARLINE-BRADLEY, National Association for the Advancement of Colored People, Baltimore, Maryland
JEANETTE BETANCOURT, Sesame Workshop, New York, New York
CAPT HEIDI MICHELS BLANCK, Centers for Disease Control and Prevention, Atlanta, Georgia
DON W. BRADLEY, Duke University, Durham, North Carolina
CEDRIC X. BRYANT, American Council on Exercise, San Diego, California
HEIDI F. BURKE, Greater Rochester Health Foundation, Rochester, New York
DEBBIE I. CHANG, Nemours, Newark, Delaware
YVONNE COOK, Highmark, Inc., Pittsburgh, Pennsylvania
EDWARD COONEY, Congressional Hunger Center, Washington, DC
KITTY HSU DANA, United Way Worldwide, Alexandria, Virginia
CHRISTINA ECONOMOS, Tufts University, Boston, Massachusetts
GINNY EHRLICH, Robert Wood Johnson Foundation, Princeton, New Jersey
IHOUMA ENELI, American Academy of Pediatrics, Columbus, Ohio
DAVID D. FUKUZAWA, The Kresge Foundation, Troy, Michigan
LISA GABLE, Healthy Weight Commitment Foundation, Washington, DC
PAUL GRIMWOOD, Nestlé USA, Glendale, California
SCOTT I. KAHAN, George Washington University, Washington, DC
SHIRIKI KUMANYIKA, University of Pennsylvania, Philadelphia
CATHERINE KWIK-URIBE, Mars, Inc., Germantown, Maryland
THEODORE KYLE, The Obesity Society, Pittsburgh, Pennsylvania
MATT LONGJOHN, YMCA of the USA, Chicago, Illinois
LISEL LOY, Bipartisan Policy Center, Washington, DC
MARY-JO MAKARCHUK, Canadian Institutes of Health Research/ Instituts de researche en santé du Canada, Toronto, Ontario
LINDA D. MEYERS, American Society for Nutrition, Bethesda, Maryland

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SHELLIE PFOHL, President's Council on Fitness, Sports, and Nutrition, Rockville, Maryland
BARBARA PICOWER, The JPB Foundation, New York, New York
NICOLAS P. PRONK, HealthPartners, Inc., Minneapolis, Minnesota
AMELIE G. RAMIREZ, Salud America!, San Antonio, Texas
OLIVIA ROANHORSE, Notah Begay III Foundation, Santa Ana Pueblo, New Mexico
SYLVIA ROWE, SR Strategy, LLC, Washington, DC
JOSE (PEPE) M. SAAVEDRA, Nestlé Nutrition, Switzerland
JAMES F. SALLIS, University of California, San Diego
EDUARDO J. SANCHEZ, American Heart Association, Dallas, Texas
BRIAN SMEDLEY, National Collaboration for Health Equity, Washington, DC
LAWRENCE SOLER, Partnership for a Healthier America, Washington, DC
LOEL S. SOLOMON, Kaiser Permanente, Oakland, California
MARION STANDISH, The California Endowment, Oakland
ALISON L. STEIBER, Academy of Nutrition and Dietetics, Chicago, Illinois
MAHA TAHIRI, General Mills, Inc., Minneapolis, Minnesota
KATHLEEN TULLIE, Reebok, International, Canton, Massachusetts
TISH VAN DYKE, Edelman, Washington, DC
HOWELL WECHSLER, Alliance for a Healthier Generation, New York, New York
JAMES R. WHITEHEAD, American College of Sports Medicine, Indianapolis, Indiana
TRACY WIEDT, National League of Cities, Washington, DC

IOM Staff

LYNN PARKER, Scholar
LESLIE J. SIM, Senior Program Officer
HEATHER DEL VALLE COOK, Program Officer
SARAH ZIEGENHORN, Research Associate
SARAH SIEGEL, Program Coordinator
RENEE GETHERS, Senior Program Assistant (*from March 2015*)

Consultant

WILLIAM H. DIETZ, George Washington University, Washington, DC

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Reviewers

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

Adam B. Becker, Consortium to Lower Obesity in Chicago Children (CLOCC)
Kate McGrail, Institute for Public Health Innovation
M. Amalia Mendoza, Foundation for a Healthy Kentucky
Marion Standish, The California Endowment

Although the reviewers listed above provided many constructive comments and suggestions, they did not see the final draft of this workshop summary before its release. The review of this workshop summary was overseen by **Hugh Tilson**, University of North Carolina at Chapel Hill. Appointed by the Institute of Medicine, he was responsible for making certain that an independent examination of this workshop summary was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this workshop summary rests entirely with the rapporteur and the institution.

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1

Introduction[1]

Obesity affects 17 percent of children and adolescents and almost 36 percent of adults in the United States. Conservative estimates suggest that obesity now accounts for almost 20 percent of national health care spending (IOM, 2012). Until the obesity epidemic is reversed, obesity will continue to drive rates of chronic diseases such as heart disease, stroke, type 2 diabetes, and certain types of cancer (IOM, 2012).

For more than a decade, the Institute of Medicine (IOM) has made a major commitment to obesity prevention. This commitment has led to 10 consensus reports offering policy recommendations; more than a dozen workshop publications; and approximately 50 other briefs, action guides, infographics, and publications in this area.

In 2014, the IOM created the Roundtable on Obesity Solutions to engage leadership from multiple sectors in responding to the obesity crisis. Through meetings, public workshops, background papers, and other activities, the roundtable fosters an ongoing dialogue on critical and emerging issues in obesity prevention and treatment and weight maintenance while enhancing and accelerating the discussion, development, and implementation of solutions.

[1]The planning committee's role was limited to planning the workshop. This workshop summary was prepared by the rapporteur as a factual account of what occurred at the workshop (see Appendix A for the workshop agenda). Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the Institute of Medicine. They should not be construed as reflecting any group consensus.

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In its first workshop, which was held in January 2014 and is summarized in *The Current State of Obesity Solutions in the United States: Workshop Summary* (IOM, 2014), the roundtable examined initiatives in seven areas that could contribute to obesity prevention:

- early care and education,
- schools,
- worksites,
- health care institutions,
- communities and states,
- the federal government, and
- businesses and industry.

In its second workshop, which was held on September 30, 2014, and is summarized in the present report, the roundtable explored ways in which these and other sectors can work together to achieve more progress than would be possible with any sector working on its own. (Box 1-1 lists the goals of the workshop.) Many sectors have recognized the need for action, and successful examples of cross-sector collaborations exist. Yet a number of barriers must be overcome before such cross-sector initiatives can be scaled up and replicated. Continued efforts to partner and develop shared goals and initiatives across sectors are key to the prevention and control of obesity. The composition of the roundtable's membership, which comprises representatives from public health, health care, government, the food industry, education, philanthropy, the nonprofit sector, and academia, makes it an ideal venue in which to discuss such collaboration.

BOX 1-1
Goals of the Workshop

- Explore models of cross-sector work that may reduce the prevalence and consequences of obesity.
- Identify case studies of cross-sector initiatives that engage partners from diverse fields.
- Identify lessons learned from and barriers to established cross-sector initiatives.
- Engage participants in how best to apply the models or issues discussed in their communities and organizations.

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THE NEED FOR CROSS-SECTOR APPROACHES

Making progress on a major problem such as obesity requires scalable and sustainable solutions that reach a large proportion of the population over a long period of time, said Nico Pronk, chair of the planning committee for the workshop and vice president for health management and chief science officer at HealthPartners, Inc., in his opening remarks at the workshop. Large-scale, transformative approaches focused on multilevel and interconnected environmental and policy changes are needed, Pronk continued. In particular, changes are required in many of the environments in which people interact, including schools, the messaging environment, the environment that influences physical activity, the food and beverage industry, and the health care and work environments. Furthermore, because these environments are affected by activities that occur simultaneously across multiple sectors, an explicit focus on cross-sector work is essential.

"What do we mean by sector or cross-sector work?" Pronk asked. A sector can be many different things: an industry or market sharing common characteristics, a distinct part or branch of a nation's economy or society, a sphere of activity such as education, or an area of the economy in which businesses share the same or related products or services. These various definitions of the word "sector" must be considered in any cross-sector approach to preventing obesity, said Pronk.

Regardless of how they are defined, sectors are distinct from each other, but they are "very much interdependent when the objective is to produce something meaningful," Pronk said. For this reason, cross-sector work calls for going beyond normal partnering or day-to-day transactional behaviors and connecting with institutions, disciplines, and bodies of knowledge in new ways. Forging these new connections in turn requires recognizing shared goals, shared ownership, shared decision making, shared burdens, and shared rewards. "This joining together will allow for synergies that move us beyond what any person or group can accomplish alone," said Pronk.

Pronk suggested that the intentional pursuit of collaborative approaches built on mutual respect and trust leads to solutions that last. Joint planning, the pooling of resources, the evaluation of outcomes across sectors, and other collaborative actions can take account of and recognize separate mandates and responsibilities while enabling collaboration toward a common goal. In some cases, this cross-sector work involves alliances of seemingly disparate nonprofit or government organizations that share the common goal of obesity prevention. In other cases, cross-sector work is more informal but still enables the leveraging of disparate strengths to achieve mutual benefits. Whatever the arrangement, Pronk observed, "shared ownership,

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transparency in decision making, mutual respect and trust, and an authenticity in purpose and process are important attributes of such approaches."

ORGANIZATION OF THE WORKSHOP AND THIS SUMMARY

The workshop began by addressing four cross-cutting issues important to cross-sector work and then turned to a series of five case studies representing cross-sector collaboratives at different levels of organization—regional and tribal, county, state, and national. The workshop structure is depicted in Figure 1-1.

As illustrated in Figure 1-1, the workshop planning committee identified the following four cross-cutting issues important to cross-sector work that formed the basis for the first four presentations at the workshop[2]:

- health equity,
- sustainability,
- leadership, and
- measurement.

Health equity ensures that all communities are free from unnecessary, unjust, unfair, and avoidable differences in their health. If obesity prevention programs are to reduce the obesity burden equitably across the population, targeted solutions for those who experience the greatest obesity prevalence will be necessary in order to close existing gaps (IOM, 2013a). Today, communities of color and communities with low incomes are likely to have a higher prevalence of obesity than communities that are predominantly white or more affluent (IOM, 2013a). Chapter 2 addresses the importance of considering health inequities in the context of obesity and of designing cross-sector collaborations that lead to greater health equity.

Sustainability entails recognizing that obesity solutions need a vision if they are to have long-term impact. Grant-funded projects generally work well to identify promising practices, but these projects tend to be difficult to standardize and scale up to reach a population over prolonged periods of time. Chapter 3 looks at the importance of long-term financing strategies for cross-sector collaboratives and considers ways of ensuring that these efforts are supported adequately.

Leadership is critical both at the organizational level, to provide the vision required for progress, and at the local level, to enable implementa-

[2]In addition to Nico Pronk from HealthPartners, Inc., the members of the planning committee for the workshop were Debbie Chang from Nemours, David Fukuzawa from The Kresge Foundation, Lisel Loy from the Bipartisan Policy Center, Amelie Ramirez from Salud America!, and Sylvia Rowe from SR Strategy, LLC.

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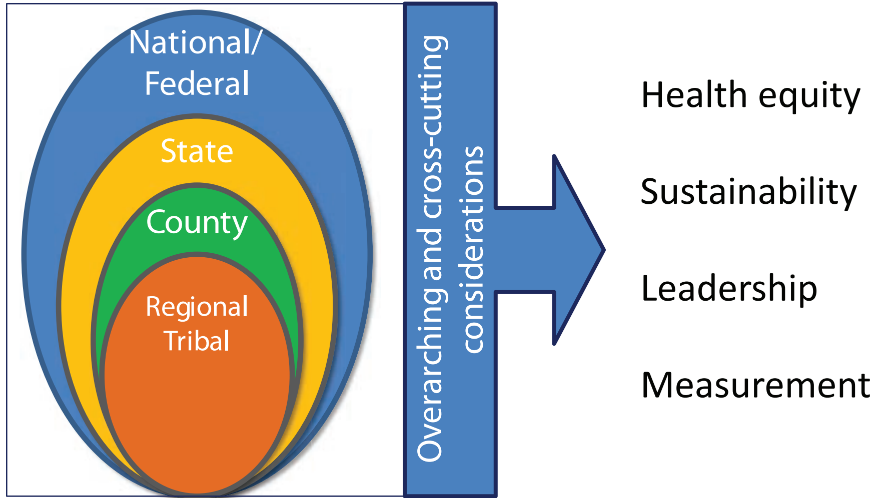

FIGURE 1-1 The workshop examined initiatives at the regional and tribal, county, state, and national levels through the prism of four cross-cutting issues.
SOURCE: Pronk, 2014. Reprinted with permission.

tion of the actions required to realize that vision. Chapter 4 examines how leaders can be identified and engaged, the role established leaders can play in mobilizing and leveraging resources, and leadership structures necessary to engage stakeholders and empower people with authenticity and respect while building trust.

Measurement involves recognizing successes or understanding when intended outcomes are not being achieved. The IOM report *Evaluating Obesity Prevention Efforts: A Plan for Measuring Progress* describes the need to evaluate obesity prevention efforts appropriately, calls for the use of evaluation to inform and improve decision making, urges that tested interventions be identified and used, and recommends broad dissemination of the most promising approaches (IOM, 2013b). Chapter 5 explores evaluation and measurement of multisector efforts.

The discussions that followed the presentations on health equity, sustainability, leadership, and measurement were incorporated into Chapters 2–5, respectively, to enhance understanding of each of these cross-cutting issues and its importance to cross-sector work. In addition to these four cross-cutting issues, the planning committee identified the following five case studies representing cross-sector collaboratives at different levels of organization:

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- the National Prevention Council,
- a statewide strategy for battling child obesity in Delaware,
- Cook County PLACE MATTERS (Chicago),
- PowerUp St. Croix Valley, and
- Sault Ste. Marie Tribe of Chippewa Indians.

In the second half of the workshop, panels of presenters described the barriers and challenges encountered and the lessons learned in establishing these initiatives.

In the sessions devoted to each of these case studies, panelists were asked to address how the four cross-cutting issues of health equity, sustainability, leadership, and measurement were reflected in the missions of these initiatives. They also considered several additional questions: What may be needed to accelerate movement forward in that cross-sector initiative? What are the core features or elements of the initiative that are necessary for scale-up and diffusion? What features need to remain flexible to allow for local adaptation? Chapters 6–10 summarize these panel presentations. A final chapter reports on the wide-ranging discussion that followed the presentation of the case studies. Appendixes B–F provide additional detail on each case study, submitted by the presenters prior to the workshop, posted online, and made available to the workshop participants. These appendixes provide the following information, presented through the lens of health equity, sustainability, leadership, and measurement:

- a description of the cross-sector model used,
- sectors included in the initiative,
- lessons learned from the initiative,
- barriers to establishing the initiative,
- what is needed to accelerate movement forward in the initiative's cross-sector work,
- the core features or elements of the initiative that are necessary for scale-up and diffusion, and
- the features that need to remain flexible to allow for local adaptation.

REFLECTIONS OF THE WORKSHOP DISCUSSIONS

During the final session of the workshop, three individuals provided their perspectives on some of the messages that emerged from the presentations and discussions. These observations should not be seen as the recommendations or conclusions of the workshop participants as a whole, but they are presented here as reflections of the discussions that took place throughout the workshop.

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- Work on obesity solutions will continue to occur within individual sectors, observed Russell Pate of the University of South Carolina. But expanded cross-sector approaches have the potential to deliver both dose and reach, which in turn can be more effective at decreasing obesity rates.
- Successful models of such approaches exist, as demonstrated by the programs discussed at the workshop. According to Pate, however, they need to be sustainable, which requires not just private support but also the backing of governmental policy, legislation, and funding.
- Although successful models exist, a unifying and compelling narrative around equity, obesity prevention, or health has not yet been developed, said Marion Standish of The California Endowment. She emphasized that clarity of goals is critical in scaling up models, enlisting community engagement, and holding programs accountable.
- Successful models need to be disseminated to and implemented in communities across the country, Standish added. Successful implementation in turn requires community capacity and the development of local leaders.
- Measures of the return on investment from cross-sector work on obesity, especially within the context of the Patient Protection and Affordable Care Act, can generate further support for such efforts, Standish said.
- Openness and optimism are needed to work across sectors successfully, said Maha Tahiri of General Mills, Inc., along with sustained dedication to the work among all partners, a deep knowledge of the communities in which partner organizations are working, and a commitment to keeping "health equity first in mind in everything we design."

"This idea of cross-sector engagement is critically important, so whether you are coming from manufacturing, transportation, urban design, education, information technology, this issue around obesity is everyone's issue."

—Yvonne Cook of Highmark, Inc.

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2

Health Equity

Highlights from the Speaker's Presentation*

- An equitable society is one in which all people can participate and prosper. Achieving equity requires intentionality, focus, and a commitment to community participation.
- Achieving equity also requires concentrating resources in the places of greatest need.
- An explicit focus on the issue of health equity when drafting policy, practicing solutions, and developing research agendas and policy options can help organizations make progress on the issue.
- Programs that involve people from the community in decision-making roles have the most impact in achieving their goals.

*Highlights identified during the presentation and discussions attributed to Mildred Thompson of PolicyLink.

Health is not just the absence of illness but an overall state of physical, economic, social, and spiritual well-being, said Mildred Thompson, director of the Center for Health Equity and Place at PolicyLink, a national research and action institute working for economic and social equity (WHO, 1948). This definition has a critical influence in the context of health equity.

PolicyLink defines equity as just and fair inclusion for all. An equitable

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society is one in which all people can participate and prosper, said Thompson. In turn, achieving equity requires intentionality, focus, and a commitment to community participation.

The contrast between communities of opportunity and low-income communities demonstrates the ways in which inequity comes into play in America (see Figure 2-1). Communities of opportunity have parks, good grocery stores, financial institutions, better-performing schools, and good public transit, explained Thompson. Low-income communities, by contrast, have fast-food restaurants, liquor stores, unsafe or limited parks, toxic waste sites, limited public transportation, and increased crime. These attributes of low-income communities contribute to health disparities in such areas as obesity, diabetes, asthma, and rates of injury, Thompson observed.

Schools are a prime example of the differences between communities of opportunity and low-income communities. In communities of opportunity, well-performing schools offer advanced placement courses to their students so they are ready for college. In low-income communities, many schools do not even offer advanced placement classes. Thus, when students get As in their courses, they think they are ready for college, but they later real-

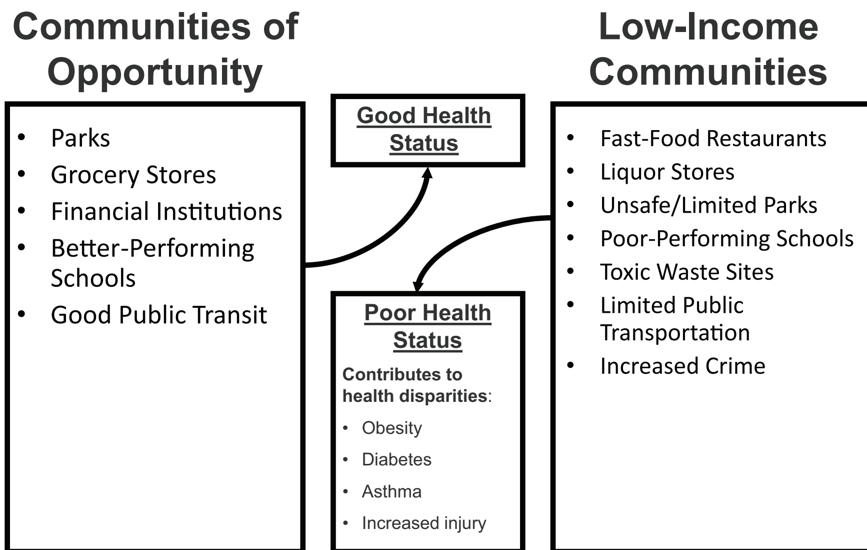

FIGURE 2-1 For communities, an abundance or lack of opportunities and income plays a direct role in influencing health outcomes. Differences in opportunities and income result in health inequities.
SOURCE: Thompson, 2014. Reprinted with permission.

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ize that they are underprepared. "It's not because they are not smart; it's because they didn't have opportunities provided to them," said Thompson.

Not all residents in communities of opportunity have good health. But they have better opportunities to be healthy, Thompson suggested, while those who do not have such opportunities tend to be at greater risk for poor health. Furthermore, when those in low-income communities are provided with such opportunities, everyone benefits. For example, the Harlem Children's Zone, which has been expanded to a large-scale federally funded initiative known as Promise Neighborhoods,[1] is premised on the belief that all children can do well, Thompson noted. An emphasis of this initiative is that all children deserve equal opportunities to lead healthy lives, graduate from high school, and have economic opportunities throughout their lives, regardless of the zip code in which they live. "If you go on the website and you read about Harlem Children's Zone," said Thompson, "you will see the remarkable number of kids who are going to college, because there was someone who really believed in them and had a vision of how to make that real."

Disparities in opportunity show up clearly in national statistics on obesity, Thompson noted. Today, 22.0 percent of all U.S. children live in poverty, but the percentages are 35.0 percent and 38.2 percent for Latino and African American children, respectively, compared with 12.4 percent for non-Hispanic white children. These percentages, suggested Thompson, reflect a relative lack of opportunity for populations of color (DeNavas-Walt et al., 2011). At the same time, 20.2 and 22.4 percent of African American and Latino children and adolescents, respectively, are obese, compared with 14.1 percent of white children and adolescents. These same differences by population group can be seen in adults: 47.8 percent of African American, 42.5 percent of Latino, 32.6 percent of white, and 10.8 percent of Asian American adults are obese (Ogden et al., 2014). Furthermore, the gaps among these population groups have been growing over time (Trust for America's Health and the Robert Wood Johnson Foundation, 2014).

Inequities also exist geographically. The physical inactivity rate for all adults in the United States is 25.4 percent, while Mississippi and Tennessee have the highest rates of inactivity at 36.0 percent and 35.1 percent, respectively. At the other end of the spectrum, the physical inactivity rate is 19.1 and 18.9 percent in California and Utah, respectively (CDC, 2014). By

[1]Promise Neighborhoods is a U.S. Department of Education program that intends to improve educational outcomes for students in distressed urban, rural, and tribal communities. The program funds nonprofit organizations and higher education institutions to design comprehensive community programs and "cradle-to-career" services. PolicyLink assists communities participating in the program through its Promise Neighborhoods Institute. More information can be found at http://www.promiseneighborhoodsinstitute.org and http://www2.ed.gov/programs/promiseneighborhoods/index.html.

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looking more closely at population segments, said Thompson, it becomes clear that population-level data can mask underlying inequities. Achieving greater equity, she suggested, means that "we have to concentrate resources in the places that have the highest incidences of these issues."

INSTITUTIONAL APPROACHES TO CREATING HEALTH EQUITY IN A CHANGING U.S. POPULATION

Reducing inequities requires changing the environment, said Thompson. More than 20 years ago, she began working with the Oakland Healthy Start Program to reduce infant mortality. "We realized back then, in the 1990s, that the condition of infant mortality was not going to be solved by just having more clinicians, by just extending the clinic hours. We did all of those things, but what was really clear was that we [had] to change the environment in which those babies were dying."

Many of the communities that have high infant mortality rates also have high rates of obesity, diabetes, and crime. The consequences for the children growing up in those communities are dire, said Thompson: "Our children are not getting the kind of attention that they need in order to thrive and to be the future leaders that we need for them to be." As an example, she returned to education. Most new jobs require education beyond high school (see Figure 2-2). "We have to make sure that we are training and preparing our students to meet those needs," Thompson said.

By 2040, the majority of the U.S. population will be made up of people of color. This is already the case in four states: California, Hawaii, New Mexico, and Texas (U.S. Census Bureau, 2013). If the children in these population groups are not being prepared for the future, the future will suffer, Thompson said. If the future workforce lacks the education needed for the available jobs, the result will be poor economic outcomes not only for people with low educational attainment but also for businesses and employers that lack adequately skilled workers, she noted.

PolicyLink has been studying institutions and organizations across the United States that are working on issues of health equity, asking about their work, their funding, their outcomes, and their partners. For example, some progressive public health departments have been going well beyond their mandates. "What we're learning from them is how they have been able to change those institutions to address health equity," said Thompson. This research has led to several observations about what works:

- inserting goals for achieving health equity into policies, programs, and practices;
- focusing on race and place in crafting policy and practice solutions;

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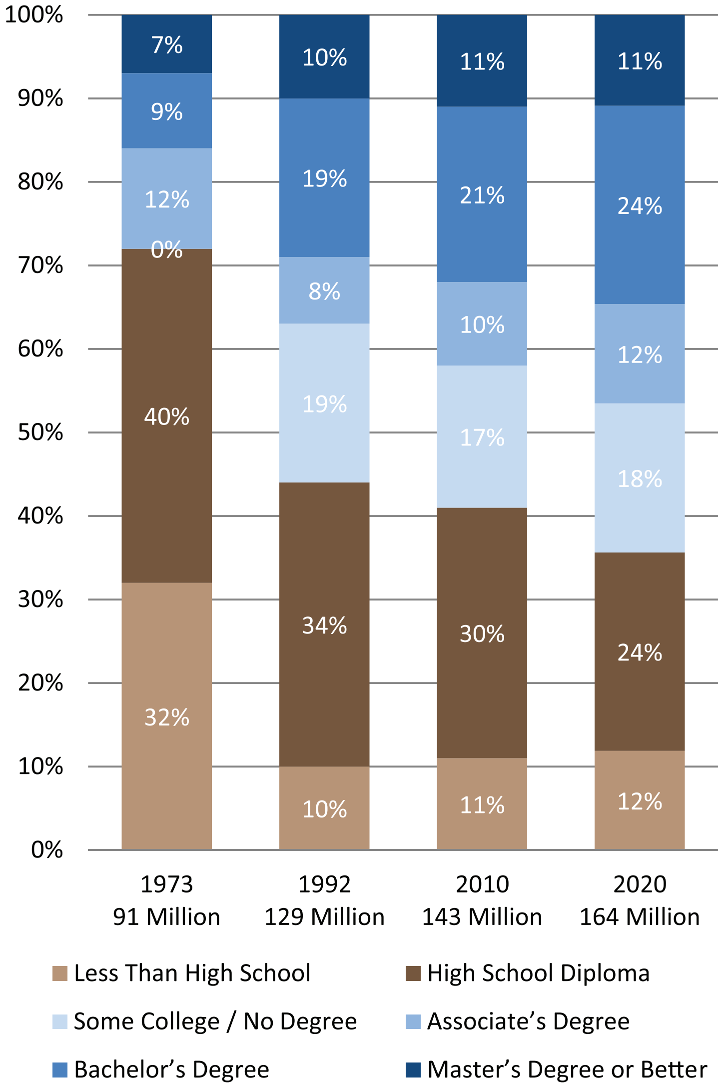

FIGURE 2-2 Jobs in the United States require increasingly high levels of education.
SOURCE: Carnevale et al., 2013. Reprinted with permission from the Georgetown Center on Education and the Workforce.

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- acknowledging health equity when developing research agenda and policy options; and
- supporting the creation of institutes or centers with a focus on specific health equity outcomes.

The challenge in practice, said Thompson, is how to make such changes happen.

QUESTIONS TO FOMENT CHANGE

Thompson offered several questions for organizations to consider when undertaking the necessary changes in addressing health equity related to race, ethnicity, and economic status.

First, in the area of *data collection and analysis*:

- What indicators are you using to better understand health inequities in your communities?
- Who is most impacted by these inequities? Where are these inequities the most severe?

In the area of *strategy development*:

- What equity outcomes are you seeking to achieve through the proposed strategy?
- Who is intended to benefit from this strategy?
- How will this strategy benefit low-income communities and communities of color?
- How does this action help to achieve greater racial and economic equity?
- What organizational practices may create barriers to achieving racial and economic equity?

Finally, in the area of *community engagement*:

- How are those most impacted by inequities involved in your initiatives?
- What opportunities are you creating to have community members actively participate?

Expanding on this final area as an example of how to move forward, Thompson noted that consensus exists on the value of community engagement, but the challenge lies in engaging communities in a substantive way.

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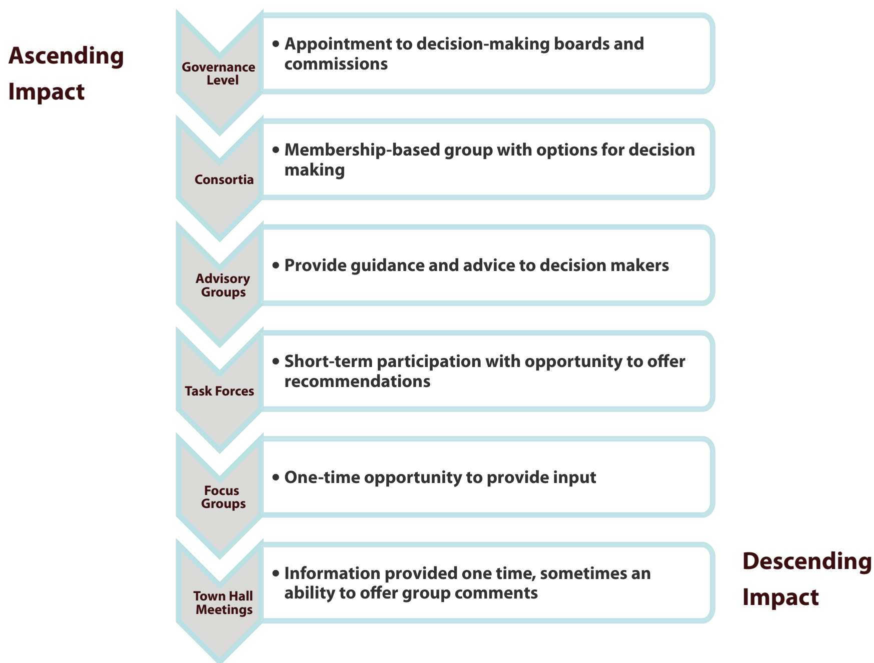

FIGURE 2-3 The community can be engaged at different levels with different impacts.
SOURCE: Thompson, 2014. Reprinted with permission.

Community engagement has different levels with different impacts (see Figure 2-3). According to research with which Thompson has been involved at PolicyLink, programs that incorporate governance-level involvement, meaning that people from the community are in decision-making roles, have the most impact in achieving their goals. "All involvement is not equal," Thompson said. However, community engagement also requires capacity building, so that community members will have the skills and the opportunities to understand the need to focus on racial and economic equity.

"How do you create an environment where everyone's voice is valid?" Thompson asked. "It's up to us to create an environment that is open and receptive so that we all see each other as having as much value and contribution as everybody else."

STEPS TOWARD A SOLUTION

A variety of programs are demonstrating what can be achieved, Thompson observed. For example, the Healthy Food Financing Initiative

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and California FreshWorks Fund have established "a wonderful example of cross-team collaboration and public–private partnerships." California FreshWorks Fund addresses equity by targeting its resources to communities that experience low access to healthy foods because of the market-based assumption that poor communities do not have adequate resources to support a grocery store. With seed money from The California Endowment that leveraged additional financing—including both investments in the fund of as little as $20 by individuals and private-sector contributions from Chase Bank and Bank of America—the FreshWorks Fund has raised more than $250 million (California FreshWorks Fund, 2014). As examples of the steps being taken by these and other organizations to promote place-based approaches to equity through local action, Thompson cited:

- working with neighborhood corner stores in those communities experiencing health inequities to help them adopt and sell healthier products while remaining profitable;
- increasing farmers' markets;
- linking farmers to consumers through such measures as urban agriculture, community-supported agriculture, and community gardens;
- establishing stronger nutrition standards in schools; and
- increasing the number of grocery stores in low-income communities.

Thompson also described a policy strategy developed by Kaiser Permanente known as Exercise as a Vital Sign (EVS) (Sallis, 2011). To monitor, measure, and improve activity levels, Kaiser health care providers in 2009 began asking patients two questions:

- How many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
- On average, how many minutes per day do you exercise at this level?

EVS has become a basis for ongoing conversations about patients' exercise habits, Thompson said. Asking these questions has motivated patients to want to be healthier and make a difference in their own health care. These conversations provide encouragement and can result in referrals to such activities as Zumba classes, yoga, hiking clubs, and other community resources. Most important, Thompson noted that a 2014 study found that asking patients about their exercise habits was associated with modest weight loss in overweight patients and some improved glucose control among diabetics (Grant et al., 2014).

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Cross-Sector Responses to Obesity: Models for Change: Workshop Summary

LESSONS LEARNED

Thompson drew several lessons from her overview of health equity issues.

First, framing is important. For example, work on health equity has to focus not on the individual but on the environment, she said—"less blaming the victim and [more] figuring out what the things are in the environment that must be changed."

Second, partnerships matter. Businesses, funders, governments, and communities all have roles to play.

Third, the context needs to be understood. "When is it going to be productive to introduce a new idea? When do you involve partners? When can you move a strategy forward? It's all based on the environmental context."

Fourth, assessment is critical. "We have to continually figure out how we are monitoring our work and doing things differently."

Fifth, capacity needs to be built continually, not only within the environment but also among staff and partners.

Finally, "how do we tell our story in our own way?" Those working on health equity need to control the narrative and not leave that to others, Thompson said.

As an example of how these lessons can be applied, Thompson described the evaluation of the Healthy Eating, Active Communities initiative (Samuels & Associates and The California Endowment, 2010). This place-based initiative helped six low-income communities approach environmental and policy changes and build health equity. These steps included

- adopting new physical education curricula to improve the quality of physical education classes;
- implementing teacher training to maximize adherence to state standards;
- adopting physical activity standards in after-school programs to improve the quality and quantity of physical activity;
- advocating for park development, maintenance, or improvement, thus creating safe and appealing spaces for physical activity; and
- instituting pedestrian safety improvements—installing traffic signals, employing crossing guards, establishing walking clubs, and creating safe walking paths between residential areas and schools—to encourage walking to and from school in all sites under the Healthy Eating, Active Communities program in California.

"We saw major changes happen as a result of these strategies that were put in place across the state of California," Thompson said.

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Finally, Thompson listed a number of ingredients for success in working for health equity:

- strong, sustained leadership;
- commitment across sectors;
- bold risk takers who can think outside the box;
- equity-focused strategies;
- creative, compelling use of data;
- government–community partnerships;
- adequate resources;
- long-term involvement; and
- continuous assessment of impact and modifications as needed.

The programs that have the greatest impact all have, to some degree, these elements of success, Thompson said. Furthermore, success requires humility: if we all acknowledge that we do not know everything and are open to continuously learning, everyone benefits. When a community says a particular approach is not working, programs need to be willing and able to adjust.

"I'm somewhat optimistic that the [obesity] crisis is solvable, but I'm also worried. I think in the population that is aware and has resources, we can probably solve this crisis in the near term. But what I'm worried about is that in the high-risk populations or the socially disadvantaged populations—which include many ethnic minority populations and people in disadvantaged communities—the [obesity crisis] will either get worse, or it won't get any better. This means that the disparity between the advantaged and the disadvantaged groups will increase. That's the part I'm worried about. We need some very deliberate solutions to make sure that we [address] why the rates are higher in certain populations."

—Shiriki Kumanyika of the University of Pennsylvania

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3

Sustainability

Highlights from the Speaker's Presentation*

- Cross-sector work can create innovative and multifaceted ways of funding and supporting an initiative while building community capital.
- Such work builds sustainability by connecting projects, people, and resources.
- Community Development Financial Institutions bring together people, financing, capacity, and data to promote socially and environmentally responsible development.

*Highlights identified during the presentation and discussions attributed to Donald Hinkle-Brown of The Reinvestment Fund.

Donald Hinkle-Brown approached the topic of sustainability from his perspective as president and chief executive officer of The Reinvestment Fund (TRF), a certified Community Development Financial Institution (CDFI) that builds wealth and opportunity for low-wealth people and places through the promotion of socially and environmentally responsible development. Hinkle-Brown noted that TRF has $1.3 billion in cumulative investments and loans throughout the mid-Atlantic states and currently manage $738 million in capital, with more than 850 investors, approximately 500 of whom are individuals.

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A CDFI is a specialized financial institution working in market niches that are underserved by traditional financial institutions, Hinkle-Brown explained. CDFI certification is a designation conferred by the CDFI Fund and is a requirement for accessing financial and technical award assistance from the U.S. Treasury. CDFIs are required to maintain accountability to their defined target markets and are rated by the organization Aeris. TRF is one of only five CDFIs in the country with the top Aeris rating, Hinkle-Brown noted.

TRF finances a variety of projects and activities in such areas as food access, health care, education, and housing. It brings together people, financing, capacity, and data, with a particular focus on the measurement of outcomes. "If you're missing one of those components," said Hinkle-Brown, "your effort will be hampered."

CDFIs do not fund giveaways, Hinkle-Brown emphasized. By underwriting loans and providing grants, it funds profitable businesses, which in turn builds sustainability. (An example of such a profitable business is described later in this chapter in the section on "Building Sustainability.") "Once we have that plate spinning, we can leave and the business works," said Hinkle-Brown. In addition, when a new idea is found to work, it can be adopted elsewhere and at a larger scale. For example, the Pennsylvania Healthy Food Access Initiative, originally financed by TRF, has since been brought to a national scale by the federal government as the Healthy Food Finance Initiative. Once the concept had been proven, said Hinkle-Brown, "we didn't need to take the actions that we had been taking for it to promulgate."

The Policy Solutions division of TRF combines rigorous data analysis with the ability to help its clients think spatially. For example, it has identified areas with limited supermarket access as part of its work on accessing data on communities and markets. One of its products is a tool known as PolicyMap®, which enables government, commercial, nonprofit, and academic institutions to perform data mapping and analysis (see Figure 3-1). The tool has more than 15,000 data indicators, as well as proprietary TRF analytics, and additions to the database are made frequently.

CREATING HEALTHY COMMUNITIES

Healthy communities have several attributes that represent a convergence of intent at the intersection of community development and public health, Hinkle-Brown observed. These attributes include affordable housing, spatial analysis of the supply and demand of human resources, accessibility, livability, walkability, access to fresh and healthy foods, an environmental focus, and sustainability (see Figure 3-2). Similarly, data are undergoing a convergence through such tools as PolicyMap, the Uniform

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Cross-Sector Responses to Obesity: Models for Change: Workshop Summary

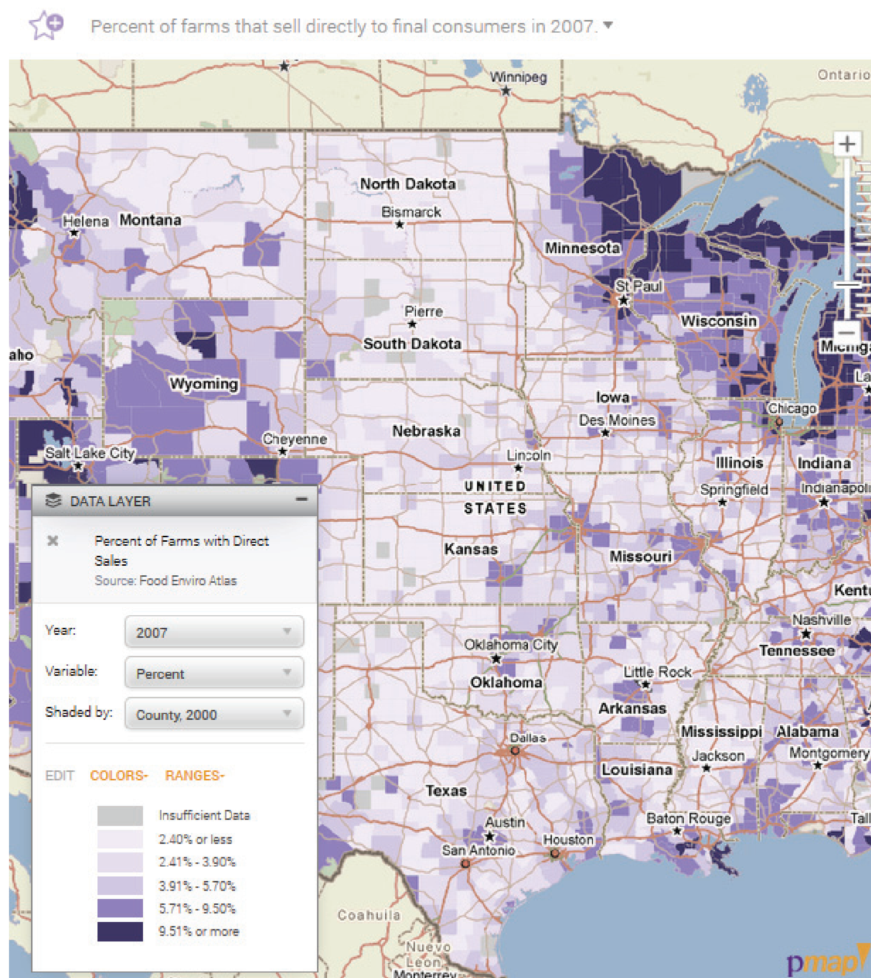

FIGURE 3-1 The percentage of farms that sell directly to final consumers is an example of the data overlays available on PolicyMap.
SOURCE: http://www.policymap.com. Reprinted with permission from Donald Hinkle-Brown.

Data System required by the Health Resources and Services Administration, and Community Health Needs Assessments required by the Patient Protection and Affordable Care Act. This convergence of data is not new in the public health or health sector, Hinkle-Brown said, "but for community development, it's a very new thing." For example, new health metrics and

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Affordable Housing "plus," Accessibility Continuum	Spatial Analysis of Human Services Supply and Demand	Transit Orientation, Livability, Walkability	Access to Healthy Fresh Foods, "Let's Move!"	Environmental Focus, Sustainability, Local Economies

FIGURE 3-2 Attributes of healthy communities.
SOURCE: Hinkle-Brown, 2014. Reprinted with permission.

indicators are continually being added to PolicyMap to make the database useful for multiple practitioners.

Another ongoing convergence involves the focus of community development. It is becoming less deal oriented, more longitudinal, less focused on quantity, and more focused on impacts. Public health is undergoing a comparable shift, said Hinkle-Brown. It is becoming less a "reaction" to poor health and more an examination of the social determinants of health. It is also moving away from broad correlations into granular, actionable interventions. "My first conversation with a public health official was based on the notion, 'We'll just get everybody to graduate from high school, and all these things will happen.' And while it's a correlation that those things are true if that thing happens, it's not actionable. You have to break it down into its integral parts."

The transactional side of community development can be helpful in the decomposition of such problems, Hinkle-Brown added. "How do you actually do it? How do you get Bob to graduate from high school? What are the barriers to getting that done? That's something that is much more our expertise [as a CDFI], breaking it down."

PROVIDING ACCESS TO HEALTHY FOOD

TRF is a national leader in financing stores that provide quality fresh food at competitive prices in low-income communities. It works to reduce inequitable access to healthy foods by underwriting loans and providing grants, advocating to increase public awareness on food accessibility, conducting policy research work, and providing technical assistance services. "Our original intent was equity of access," Hinkle-Brown observed. "We wanted low-income people in dense communities that lacked a grocery store to have equitable access to healthy foods, period. We did not attempt to lower obesity rates. We did not attempt to change the specific metrics of health in these places. We just thought it was unfair."

Hinkle-Brown noted that as of the time of the workshop, TRF had financed 135 healthy food projects across the mid-Atlantic totaling more than $184 million. In particular, TRF's healthy food financing program is

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designed to attract supermarkets and grocery stores to underserved urban and rural communities. Different locations call for different solutions, Hinkle-Brown also observed. For example, the approaches that work in urban areas often will not work in rural areas, where different models, such as joint ownership of distribution systems, are needed.

TRF also is a leader in research on issues related to improving access to healthy foods in distressed communities. It identifies areas with inadequate access to supermarkets and analyzes supermarket competition and barriers to entry. In addition, it examines the economic reasons for the lack of supermarkets, analyzes the economic impact of new supermarket development, and studies existing programs designed to encourage people to eat and shop for healthier foods.

Hinkle-Brown provided an example of this work by describing TRF's nationwide analysis of areas with inadequate and inequitable access to healthy foods. Areas with limited supermarket access are those whose residents must travel significantly farther to reach a supermarket than the "comparative acceptable" distance traveled by residents in well-served areas. TRF's analysis identified 1,519 clusters around the United States, with an average size of about 9,000 people, where enough revenue opportunity exists for a store to locate in an area with limited supermarket access (CDFI Fund, 2011).

BUILDING SUSTAINABILITY

Actions based on TRF's analysis of areas with limited supermarket access demonstrate the role of sustainability in such efforts. In Vineland, New Jersey, TRF helped finance a grocery store anchor for a 79,000-square-foot retail center in a location adjacent to two such areas. At the same time, it was able to house a Federally Qualified Health Center (FQHC) in the development. The store and FQHC are now sharing objectives around diabetes education and coordination, "which is remarkable," said Hinkle-Brown, "in that grocers don't normally engage with public health issues." The FQHC has a captive audience of people shopping at the grocery store who would not normally walk into a clinic.

A different kind of example involves a grocery store in Chester, Pennsylvania, known as Fare and Square. It is a first-of-its-kind nonprofit grocery store in an area of limited supermarket access with 15,000 people. It combines the food distribution qualities of a food pantry, the distribution of at-cost donated food, and a regular grocery store to fill in the gaps. It also houses a community center to assist in signing up for the Supplemental Nutrition Assistance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children; and other programs and services. And it offers a 5-week service industry training course that has helped create 40

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to 50 jobs. "This is a beautiful model of a combination of free, discounted, and market-rate food in one venue," said Hinkle-Brown.

Fare and Square is an experiment that may not be sustainable, Hinkle-Brown acknowledged. "But it is more sustaining than only doing free food." Furthermore, it builds relationships, and partnerships built on relationships are sustainable because relationships are slow to change.

"Simply put, we just won't be effective if we focus our efforts in the medical office building. As soon as our patients walk outside of the medical office building, they are impacted by an environment that makes the healthy choice not necessarily the easy choice. So we have to work outside the medical office buildings, we have to work with multiple sectors, multiple interests."

—Loel S. Solomon of Kaiser Permanente

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4

Leadership

Highlights from the Speaker's Presentation*

- Leadership is central to the creation, maintenance, and success of cross-sector collaborations.
- Consideration and understanding of terminology, time and timing, and trust are key elements of leadership in cross-sector collaborations.
- Many characteristics of good leaders—such as being a strong relationship builder, letting go of one's ego and believing in shared leadership and ownership, and deeply valuing collaboration—are based on values and attitudes rather than skills.
- Resident leaders have the power to change neighborhoods in ways that organizations may not be able to accomplish.

*Highlights identified during the presentation and discussions attributed to Debra Oto-Kent of the Health Education Council.

Leadership is the "secret sauce of cross-sector work," said Debra Oto-Kent, executive director of the Health Education Council. "It can make or break collaborative efforts."

The Health Education Council has worked with nontraditional partners in a variety of health initiatives, including obesity prevention, and has sought input from key stakeholders who "exemplify leadership," according

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to Oto-Kent. She focused in particular on the work of the South Sacramento Healthy Eating, Active Living (HEAL) Zone, an initiative supported by Kaiser Permanente.

THE THREE Ts

Oto-Kent began by discussing what she called the three Ts: terminology; time, including timing; and trust.

With respect to terminology, Oto-Kent noted that cross-sector partnerships focused on obesity can involve multiple sectors and foci, including law enforcement and public safety, housing, financing and economic development, education and workforce development, parks and recreation, obesity, food insecurity, community development, public health, clinical health care, transportation, and regional planning. Each has its own terminology and jargon, and "it can be difficult to gain common understanding when there's such varied lingo and interpretation of meaning in each sector," said Oto-Kent. As an example, she mentioned the word "safety." For some partners in the HEAL Zone, safety means violence prevention or gang intervention. Business and retail partners tend to see safety in relation to property crime, loitering, or crime against business. Partners focused on addressing improvements in the built environment see safety in terms of creating safe parks and public places. And school partners focus on Safe Routes to School. "We need to invest in understanding the terminology and language of other sectors, what they mean, and recognize that their language may not be the same," said Oto-Kent.

With respect to time and timing, cross-sector collaboration requires an intentional investment of time to become familiar with the language of other sectors, how they view the problem, and their reasons for being involved. When the South Sacramento HEAL Zone collaborative started several years ago, the partners were not spending enough time together to develop synergy and leverage the great work going on, Oto-Kent said. Since then, the partners have been meeting monthly, communicating through updates, and deepening their understanding of what community health means for each partner. Timing also is a factor, in that the timing for cross-sector partnership needs to be right. Partners must be ready to break out of their silos, which requires leadership at the organizational, program director, or staff level. Also, opportunities can sometimes arise that cause collaboration to gel. The South Sacramento HEAL Zone has one of the highest crime rates in Sacramento, and violence peaks during the summer months. In response, a program called Sacramento Summer Night Lights was launched by a number of organizations, each with its own reason for wanting to be part of the program (see Figure 4-1). Over the summer, the collaborative organized 42 nights of activities over 14 weeks from May to

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FIGURE 4-1 The Summer Night Lights program in Sacramento brought together multiple sectors to work toward overlapping goals.
NOTE: HEAL = Healthy Eating, Active Living; HEC = Health Education Council.
SOURCE: Oto-Kent, 2014. Reprinted with permission.

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August, every Thursday through Saturday, including meals, games, entertainment, basketball, and other activities for residents, youth, and the partners. The results "have been dramatic," Oto-Kent reported. Calls to police and business security, loitering, property crime, arrests, and emergency room visits for violence-related trauma all declined. "Most importantly, not a single homicide [occurred] in the zone over the summer," said Oto-Kent. "Our partners at the Sacramento Police Department told me that they can't remember the last time in the HEAL Zone there wasn't a homicide."

Finally, with regard to trust, Oto-Kent said that when she started working with African American churches, she was told she needed to build trust, history, and relationships. "Trust is time-driven. It doesn't happen overnight," she said. This interplay between time and trust is essential, she emphasized. For example, she encourages her staff members to attend meetings held by other sectors to understand their perspectives and develop relationships. As Hinkle-Brown had pointed out earlier, sustainability is about connections, and relationships help make things happen (see Chapter 3).

THE ROLE OF LEADERSHIP

All of the above factors (terminology, time and timing, and trust) are key to leadership in cross-sector collaborations, said Oto-Kent. Leadership builds the commitment to learn terminology, recognize solutions, and develop trust. "Leadership work is central to the creation, maintenance, and success of cross-sector collaborations."

Oto-Kent listed the characteristics of good leaders based on her observation of cross-sector collaborations, noting that many are based on values and attitudes rather than skills:

- A leader is a strong relationship builder, "someone who deeply values collaboration, respects others' expertise, and strongly believes that separate efforts to address obesity or health have not worked and cannot solve the problem."
- A leader recognizes that champions come from many levels and provides both formal organizational and informal leadership.
- The best leaders are those who let go of their ego and believe in shared leadership and ownership. "They build understanding of why everyone needs to be at the table. They gain the trust of the collective group and of individual partners."
- A leader is results oriented, understands the process of collaboration, and sets milestones to be achieved.
- A leader understands that a sweet spot exists among learning, listening, and taking action.

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- A leader is flexible, working toward a collaboration that can adapt to changing circumstances, but also stays focused and moves forward strategically.
- A leader understands that the type of leadership needed in cross-sector work may change over time and is constantly asking who else needs to be at the table.
- Leaders "keep their eye on the prize, and that prize, for us, is always driven by community and resident needs, as opposed to organizational needs and objectives."
- A leader is an influential communicator who recognizes that conflict is common in partnerships and uses relationships and strategies to equalize power and seek solutions. "The reality is that there's a lot of self-interest, there's a lot of competition, there's protection of interests, and there are money, recognition, and competing barriers that get in the way of cross-sector collaboration." A leader believes that everyone has an important voice.

Oto-Kent also called attention to the importance of resident leadership in addition to organizational leadership. Resident leaders have the power to change neighborhoods in ways that organizations may not. "We believe that changing the narrative must include strong resident-led and -driven advocacy in creating a new community narrative," she observed. For example, in the evolution of the Summer Night Lights program, several residents commented on the benefits of changing the community narrative. As one community member told Oto-Kent, "It's so nice to not hear all the bad things happening in our community. This was very positive for our neighborhood."

Collaboration can be unclear and messy, Oto-Kent concluded, but "it is the right thing to do."

"No one sector can do it alone. Philanthropy can't do it by itself, public health can't do it by itself, media can't do it by itself, the food and beverage industry can't do it by itself."

—Dwayne Proctor of the Robert Wood Johnson Foundation

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5

Measurement[1]

Highlights from the Speaker's Presentation*

- Measuring the changes produced by an initiative requires a logic model that connects inputs to short-term, intermediate, and long-term outcomes. Long-term changes in health outcomes can be difficult to create and measure; therefore, more immediate outcomes must be assessed and linked to population health improvements.
- One approach to evaluation is through "dose," which combines reach, or the number of lives affected by an intervention, and the strength of that effect.
- The effects of an intervention (single interventions and/or a collection of interventions targeting the same outcome) can be estimated through a combination of effect sizes derived from the scientific literature, evaluations of individual strategies, and dose estimates based on reach and strength.
- Estimated effects of interventions compared with surveys of the target population then can reveal associations between estimated and observed impacts.

*Highlights identified during the presentation and discussion attributed to Pamela Schwartz of Kaiser Permanente.

[1]The term "measurement" in this chapter includes consideration of assessment, surveillance, monitoring, and summative evaluation efforts as described in the Institute of Medicine report *Evaluating Obesity Prevention Efforts: A Plan for Measuring Progress* (IOM, 2013b).

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Kaiser Permanente's Community Health Initiative (CHI) is an obesity prevention initiative aimed at creating opportunities for safe physical activity and healthy eating in communities across the nation. There are more than 50 CHI sites, including Healthy Eating, Active Living zones in California (see Chapter 4), LiveWell in Colorado, and joint efforts across the nation, and the initiative is continuing to grow.

Throughout its first decade, CHI has had a rigorous evaluation process in place, noted Pamela Schwartz, director of program evaluation at Kaiser Permanente. "We have taken that evaluation very seriously, taking an honest look at what has worked and what hasn't worked and making course corrections along the way—trying to be brutally honest with ourselves and using the evaluation to improve our investments." Schwartz provided several key lessons learned from the evaluation, with a particular emphasis on the challenges posed by measurement.

THE NEED FOR A LOGIC MODEL

Discussion of measurement requires a logic model, said Schwartz. The cross-site logic model for CHI begins with inputs that are converted through various processes into short-term, intermediate, and long-term outcomes (see Figure 5-1). "We're interested in understanding the community changes and how those changes are impacting behavior and eventually health."

About 5 years into the program, the evaluators realized that the initiative was unlikely to reach its goal of population health improvement if it did not make two key course corrections. First, they concluded that the interventions needed to be more impactful. Second, they realized that the initiative needed to focus more on intermediate outcomes. Long-term changes in health outcomes can be difficult to create and measure; therefore, more immediate outcomes must be assessed and linked to population health improvements.

These two conclusions led to several adjustments in CHI. First, the initiative began to emphasize what Schwartz and her colleagues call "dose," which is the product of how many lives an intervention is affecting (i.e., reach) and how strong that effect is (i.e., strength). The concept of dose resonated with funders, practitioners, researchers, and community partners, said Schwartz, but it has not been easy to operationalize. Doing so requires working with the community to create dose and devising ways of measuring the effects of a single intervention and a collection of interventions targeting the same outcomes. With healthy eating, for example, calculations of dose might involve the percentage of healthy options in vending machines, the kinds of food offered in cafeterias and other school-related outlets, the establishment of community gardens, and reforms in corner stores

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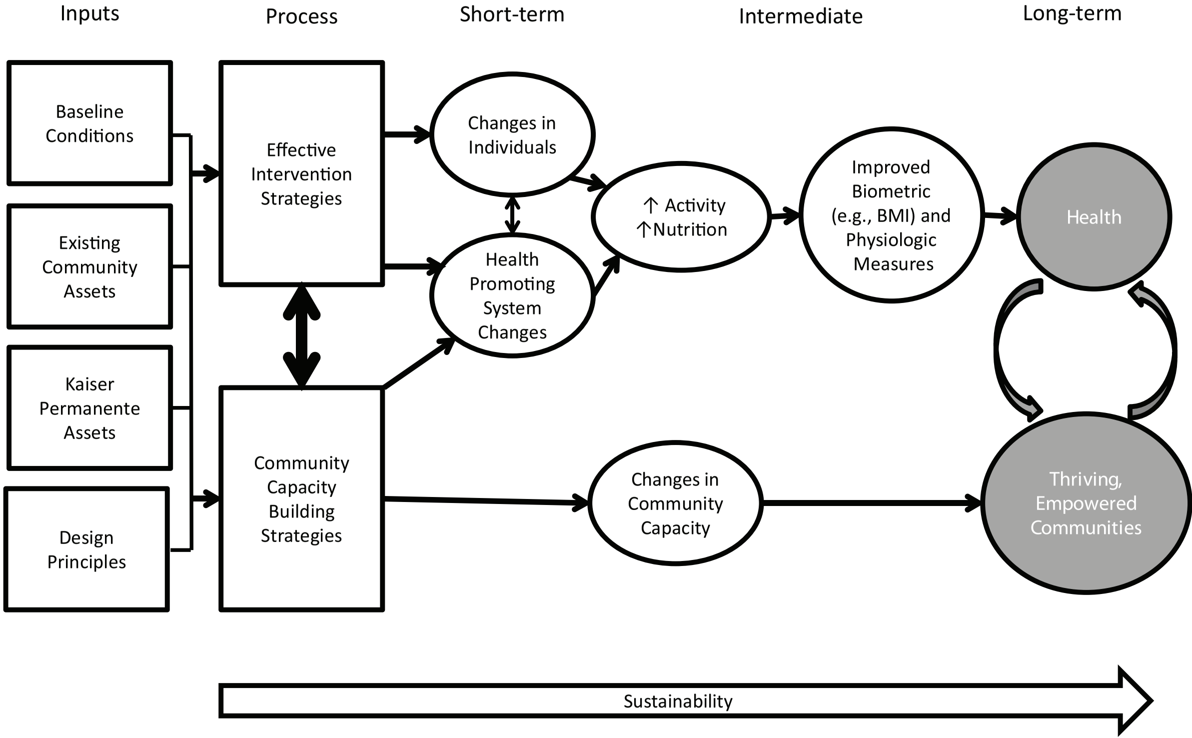

FIGURE 5-1 The logic model for the Community Health Initiative connects inputs to short-term, intermediate, and long-term outcomes.
NOTE: BMI = body mass index.
SOURCE: Kaiser Permanente, 2014. Reprinted with permission from Pamela Schwartz.

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and other sectors. With physical activity, dose could involve the number of students who walk to school, changes in the community to encourage walking, revamping of the physical education curriculum, and increased physical activity in the classroom. "This is about starting where the community is and continually asking the question, 'Can we reach more people, more times, more often, for a longer period, throughout the year, and [do] it in any sector?'" Schwartz said.

Another adjustment involved improved measurements. The evaluators sought new ways of quantifying the impact of individual strategies. They also worked with communities to understand more about the opportunities for better measurement, partly because communities were asking for improved metrics for what they were doing.

A ROADMAP TO APPROACHING EVALUATION

The above adjustments led to several important results. The evaluation of a Safe Routes to School program among 13 schools in a community, all implementing some combination of efforts such as safety enhancements, infrastructure changes, and walk-to-school days increased the number of children walking to school from 24 percent to 36 percent over the course of 2 years. In another program, installing a salad bar in an elementary school cafeteria in Colorado increased students' consumption of fruits and vegetables by 13 percent. These and other similar results, provided a sense that "dose mattered," said Schwartz.

Because CHI is a multisectoral initiative, however, it was necessary to find ways of quantifying the collective impact of multiple strategies being implemented at the same time. To meet this challenge, the evaluators used dose as a common metric across interventions. For example, one community in Colorado focused on a strong physical activity intervention in the school setting. The community worked to revise the physical education curriculum, increase walking to school and physical activity in the classroom, and promote physical activity through wellness policies and after-school programs. The evaluators took three approaches to measuring the effect sizes of each strategy:

- They surveyed the scientific literature to identify evidence of effect sizes.
- Where evidence did not exist, they performed evaluations of individual programs such as those described above.
- Where both the literature and evaluations were lacking, they estimated the dose of each individual strategy based on the combination of reach and strength.

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Revised PE curriculum	5.0%	
Action-based learning in classrooms	2.3%	
Active transport to school	1.1%	
School wellness policies promoting PA	0.5%	
After-school physical activity	0.45%	
Overall dose of school PA strategies	**9.35%**	

FIGURE 5-2 Calculations of dose for multiple physical activity–focused interventions yielded a large overall estimated effect size for a Colorado community.
NOTE: PA = physical activity; PE = physical education.
SOURCE: Schwartz, 2014. Reprinted with permission.

Using these three approaches, "we were able to add up the apples and oranges," Schwartz said. The cumulative estimated effect was 9 percent, which Schwartz described as "very high" (see Figure 5-2). This effect would justify a prediction that the community would see improved population health.

The evaluators then compared the predicted estimated effect with changes in population health derived from pre- and post-intervention surveys of students at the school. The surveys found a 4 percent increase in students reporting more minutes of physical activity, which is also high. To understand secular changes, the evaluators compared their findings with data from the Youth Risk Behavior Surveillance Survey, which showed just a 0.5 percent increase in a widely used measure of physical activity among Colorado youth during the same time period (see Figure 5-3).

The association between estimated and measured impacts provided confidence that the changes seen in population health could be attributed to the interventions. "This supported our hypothesis that if you have a strong intervention, you can move population health," said Schwartz. "It reinvigorated our belief that we need to create dose and we need to measure it."

This approach still leaves some questions unanswered, Schwartz acknowledged in response to a question, such as whether interventions are additive or synergistic. But the associations found indicate that change is heading in the right direction.

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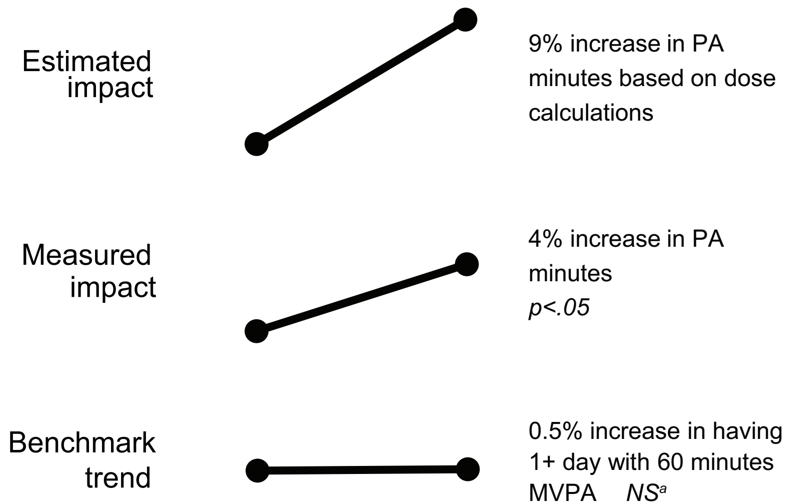

FIGURE 5-3 Example comparing estimated dose with actual population health impact.
NOTE: MVPA = moderate- to vigorous-intensity physical activity; NS = not statistically significant; PA = physical activity.
[a]Youth Risk Behavior Surveillance Survey data, Colorado, 2009–2011.
SOURCE: Schwartz, 2014. Reprinted with permission.

CONSIDERATIONS IN COMPARING DOSE WITH POPULATION-LEVEL CHANGES

To compare the dose of interventions with changes in population-level behavior and health, Schwartz emphasized, measures of population health are important. These measures can take a long time to create and collect, "and sometimes you can't measure it, even when you have a strong intervention, due to power or other problems with the data," Schwartz observed. "But even small changes are very meaningful. If you can detect small changes, it's over a population, so it's a big deal."

Other forms of evaluation also can be valuable. For example, one strategy Schwartz and her colleagues have used is PhotoVoice, which entails giving people cameras and having them take pictures related to barriers to health in their community, and then write captions to describe those barriers and how they can be overcome. "We have seen huge results there," she said, "and meaningful changes created and documented by residents . . . advocating their needs through their voice and a photo."

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Evaluations also need to provide immediate feedback for program improvement, Schwartz said. Communities and programs need to know that they are on track. When a program can be improved, the evaluation should provide information that can lead to revised strategies that enhance impact.

The concept of dose is exciting, Schwartz concluded, but it also is a new concept that needs to be further developed and tested. To date, it appears to be a valid and useful measure, "but we're early on in our learning," she said. In addition, while behavior change at the population level can be measured more easily in schools, its measurement is more difficult in the community at large. Still, the concept of dose can help identify promising interventions and give priority to those that work.

"Everyone is willing to contribute a piece to the solution. Everyone has a part to play, and we need to think creatively of how we can synergize those parts to work together for the greater good."

—Amelie G. Ramirez of Salud America!

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6

The National Prevention Council: Bringing Federal Agencies Together to Build Health and Resilience in Americans[1]

Highlights from the Presentations of Individual Speakers*

- Mandated by the Patient Protection and Affordable Care Act of 2010, the National Prevention Council (NPC) is coordinating health prevention activities across and within federal agencies that employ more than 4 million Americans. (Lushniak)
- The U.S. General Services Administration, an NPC member, has brought in farmers' markets, promoted healthier food in its cafeterias, and supported bicycle share programs and walking paths around federal government buildings. (Damour)
- Major challenges in changing health behaviors within the federal government are a shortage of funding and the difficulty of sustaining momentum over time as administrations and political appointees change. (Levi)
- Leadership at the local level can unite a community and change its culture with respect to health issues. (Levi)

*Highlights identified during the presentations and discussions; presenter(s) to whom statements are attributed are indicated in parentheses.

The second half of the workshop focused on five case studies of successful cross-sector initiatives aimed at fighting obesity. Speakers described the

[1]See Appendix B for additional information.

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barriers and challenges faced by and lessons learned from their initiatives in the context of the four overarching considerations of health equity, sustainability, leadership, and measurement discussed in Chapters 2–5, respectively.

The first case study, discussed in this chapter, focused on the National Prevention Council (NPC), which was created under the Patient Protection and Affordable Care Act of 2010 to provide leadership and coordination across 20 federal agencies in working together on prevention, wellness, and health promotion activities.[2] The member agencies represent sectors ranging from health and environment to education, housing, transportation, and defense.

Workshop attendees heard about the council's efforts from the perspectives of three speakers: NPC chairman Rear Admiral Boris Lushniak, who is acting U.S. Surgeon General and oversees the U.S. Public Health Service Commissioned Corps; Susan Damour, regional administrator for the Rocky Mountain region of the U.S. General Services Administration (GSA), an NPC member; and Jeffrey Levi, executive director of the Trust for America's Health, who chairs the NPC's Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. Melissa Lim Brodowski, acting senior advisor for policy and outreach with the Office of the Surgeon General at the U.S. Department of Health and Human Services, and Brigette Ulin, director of the Office of the National Prevention Strategy in the Centers for Disease Control and Prevention's Office of the Associate Director for Policy, participated in the subsequent discussion.

DEVELOPMENT OF THE NATIONAL PREVENTION STRATEGY

Lushniak began by explaining that embedded among the hundreds of pages of the Affordable Care Act is a section emphasizing the importance of health prevention. "This is the law of the land," he said. "This is really the first time that a major legislative piece told us, hey listen, it is not just about us treating illnesses and injuries—that we do have to get ahead of the curve."

The NPC was formed within the U.S. Department of Health and Human Services and was initially chaired by former Surgeon General Regina Benjamin. Some of the 20 member agencies had to be convinced that they needed to be in the room, Lushniak recalled, because their department or office did not have the word "health" in its name, so they questioned what connection they had with health and wellness. "The learning curve, although at times rather steep, really pointed in that direction saying, 'Guess what, we are all responsible for health and wellness by government

[2]For more information, see http://www.surgeongeneral.gov/initiatives/prevention/index.html.

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policies, by the fact that we have . . . employees that we can influence,'" said Lushniak. Roughly 4.1 million people work for the federal government, all with family members, he noted. "What the feds do—this big elephant—in fact does leave an impact," partly by setting a policy example for others to follow. "What we are asking people to do is stand in line with us because the prevention and health and wellness movement has to grab hold in this country," said Lushniak.

In 2011, the NPC released the National Prevention Strategy (NPC, 2011), which focuses on seven priority areas for improving health and wellness among Americans (see Figure 6-1). Two of these priorities—active

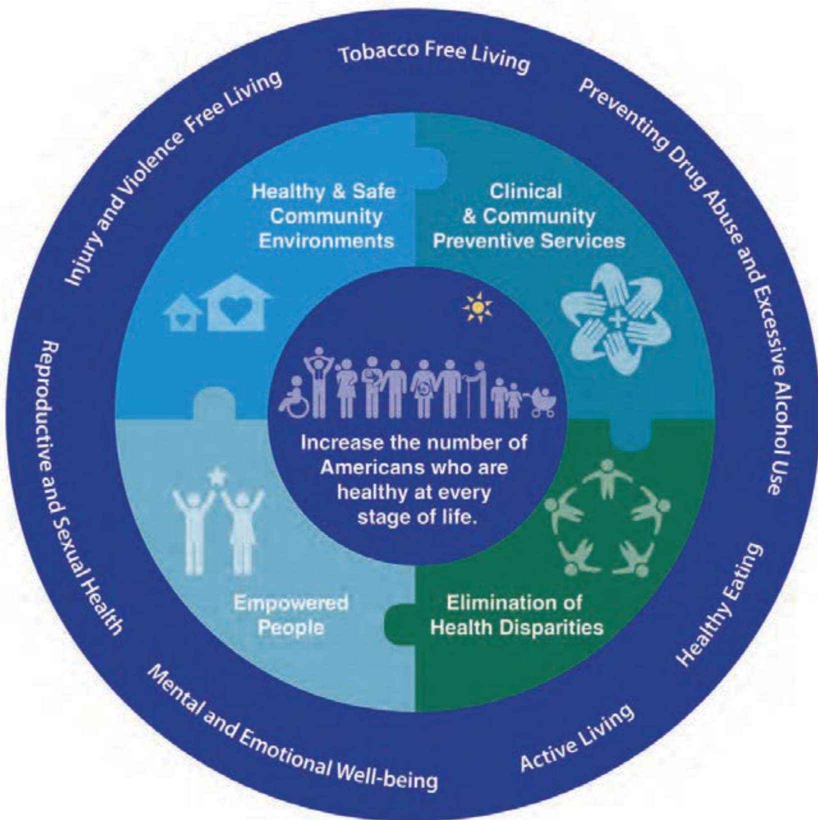

FIGURE 6-1 The National Prevention Strategy has four broad goals (inner circle) and seven priority areas (outer circle) for improving health and wellness among Americans.
SOURCE: NPC, 2011.

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living and healthy eating—apply to the discussion at the workshop and are major parameters "that need to be altered in the formula of obesity in this country," Lushniak said. "It is a complex world out there, but sometimes simplicity will bring us a step forward."

The National Prevention Strategy lays out four strategic directions: healthy and safe community environments, clinical and community preventive services, empowered people, and the elimination of health disparities. The concept of "empowered people" is key, Lushniak observed, because Americans do not like to be told what to do. The job of public health officials is to get past health literacy barriers and provide people with correct information, whether it is about smoking or a nutritious diet, "so that ultimately, when it is decision time, they make the right decision." With healthy eating, the goal is to provide the tools, the knowledge base, and the opportunity to access healthy food, including in "food desert" areas.

In 2012, moving toward implementation within its member agencies, the NPC created an action plan with three areas of focus (NPC, 2012): (1) introducing the concept of prevention into the lives of employees and staff, (2) tobacco-free workplaces, and (3) access to healthy foods within the "federal family." "In public health, you cannot afford to be a pessimist," Lushniak noted. "We have a new flag, and that new flag in the federal system is the National Prevention Strategy." The Affordable Care Act "was not the most popular thing on this planet," he pointed out, but it is the law and it is supported by the President. Lushniak's personal view as acting surgeon general is that "we cannot drop the ball on this one. It has to continue with or without us in these leadership positions," given that changes in administration will happen.

Lushniak hopes to elevate the public discussion of health to a level where people understand that "health is the most important thing for the future of our nation," he said. "It runs the economy. It runs the defense of our country." But the change in attitude has to begin at the individual level, starting with public health experts and health care officials "walking the walk," Lushniak said. "We all need to be examples for everybody else."

OBESITY PREVENTION IN THE GENERAL SERVICES ADMINISTRATION

Damour next described how prevention-related work is playing out within GSA and the "federal family" in the Rocky Mountain region. She is not a health expert but rather a "dealmaker" who oversees GSA operations in Denver and the five surrounding states.

GSA has child care centers, and 97 percent of all the child care centers across the United States sponsored by GSA are certified by the "Let's Move! Child Care" campaign as promoting exercise and healthy food. Damour's

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agency also coordinated 19 farmers' markets across the federal government, is working to ban e-cigarettes in its buildings, and is promoting healthier food and sustainable practices in its cafeteria and vending machine operations. The latter is an uphill battle, though, because "many of the people who are vendors in our areas are very frightened that the revenue will go down if they shift what they are doing," she noted. GSA also supports bicycle share programs, walking paths, and fitness centers.

Damour's favorite program is Feds Feed Families, in which all the federal agencies give food to community food banks. In her region, "we donated healthy food," she said. "We bought food from our farmers' market all summer long that was fresh fruits and vegetables—the only donations like that going into our food bank."

On the federal level, the Rocky Mountain region is one of two regions in which regional surgeons general have brought U.S. agencies in their area together to form an active National Prevention Strategy team. Team members share best practices on, for example, making their buildings smoke-free and healthier for greater employee productivity.

Damour also has been building partnerships with communities, state health departments, and nonprofit organizations. In collaboration with the Boston-based literacy-promoting nonprofit Reach Out and Read, she created bookmarks in Spanish and English to hand out to families at child care and health centers as "a way to talk to parents, not only about good reading, but about good eating and good exercise." Another exciting project she is developing is with Denver International Airport, which is a waystation for travel to states with limited services such as Montana, North Dakota, South Dakota, Utah, and Wyoming. Damour's idea is to get the airport to partner with the NPC on creating walking paths in and out of the building and offering healthier food options or gifts, such as jump ropes, for children.

The strategies and projects Damour highlighted are about behavior change, but the challenge of bringing change to the federal government is "we don't have the money," she said. In addition, Damour noted that with people like herself being political appointees who come and go, a big question is how to sustain prevention and wellness champions when administrations change.

INSPIRING BROAD LEADERSHIP

While there is consensus that multisector collaborations are needed to address the obesity epidemic, the question is whether the National Prevention Strategy can inspire broader federal leadership on this issue. Levi suggested that the NPC can be a model for how to proceed. The very process of writing the National Prevention Strategy helped shift the thinking of some

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agency representatives who initially did not understand why they were part of the council, Levi pointed out. "That is the kind of culture change we need to be replicating," he said

The Advisory Group's mission is to think about the NPC's potential for leading cross-sector approaches. That potential is important because Damour's examples of bringing people together to collaborate are unfortunately the exception rather than the rule, Levi said. "Even with the obesity-related goals of the Prevention Strategy, the agencies have really been focused on interventions that can be achieved within their own silos," he noted. The real success of the NPC and its National Prevention Strategy "will be measured when and if we see much more work across jurisdictions," he said, and if federal agencies inspire common action among their employee constituencies and grantees.

To demonstrate the value of the cross-sector approach, the Advisory Group recommends that the future incoming surgeon general develop one or more focused community health initiatives designed to engage several Cabinet-level agencies in collaboratively addressing obesity or some of the social determinants of health. The Advisory Group also suggests that NPC agencies use a collective impact framework for assessing the initiative, including the use of common data-gathering mechanisms and outcome measures (Advisory Group on Prevention, Health Promotion, and Public Health, 2014).

Such an effort will encounter significant practical challenges, such as how different collaborating agencies will "braid and blend" funding streams on the ground, Levi noted. "If we really believe in these multisector collaborations, if we really believe that these things ought to come together, the federal government shouldn't just be inspiring," he said. "It needs to create the mechanisms that allow this to happen in an easier way at the local level."

One new opportunity that has emerged from the Advisory Group's work is a national collaborative on education and health that it established with support from the Kellogg Foundation, the Robert Wood Johnson Foundation, and Kaiser Permanente. The project is bringing people from the health and education sectors together to develop common health metrics that could be integrated into school report cards, and to work on integrating schools as key players in the health reform system. The Advisory Group also sees an opportunity for addressing obesity through the ongoing work on population health initiatives supported by the Centers for Medicare & Medicaid Services, which appears to be increasingly interested in addressing social determinants of health, Levi said.

Levi added that a particularly critical element for success is leadership at the local level that changes the culture in a community and brings it together. At the federal policy-making level, the fact that obesity is a major

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driver of health care costs, which could diminish the nation's economic competitiveness, helps in getting people to pay more attention to the problem. But workable solutions also are needed, and "we are now at the stage where we actually have some of those viable solutions," Levi said.

"To me, cross-sector is the alignment of resources to meet common goals. . . . Obesity is one of those issues that we really need to address as parents, within the schools, within the community."

—Lisa Gable of the Healthy Weight Commitment Foundation

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7

A Statewide Strategy in the Battle Against Child Obesity in Delaware[1]

Highlights from the Presentations of Individual Speakers*

- Nemours, a pediatric health system traditionally focused on individuals and patients, has devised a cross-sector, statewide community-based approach to preventing childhood health problems, including obesity, across Delaware. (Chang)
- Nemours has served as an "integrator," bringing together all the systems in the community involved in caring for children to work collaboratively. (Chang)
- One key lesson learned from prevention work in Delaware is to be flexible and let community partners lead the way. (Chang, Mouser)
- Early childhood programs offer an opportunity for instilling healthful eating and physical activity habits at a young age that children can take home to their families and communities. (Riley)
- Key elements of successful school programs focused on physical activity include state-initiated policy changes, leadership, and a wellness committee; sustaining the programs requires supporting individuals who are implementing them. (French)

*Highlights identified during the presentations and discussions; presenters to whom statements are attributed are indicated in parentheses.

[1]See Appendix C for additional information.

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More than a decade ago, Delaware-based Nemours, one of the largest children's health systems in the United States, decided to tackle the root causes of childhood illnesses through a new emphasis on prevention. The organization made a strategic move to look beyond the 50,000 children who came into its hospitals and clinics and to work on improving health outcomes for all 230,000 children served by its system across Delaware. An operating division called Nemours Health & Prevention Services (NHPS) was created to improve pediatric health over time through a cross-sector, community-based approach that includes developing, implementing, evaluating, and promoting model prevention interventions.

Four speakers presented an overview of the Nemours experience: Debbie Chang, who created NHPS and is enterprise vice president of policy and prevention at Nemours; Helen Riley, executive director of St. Michael's School and Nursery in Wilmington, Delaware, which was a pilot site for the first early care and education NHPS project in the state; Mary Beth French, a physical educator who is content chair for physical education and health teachers in the Christina School District and chairs the Health and Physical Education Committee for the Christina School District, an NHPS partner; and Mary Kate Mouser, operational vice president of NHPS.

AN INTEGRATED COMMUNITY HEALTH MODEL

Chang explained that Nemours shifted its approach "from looking at biomedical [issues] to focusing on a multifaceted view of health, from focusing on acute episodes to focusing on chronic disease and prevention, from focusing on individuals and patient panels to focusing on communities and populations." The goal was to connect clinical care and population health into an integrated community health model. "It really starts with a vision," Chang said, "and the vision is optimal health and well-being for all children in the state of Delaware."

Nemours initially developed the model around reducing overweight and obesity in children and has since applied it to asthma, emotional and behavioral health, and other areas. Using the best science available, Chang and her colleagues have worked on policies and practices in multiple sectors, including child care, schools, primary care, and the community. Nemours has "served as an integrator in the community," Chang said, meaning that it has been working to bring together all the sectors that care for children to produce improved health (see Figure 7-1). One lesson learned from this experience "is to be flexible and take the lead from the community," she noted.

One component of the Nemours initiative started with local pilot projects in early care and education focused on obesity prevention. The initiative then began working at the state policy level on collaborative projects—such

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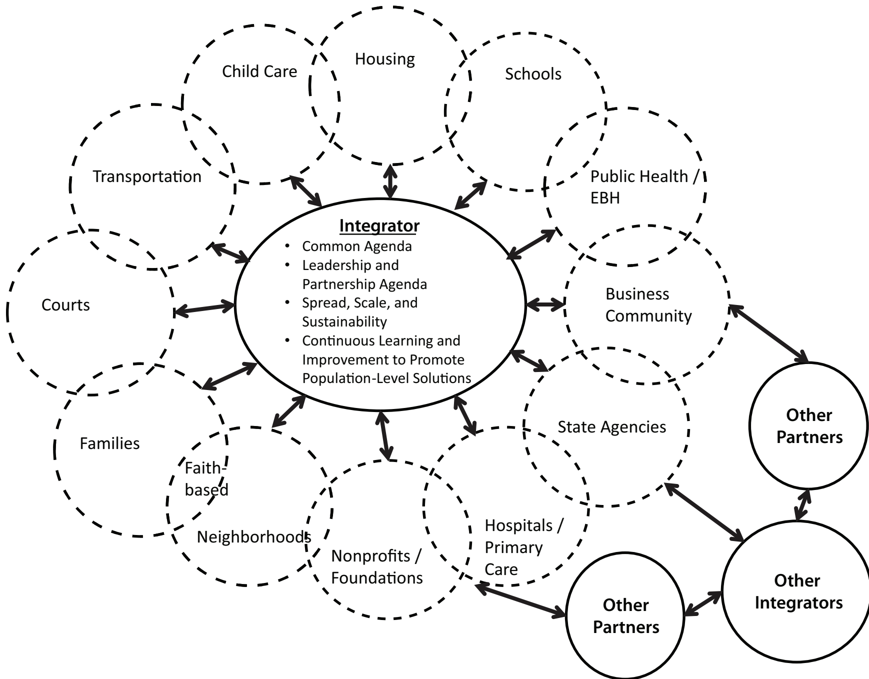

FIGURE 7-1 Nemours served as an integrator for efforts to prevent childhood obesity.
NOTE: EBH = evidence-based health care.
SOURCE: Chang, 2012. Reprinted with permission.

as with Sesame Street—aimed at promoting healthy eating and physical activity. Most recently, the initiative has gone national: Nemours is now working with the Centers for Disease Control and Prevention on diffusing its collaborative approach to nine other states across the nation. "The time is right now for spreading and scaling what works," Chang said.

GETTING STARTED ON PREVENTION IN EARLY CHILDHOOD PROGRAMS AT ST. MICHAEL'S SCHOOL

Riley presented "a case study within our state case study," summarizing 10 years of work at St. Michael's School in collaboration with NHPS. The school works with 160 children from 2 months to 8 years old, interacts with more than 200 families, and has 50 adult staff members.

A number of key factors influence every child's health, Riley said: behavior accounts for 40 percent of the determinants of health, genetics

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for 30 percent, social and environmental factors for 20 percent, and quality health care for 10 percent (McGinnis et al., 2002). Riley noted that many children spend most of their daily hours in early education settings and between the behavioral and social/environmental factors, "we have control over 60 percent of the determinants of children's health." In addition, schools help ensure that children receive immunizations and annual health care checkups and assist with early identification of and interventions for genetic issues. "We address every aspect of a child's determinants of health," Riley said.

Riley's message on prevention is to begin early: "It is never too soon. If you want to work on prevention, start when a child is born." For example, St. Michael's carried out a healthy eating project with NHPS in which even very young children worked on planting lettuce gardens. "Early childhood programs are a good place to start," Riley said. "Our parents come into the building twice a day to drop their children off, pick their children up. We have a high level of trust and a strong relationship that is built with them."

Riley recommends teaching healthy living in early childhood curricula and keeping important lessons clear, short, simple, and stated in positive terms. Hands-on learning activities are best. To encourage exercise, educators can try movement to music, yoga, and dance. "Activities for children need to be balanced between structured exercise, organized games, and free play," Riley suggested. Rest and relaxation also are extremely important, she observed, since young children experience a great deal of anxiety, stress, and tiredness.

While St. Michael's has seen success with its prevention projects, ensuring sustainability in spreading its health messages is a challenge. The hope is that the children become "the Trojan horses" who carry the healthy lessons home to their families, and that those families then spread the messages to their neighborhoods and communities. Riley also pointed out that she and other teachers and parents are not always the best models for healthful behaviors. Nevertheless, early childhood education is a fertile opportunity to address a very large population: when the school is successful, students go home and talk to their families, friends, and neighbors about what they have done and what they have learned.

GETTING KIDS MOVING IN THE CHRISTINA SCHOOL DISTRICT

French shared the Christina School District's perspective on creating sustainable change in health prevention as a partner with NHPS. In 2006, Delaware state lawmakers concerned about childhood obesity passed legislation to pilot physical education and physical activity programs for

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students.[2] House Bill 372 also required schools to assess the fitness of students at least once in elementary, middle, and high school.[3]

Those policy changes spurred the development of school pilot programs, which were subsequently scaled up for diffusion to other schools. Key factors in creating successful pilot programs included wellness committees formed within each school and technical training sessions held by NHPS with the state Department of Education. Other important factors, French noted, included acknowledging barriers and helping to find solutions.

Eight years later, these programs still continue in many Delaware schools. An example is an initiative designed to help public elementary schools incorporate 150 minutes of moderate to vigorous physical activity into the school week for every student. "Make School a Moving Experience" at Brader Elementary in the Christina School District—developed by NHPS and funded by a Carol M. White Physical Education Program grant includes a "ride and read" option whereby students can pedal stationary bikes while reading books. "These bikes are located throughout our building," including classrooms, French said. The school district also has embedded physical activity into the busy school day with morning exercises and into subject areas with such programs as Take 10! and North Carolina Energizers.[4]

Some of the elementary schools in the Christina School District, such as Brader Elementary, have a review process in place that entails using data and student surveys to measure progress. Student-interest surveys are useful for determining which physical activities the children like, French said. The district also assesses fitness in students using the FITNESSGRAM®[5] tool.

To sustain prevention work, noted French, it is important to provide opportunities to attend conferences where the people involved can discuss and celebrate successes and connect with current and potential future partners for cross-sector collaboration. Also important is support for writing and applying for grants to obtain financial backing. Moreover, said French, "to accelerate our movement forward, we need to take a look at continued collaboration . . . but also professional development for all parties."

In French's view, changing school culture to embrace physical activity in the daily routine will require making changes at the national level—such as working with textbook publishers to embed physical activity and nutrition in lessons and including physical activity in national initiatives such

[2] 41 Delaware Code, Title 14 § 4133 Physical Education/Physical Activity Pilot Program.

[3] 41 Delaware Code, Title 14 § 122(b)(23) Rules and Regulations.

[4] For more information, visit http://www.take10.net and http://www.eatsmartmovemorenc.com/Energizers/EnergizersForSchools.html.

[5] For more information, visit http://www.fitnessgram.net.

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as No Child Left Behind. Preservice teacher education programs also need to make physical activity breaks part of their lesson development, she said.

During the discussion period, Chang asked whether leadership from the top is one of the requisite ingredients for successfully replicating the Delaware health prevention experience. Such leadership is not necessarily required, French responded. In the Christina School District, the work started with French, as a member of its wellness committee, giving a presentation on the obesity-fighting and academic benefits of physical activity for students. Twelve schools signed onto a physical activity pilot program. Each school may have started off with one champion, but the effort took off from there. Many teachers stepped up to take on after-school programs, French said, such as the successful vegetable garden at the school where she teaches. She did not have to beg colleagues to pitch in or to bring others to help. "They just start to come," she said.

THE NHPS APPROACH: LETTING COMMUNITY PARTNERS LEAD THE WAY

Mouser rounded out the Nemours case study presentations by showing a slide of the NHPS conceptual model (see Figure 7-2). She summed up the NHPS philosophy: "We try to help our partners be as successful as they can. We try to remove barriers. We work with them. We take the lead from them as to what we should be doing and what we shouldn't be doing."

Although much work remains, Mouser and her colleagues are seeing a qualitative and quantitative impact of the NHPS efforts across the state. Evidence indicates that "in schools, we can show that a child who is more physically fit is able to have greater academic achievement." Child care centers participating in pilot programs with Nemours all showed an increase in active living and healthy eating in their facilities. Children engaged in CATCH (Coordinated Approach To Child Health) sites with which NHPS has worked across the state increased their physical activity by 20 percent.[6]

Mouser pointed to other impacts, including improvements in child care regulations and a $30 million state investment in public trails and multi-use pathways.

At the population health level, a statewide children's health survey that NHPS launched in 2006 and repeated in 2008 and 2011 has shown that rates of overweight and obesity among Delaware's children have leveled off (NHPS, 2011). The proportion of children who get at least an hour of physical activity per day increased from 38.9 percent in 2008 to 44.8 percent in 2011 (NHPS, 2011).

One challenge has been developing a shared measurement system across

[6]For more detail about CATCH, visit http://www.catchinfo.org.

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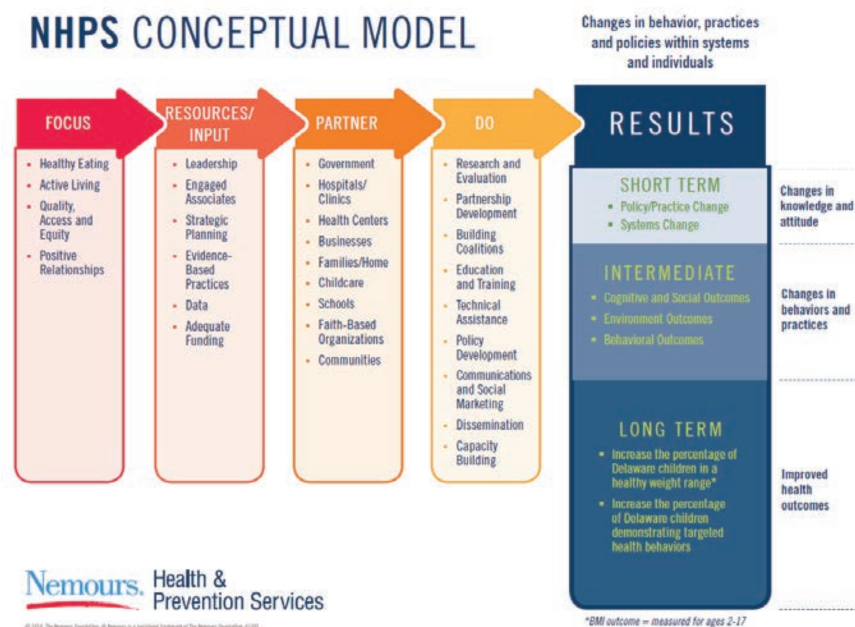

FIGURE 7-2 The NHPS conceptual model moves from broad focus areas to specific changes in behavior, practices, and policies.
SOURCE: Mouser, 2014. Reprinted with permission.

all the community partners for tracking improvement in child health outcomes so as to demonstrate the collective impact of their efforts, Mouser said. A lesson learned is the importance of mining and analyzing data to drive decision making and continuous improvement. This and other lessons learned can be harnessed to inform diffusion, scale-up, and sustainability.

In the past 2 years, NHPS has begun looking at its prevention work through the lens of health access and equity (see also Chapter 2). Mouser and her team want to apply the most appropriate evidence-based interventions to address disparities in child health while carefully considering cultural needs and environmental factors that contribute to the problem.

To ensure that the Nemours cross-sector initiative yields lasting impacts, sustainability must be at the forefront, Mouser emphasized. Three lessons learned in this regard stand out. First, Nemours and its partners must be opportunistic in determining which policy systems and environmental changes will lead to improved child health outcomes over time. Second,

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they must identify and leverage grants and maximize other funding streams with partners and coalitions. Third, they must build programmatic and leadership capacity with targeted community partners and coalitions to diffuse, scale up, and sustain change.

The bottom-line requirement for establishing a sustainable statewide strategy to combat childhood obesity, Mouser emphasized, is to have effective leadership at all levels across sectors—leaders willing to make the investment to create policy systems and make environmental changes that help children grow up healthy. According to Mouser, effective leadership means coordinating programs and connecting services so that program silos are eliminated, building trusting relationships with partners to foster shared goals and leverage resources, and identifying and supporting "champion integrators." As to the question of whether leadership must come from the top, Mouser said that leaders come in all shapes and sizes and that leadership is about "having the dream and the vision."

Although Delaware's statewide prevention initiative got off the ground with Nemours' support, Mouser said, the health care system from the outset sought to work closely with community partners to determine how to make that happen. "It has really been led by partners," Mouser emphasized. The initiative is "taking the community, the needs, and looking and seeing what those are and driving forward from there. It is a very organic approach in some ways."

GETTING PARENTS AND FAMILIES ON BOARD

During the discussion period, Joseph Vivens, author of *Chunky and Friends: Chunky and the O-Beast*—a children's book about healthy eating, active playing, and obesity—asked about strategies for engaging parents. When out selling his book, he has seen overweight children who are very receptive to messages about healthy eating, but sometimes their parents will look back at their children in an individualized blaming sort of way, Vivens said. How does one deal with that?

Riley responded that one strategy is to "start as early as possible" with talking to children about healthy habits that they then take back to their families. At St. Michael's School, she sits in the lobby every day from 4:30 p.m. to 5:30 p.m. and engages with parents as they pick up their children. She asks students, "Can you tell your mom what vegetable you had for lunch today, or can you tell your dad what was on the menu this morning for breakfast, and did you like it and do you want it again?" The parents are standing there and hearing their children say they love beets. "Let the child make the case," Riley said.

Another way to involve parents is by showing them what their children's school is doing to ensure that they are healthy and then providing

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opportunities to expand that approach into their homes, French said. Her school, for example, which has a successful vegetable garden, has brought parents in at night and given them vegetable seeds so they can plant their own gardens at home.

Mouser added that Nemours is starting to look at multigenerational approaches that entail involving families in its prevention work. Nemours has had a great deal of success in working with partners to get parents, grandparents, and children gardening together, she said.

THE PROS AND CONS OF A STATEWIDE APPROACH

During the discussion period, Chang asked the other panelists to comment on the advantages and disadvantages of taking a comprehensive, statewide approach. When Nemours decided to work with all the sectors that care for children (see Figure 7-1), "it was a lot to do at once," she recalled. "It has paid off to approach it that way. But at the time, it was a tremendous amount of work."

Mouser emphasized the importance in the NHPS model of bringing all the sectors together. Initiative leaders must prioritize, depending in part on the readiness of different communities, which range from inner cities to rural areas. "It is not a one size fits all," she said of the statewide strategy. "Approaches have to be customized appropriately, taking into account the great diversity and cultures that we are working with in our state."

A statewide approach does not mean "that everything is going to look the same in every building," French added. Within the NHPS strategy, different partners have the flexibility to develop their own programs.

"It's about making the case that there is common ground, and that there is value in working collectively to, again, achieve what might be different end goals for everybody, but they're all going in the same direction."

—Eduardo J. Sanchez of the American Heart Association

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8

PLACE MATTERS: Building People Power to Tackle Fundamental Causes of Obesity in Cook County, Illinois[1]

Highlights from the Presentations of Individual Speakers*

- Cook County PLACE MATTERS (CCPM) addresses the interconnection of systems of food production, distribution, marketing, and consumption by combining research documenting the inequitable distribution of health risks and resources across communities with grassroots organizing and activism and policy analysis. (Bloyd)
- People who are affected by health inequities are often the experts in their own challenges and are the ones who can develop effective solutions to the inequities. (Tendick-Matesanz)
- CCPM works to build the capacity of leaders and communities to address social, economic, and environmental conditions that shape health inequities. (Bloyd)
- CCPM's community partners include a labor organization that fights inequities in the food service industry, such as by advocating for paid sick days for low-wage restaurant workers (Tendick-Matesanz).

*Highlights identified during the presentations and discussions; presenter(s) to whom statements are attributed are indicated in parentheses.

[1]See Appendix D for additional information.

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Cook County, Illinois, is the focus of a cross-sector effort that entails advocating for food justice as an essential way to target the fundamental causes of obesity. The work there is one of 19 regional projects participating in PLACE MATTERS, a national initiative of the National Collaborative for Health Equity (NCHE), which connects research, policy analysis, and communications with on-the-ground activism to advance health equity (Christopher et al., 2010; see also the discussion of health equity in Chapter 2).

NCHE executive director Brian Smedley explained that the collaborative's mission is to build the capacity of leaders and communities to address social, economic, and environmental conditions that shape health inequities. PLACE MATTERS' 19 teams across the country are beginning to build political and public will for "policy and systems change that will address the heavy concentration of health risks that are too often found in highly segregated communities of color around the country," he said.

Food justice, the focus of Cook County PLACE MATTERS (CCPM),[2] is not just about what people put into their bodies, Smedley said; it is also about how the systems of food production, distribution, marketing, and consumption interconnect. The Cook County initiative combines research documenting the inequitable distribution of health risks and resources across communities with grassroots organizing and activism and insightful policy analysis to identify solutions.

Smedley introduced the panel of three speakers who shared their accounts of the Chicago-area case study: Jim Bloyd, leader of the CCPM team, who co-leads the community health improvement and planning process at the Cook County Department of Public Health; Felipe Tendick-Matesanz, programs coordinator at Restaurant Opportunities Centers (ROC) United in Chicago, which seeks to create a sustainable food economy; and Bonnie Rateree, a community advocate who leads the Human Action Community Organization in Harvey, Illinois, and is school board vice president for Public School District 147.

THE CONNECTIONS AMONG FOOD, NEIGHBORHOODS, AND HEALTH INEQUITIES IN COOK COUNTY

Bloyd described the CCPM vision: "to build a health equity movement that works to eliminate structural racism[3] and creates the opportunity for

[2]For more information, see https://www.facebook.com/ccplacematters and youtube.com/ccplacematters.

[3]This workshop summary provides a brief discussion of structural racism, but a deeper treatment of the topic is available in the 2003 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (IOM, 2003).

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all people of Cook County, Illinois, to live healthy lives." The main point of the program is that the roots of the obesity epidemic lie in poverty; structural racism; education; and unhealthy neighborhood and living conditions, including a lack of access to healthy food that disproportionately affects people of color. Bloyd's team wants to address these barriers, he said.

The CCPM strategy is informed by the research of Adam Drewnowski, who has observed that while studies of obesity in the United States have steered clear of the complex issues of poverty and social class, the quality of people's diets is reliably predicted by education, occupation, income, and other indices of social class (Drewnowski, 2012). Organizing "people power" against the greater influences of money and privilege is the way to enact healthy public policy, Bloyd said. CCPM does that by working with ROC United—which aims to address racial segregation and improve labor conditions for restaurant industry workers—and by building alliances with social justice champions such as Rateree.

The program raises public awareness of health inequities through its newsletter, social media, and discussions of such films as the *Unnatural Causes* documentary series (California Newsreel, 2008). It also educates and builds relationships with policy makers such as Cook County board president Toni Preckwinkle. When CCPM released its 2012 report (Joint Center for Political and Economic Studies, 2012), Bloyd quoted Preckwinkle as commenting: "It is shameful that we live in one of the wealthiest countries in the world and that a person's life can be cut short by more than a decade because of factors outside her or his control. People living in areas with a median income greater than $53,000 per year have a life expectancy that is almost 14 years longer than people living in areas with a median income below $25,000 per year" (see Figure 8-1). The CCPM report offers several recommendations, Bloyd said that sufficient funds be allocated to increase healthy food retail outlets in neighborhoods with low food access; that the voices and aspirations of neighborhood residents be reflected in solutions to hunger and poor nutrition; that workplace justice be ensured for workers throughout the food chain, including the restaurant industry; and that persistent poverty be addressed through the engagement of multiple sectors.

To illustrate how population demographics relate to income levels and diet, Bloyd noted that the child poverty rate in Harvey in south suburban Cook County—where two-thirds of residents are people of color—is 45.4 percent (Cook County Department of Public Health, 2008). That rate is six times greater than the rate in north suburban Cook County, where two-thirds of residents are white. Other data show that African American ninth graders in suburban Cook County reported eating less fruit, fewer green salads, and fewer carrots in the previous week compared with other racial groups (Cook County Department of Public Health, 2010).

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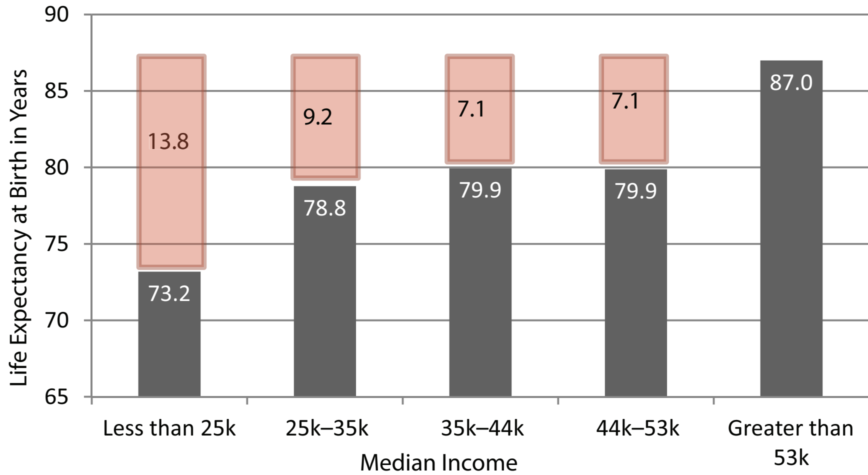

FIGURE 8-1 Average life expectancy is lower for people who live in census tracts or municipalities in Cook County with lower median incomes. Life expectancy calculated by the Virginia Commonwealth University Center on Human Needs from 2003–2007 data provided by the Cook County Department of Public Health and the Chicago Department of Public Health; median income based on Geolytics Estimates Premium for 2009.
SOURCE: Adapted from Joint Center for Political and Economic Studies, 2012. Reprinted with permission.

Further evidence of how place matters to people's living conditions is the dramatic effect of segregation in Metro Chicago: while 90 percent of poor white children live in low-poverty neighborhoods, about 75 percent of poor black children and 45 percent of poor Latino children are exposed to "the life-threatening environments of higher-poverty neighborhoods," Bloyd said (Heller School for Social Policy and Management, 2011; IOM, 2008). He noted that this pattern "has some of its roots in the state-sponsored segregation of the 1930s Home Owners Loan Corporation" (California Newsreel, 2003; Jackson, 1980).

PROTECTING WORKERS IN THE FOOD SERVICE SECTOR

Tendick-Matesanz highlighted the social justice struggles of the 13 million workers who prepare, deliver, and serve the nation's food in the restaurant industry. He hoped to "plant a little seed" to make listeners realize that "a lot of the conversation we have been having today is actually a human rights conversation, versus just a public health conversation."

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Tendick-Matesanz grew up in a family that owned a fine-dining restaurant and paid their employees relatively high wages, with sick days and benefits. In 2008, he co-founded ROC United, and since then he has been "building power with workers and addressing inequality and inequity in the food system."

ROC United is the only national nonprofit dedicated to improving the wages and working conditions of U.S. restaurant workers. Its national worker center has more than 10,000 members. Its innovative approach to system change is based on research and policy, workplace justice, and promotion of the "high road" to profitability. "At our core is the human right to work with dignity," Tendick-Matesanz said. "We provide this through building power and community organizing with workers, owners and entrepreneurs, and consumers to create what I like to call a shared prosperity outcome."

The restaurant industry is one of the fastest-growing sectors of the U.S. economy and the country's second-largest employer. Yet ROC United's research has found that the industry has some of the nation's lowest-paying jobs, with little access to benefits and career advancement. "Nearly 90 percent of workers do not receive paid sick days. And lower-wage positions within the industry are predominantly filled by women and people of color," Tendick-Matesanz said.

Racial discrimination is widespread in the industry, Tendick-Matesanz noted: workers report being passed over for promotion because of their race, and employees of color are paid less than white employees (Restaurant Opportunities Centers United, 2014b). Other major problems include rampant labor violations, consistent failures to ensure occupational health and safety and public health, and wage stagnation (Restaurant Opportunities Centers United, 2010, 2011). The federal wage paid to tipped workers has been frozen since 1991. Although federal law requires employers to make up the difference between the tipped wage and the minimum wage, a U.S. Department of Labor investigation found that 84 percent of employers were noncompliant. Tipped workers live in poverty at three times the rate of the U.S. workforce, and 46 percent of them are single mothers (Restaurant Opportunities Centers United, 2014a).

To address such injustices, ROC United is tackling large players, including the Darden Company, which owns 13 brands, including the Olive Garden. "We have found consistently poor working conditions," Tendick-Matesanz said. "We are putting a lot of pressure . . . to change the working conditions in the restaurants and then influence other players."

Recently, ROC United helped a coalition pass the first law in Washington, DC, requiring paid sick days for restaurant workers. Paid sick days are "a very important and essential need for many of us if we are going to talk about health and health inequity," Tendick-Matesanz pointed out.

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FIGHTING FOR FOOD JUSTICE IN HARVEY, ILLINOIS

Rateree spoke about food justice issues facing the working poor of south suburban Cook County, where she has been active in cross-sector efforts involving partners ranging from her public school district and the county health department to Ingalls Hospital and the Harvey Community Center. She began by showing a photograph of a local playground for which she helped lay concrete. The playground was a collaborative project with KaBOOM! "We built the playground, we built the garden boxes, an outdoor classroom. . . . It is a wonderful experience to show what we can do when we collaborate."

PLACE MATTERS research showed that Rateree's community has suffered from discrimination through public policies and procedures, she said. Rateree is a school board member in the same school district where she was a student growing up. Between the time she was in kindergarten and the end of eighth grade, Rateree noted that the racial makeup of Harvey changed substantially, with African Americans increasing to 80 percent of the population (Cook County Department of Public Health, 2008). That shift changed how children were educated and provided with health care. "We stopped getting the quality education that we had before," she recalled. "We stopped getting the funding because we [as a society] stopped caring about the children in the room."

Those changes in education financing had consequences for school food, Rateree pointed out. She tries to teach students to plant their own gardens and eat more fruits and vegetables, but as a school board member, decision maker, and leader, she can only give the children what she can financially afford. Her neighborhood is a place where people "get the least amount of money for education," a fact that dictates the school breakfast and lunch programs. Research by Ralph Martire at the Center for Tax and Budget Accountability shows that Illinois ranks 50th among states in the portion of public education funding covered by the state rather than by local resources, Rateree noted (Center for Tax and Budget Accountability, 2013).

Talking about race with a group such as the workshop attendees can be uncomfortable, Rateree said. Such talk "very often shuts you down," she told them. "You do not want to talk about it. We often do not want to think about it. It is that ugly part of our history that we wish would just go away. But today we use geography to continue this unequal system that causes obesity, chronic diseases, and early death. Food deserts exist in a neighborhood where grocery stores and community gardens used to stand."

Teaching children to grow gardens motivates them to eat healthfully, Rateree said. But it also teaches the importance of nutrition, the sciences, mathematics, and character development while exposing them to potential

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future career opportunities in health and nutrition. Education is a right. Yet the laws, policies, and procedures in the United States have historically and to this day denied people of color their human rights, Rateree said. She ended with a plea: "I am asking you, all of you who are here who are in any policy-making positions . . . please realize that what these communities need more than anything else is the same resources you have in yours."

CONVERSATIONS TO CONNECT

During the discussion period, Smedley asked the CCPM speakers how they began the conversations with each other to connect across sectors. What did it take to help them come to the same table and then continue to work together?

The process was gradual, Bloyd recalled. He and his colleagues had been interested in looking at nutrition, food systems, and food justice and were excited to promote the Healthy Food Financing Initiative in Illinois. In the course of that work, he met Rateree because of her activities in organizing community gardens and a farmers' market in Harvey. Meanwhile, CCPM's steering committee had observed that labor in the food system often was absent from discussions about healthy food, but recognized that the people who produce and harvest food and who cook, prepare, and serve it to customers in restaurants "need to have the same ability to feed themselves and their family nutritious foods," Bloyd said. So CCPM decided to pursue collaborations with labor, and ROC United was a perfect partner.

For his part, Tendick-Matesanz added that the CCPM partners all came from a "core of building together and from the ground up," looking for new approaches to accomplishing change. They often talk about how to foster decision making on the ground for those who are affected, especially since "people who are affected are often the experts in their own challenges." Building relationships "is easy," Tendick-Matesanz said. "Just go into the community and ask them what they need . . . and they will come up with the solutions."

"The great thing is that all of those different goals have convergent interests, convergent strategies, and that's where the real juice is."

—Loel S. Solomon of Kaiser Permanente

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9

PowerUp: Mobilizing Against Obesity in St. Croix Valley, Minnesota, and Wisconsin[1]

Highlights from the Presentations of Individual Speakers*

- PowerUp, a long-term regional children's health initiative that is anchored by two lead health care institutions in the St. Croix Valley, harnesses the resources and the power of social capital of 13 sectors and 130 community advisors, including schools and health departments. (Hedlund)
- Multiple levels of intervention are needed for a comprehensive approach to combating childhood obesity, including community engagement, changes in the environment, programs to change individual behavior, clinical care systems, and relationship building across sectors and levels. (Canterbury)
- Shared leadership with communities is essential for authenticity, momentum, and sustainability. (Hedlund)
- Practical and meaningful evaluation over time is key, and may include short- and long-course measurements of investment in partnership development, attitude shifts around eating and physical activity, policy, practice, and environmental change. (Canterbury)

*Highlights identified during the presentations and discussions; presenters to whom statements are attributed are indicated in parentheses.

[1]See Appendix E for additional information.

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Situated 25 miles east of the Minneapolis-St. Paul metropolitan area, the St. Croix Valley region straddles Minnesota and Wisconsin, with the St. Croix River defining the interstate boundary. The region encompasses two counties, 12 towns, and five school district areas and is home to 22,000 households with children aged 3 to 13.

This school-aged population is the target of PowerUp, a community-wide initiative to make better eating and active living easy, fun, and popular so that youth can reach their full potential. The program, which debuted last year, reflects a 10-year commitment by the nonprofit health care organization HealthPartners and its affiliate Lakeview Health to work with the community in improving population health in the St. Croix Valley region. Two speakers presented an overview of this initiative: Sue Hedlund, former deputy director of Washington County Department of Public Health and Environment in Stillwater, Minnesota, who currently chairs the Health and Wellness Advisory Committee for the Board of Directors of Lakeview Health Foundation; and Marna Canterbury, director of community health at Lakeview Health Foundation. Donna Zimmerman, senior vice president of government and community relations for HealthPartners, participated in the discussion following these presentations.

A MULTITIERED APPROACH

PowerUp uses a public health approach that considers multiple determinants of health to guide its efforts to improve health behaviors, reduce social and economic barriers to health, and change the environment, Hedlund said.[2] She noted that recent hospital and local public health assessments of community needs identified obesity as a top health priority for the St. Croix Valley region, and that addressing the problem will take strong cross-sector collaborations and "real relationships with real people" in the community.

The project was conceived when, in early 2011, HealthPartners formed a new affiliation with Lakeview Health, which is based in Stillwater, Minnesota, and each party made a commitment to advancing health in the areas served by the Lakeview Health system. In an unusual move, the decision on how to pursue that goal was not made by health executives but was instead "delegated to people in the community," Hedlund said. Tasked with determining what residents thought their community's needs were, the Board of Directors of Lakeview Health Foundation formed a Health and Wellness Advisory Committee, which came to include board members, community residents, school representatives, a pediatrician, and a nutritionist.

After learning about local health issues, the Advisory Committee

[2]For more information, visit http://www.powerup4kids.org.

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decided that preventing childhood obesity would be its priority. In 2012, it hired full-time staff, including a director, to help develop the children's health initiative. Many community members wanted to get involved, so the organizers "adopted a flexible committee and governance structure to accommodate the growth and get our communications, activities, and intervention strategies to work," Hedlund said. An initiative steering committee and workgroups were created. PowerUp was officially launched in May 2013 at a community event. "When we saw the enthusiasm of the community and the response from kids and parents, we knew we were on the right track at that point and were very happy with our planning process," Hedlund recalled.

The initiative is growing. In 2014 it added two more communities—Hudson and New Richmond, both in Wisconsin—in partnership with two other hospitals affiliated with HealthPartners. The organizers are finding that they need to use "different strategies that are very specific to each of those communities, because even though we are all in this region of the St. Croix Valley, each community is unique and different," Hedlund said.

PowerUp currently has around 130 community advisors who help lead and guide the initiative, support its strategy development, set priorities, and hold the organizers accountable for results. Approximately 13 sectors (depending on definitions) are represented in the initiative, including health care, school district administration, early childhood programs, businesses, nonprofit organizations that serve youth, civic groups, and faith community groups. Local health departments in Washington County, Minnesota, and St. Croix County, Wisconsin, have been key partners, bringing expertise in how to effect community engagement and implement obesity prevention strategies.

PowerUp's approach to building partnerships is to find "people who are committed to our vision," Hedlund said. "Many of our stakeholders are parents and kids. They are the ones we really need to listen to, because they are the ones telling us what the real-life experience is and what really happens." For instance, foundation board member Jim Leonard and his wife Mandy, who have daughters, have been tireless volunteers for PowerUp. "Mandy worked with the parent-teacher association to power up their entire school carnival," Hedlund said. "No donuts, no candy—just fruits, veggies, and a whole lot of fun for kids and adults." And when the outdoor community ice rink needed ongoing maintenance, Jim acquired a Zamboni machine and took on the job.

A key lesson from PowerUp is that shared leadership is essential for authenticity, momentum, and sustainability. "Our communities are making this happen with a wide variety of stakeholders who are bringing innovative ideas," Hedlund said. The stakeholders have forged many different connections and relationships, which have created a solid platform to build upon.

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At the same time, the initiative needs a strong collaborative lead organization, Hedlund said, "to hold everyone true to the vision and message." She noted that Lakeview Health and HealthPartners both have the value of collaboration ingrained in their "organizational DNA." "Even though they have a large financial stake in this initiative, they are allowing us in the community to do the work, and yet continually provide value, support, guidance, and expertise to the partners," she said. "Together we are sharing leadership, decision making, and recognition, and not only at the start of the initiative, but throughout as we implement the whole process."

Finally, dedicated project staff have been critical in advancing the initiative's efforts. Their contributions have included convening and listening to the community advisors, facilitating consensus, building community relationships, and providing expertise in evaluation.

A COMMUNITY-BASED FRAMEWORK THAT POWERS UP PARTNERSHIPS

Canterbury described the PowerUp initiative's community-based, multilevel operating framework (see Figure 9-1). As noted earlier, PowerUp is centered within the community, with community advisors providing guidance on its efforts. The initiative's multiple levels of effort include changing the environment of food and physical activity, engaging the community, providing programs to change individual behavior, and connecting with clinical systems that can identify and help higher-risk individuals. Building connections and engaging across these multiple levels of work also is important, Canterbury said.

Each partner in PowerUp brings unique strengths and perspectives to the table. For instance, Lakeview and HealthPartners contributed know-how in communications that was critical for community engagement. One goal was to ensure that the initiative's public health messages were positive and fun rather than finger-wagging "should" messages. The end result was a communications campaign featuring a cartoon carrot "superhero" named Chomp. "Children love him," Canterbury said. "They hug him. They write him letters. . . . While it is a great marketing tool, the reality is that this character brings kids in."

The real, on-the-ground progress of the initiative is being achieved through partnerships, whether with the local health department, early childhood centers, or hospital cafeterias. One example is the Open Gyms program, which came about because Wisconsin and Minnesota are cold and dark for many months of the year. This climate creates an issue for parents: Where do they go for a free or affordable place to be active with their children when it is too cold or unsafe outside? Starting in the Stillwater School District, PowerUp developed partnerships to make school gyms

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FIGURE 9-1 The PowerUp framework encompasses multiple levels within communities.
SOURCE: HeathPartners, Inc., 2013. Reprinted with permission.

and pools more accessible to families. "This year, five communities through school districts or their community centers will be opening up Open Gyms weekly," Canterbury said. "They are almost always free; occasionally, low cost. We have had up to 120 people come on one given evening, and parents are telling us how important it is."

PowerUp also has worked with Valley Outreach—a client-centered local "food shelf" organization that feeds hungry families—to increase its offerings of healthful foods. Valley Outreach serves more than 400 households a month, and 80 percent of its clients have children. The partnership led to a few key changes, such as bringing in frozen vegetables, with funding support from external grants. "We insisted that we figure out a way to have vegetables available in more forms than just canned and fresh," Canterbury said. Produce was arranged in bright baskets to improve how it looked; volunteers repainted the walls and shelves.

The real "magic," however, was revamping the food lists from which clients choose the foods for their families. Before the makeover, the first four ingredients on the list were pancake mix, pancake syrup, baking

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ingredients, and oil. "We completely restructured the order of everything," said Canterbury. "The list now starts with fruits and vegetables and less processed foods. It is making a huge difference." Canterbury noted that data from a survey of Valley Outreach clients show that 79 percent want to eat better. Because almost 90 percent of clients get at least half of their fruits and vegetables from the food shelf organization, Canterbury said the team has much more work to do.

One key lesson learned from the initiative is the need for practical and meaningful evaluation, Canterbury said. PowerUp tracks the number and types of its outreach efforts on an ongoing basis. More important, it measures what difference the initiative is making, such as through surveys of parents on awareness, priorities, and their children's eating behaviors.

During the discussion, panel facilitator Bill Dietz of George Washington University asked how the project's evaluation metrics have evolved, noting that although the initiative focuses on obesity, body mass index (BMI) is not one of the outcome measures. Canterbury responded that, as others had mentioned earlier in the workshop, it is necessary to look at mid-term measures of behavior changes in children and families. Evidence indicates that such changes can and should result in changes in BMI, which PowerUp's organizers do indeed plan to look at, she said.

Canterbury and her colleagues also are tracking how much time is invested in partnership development and how many policies, practices, and environments are changing. For instance, the Stillwater School Board adopted a wellness statement for pupils, which could set the stage for long-term health improvements in students. Measuring over time is critical, Canterbury said.

Some of the anecdotal accounts of partners and community residents can say much more than her graphs of evaluation data, Canterbury concluded. Such accounts show "the gratitude that people have for somebody taking the lead and taking action, and then they invariably say, 'How can I get involved?' That is how community engagement grows."

HOW LONG-TERM FUNDING SUPPORT AND SOCIAL CAPITAL MAKE A DIFFERENCE

During the discussion, Dietz asked what assurances there are that PowerUp will be sustained. Donna Zimmerman of HealthPartners replied that Lakeview will be serving these communities for a long time and has committed to the initiative for 10 years at a minimum. Canterbury added that community partners often initially assumed that the project would last just 2–3 years and that its organizers would have to write grants to continue its operations. When they learned that was not the case, the dynamic of the conversation changed. With longer-term funding assured, the focus

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became, "What can we do together? What parts do you bring to this partnership? . . . Better ideas, better work happens," Canterbury said.

Dietz commented that the "power of social capital" characterizes what is happening in the St. Croix Valley with PowerUp. He wondered whether that social capital is indigenous to Minnesota and Wisconsin as opposed to Washington, DC, or elsewhere. "Are people in Minnesota and Wisconsin just nicer and more committed?" he asked.

There is a joke in Minnesota that it "is the home of 10,000 collaborations," Hedlund replied with a smile. "It is somewhat of our nature." Minnesota has a strong health care system, a public health system built on statewide partnerships, and a vibrant nonprofit community that works together. However, "you have to still provide opportunities for people to get engaged" in whatever way they can, she said. "Social capital needs to meet people where they are at and give them those opportunities on what they can do, because that will grow."

"In this country when we agree about something this important, and when we engage together, we have always been successful."

—Bill Purcell, Former Mayor, Nashville, Tennessee

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10

Community Transformation in the Sault Ste. Marie Tribe of Chippewa Indians in Michigan[1]

Highlights from the Presentations of Individual Speakers*

- The Sault Ste. Marie Tribe of Chippewa Indians' (Sault Tribe) Community Transformation initiative has been strategically expanding and building upon successful cross-cutting strategies to improve health and reduce disparities among communities of Sault Tribe members living in the Sault Tribe service area of Michigan's eastern Upper Peninsula. (Norkoli)
- A collaborative and participatory approach has helped engage and bring change across tribal and nontribal sectors. (Laing)
- A participatory, respectful, and culturally sensitive approach to data collection was key to earning the Sault Tribe leadership's cooperation in sharing the community's health assessment information. (Laing)
- Population health survey data are enabling the tribe to tailor its strategies and planning, such as its efforts to target obesity in schools and early childhood programs. (Laing)

*Highlights identified during the presentations and discussions; presenters to whom statements are attributed are indicated in parentheses.

[1]See Appendix F for additional information.

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The eastern half of the Upper Peninsula of Michigan is an 8,500-square-mile region sparsely populated by 179,000 residents. Roughly 14,000 of them are members of the Sault Ste. Marie Tribe of Chippewa Indians (Sault Tribe) who live in communities across the region rather than in a reservation area. For the past decade, tribal leaders have been working on a cross-sector initiative aimed at reducing the high rates of obesity and other health disparities in the tribe's service area. The workshop participants heard a description of this initiative from Donna Norkoli, project coordinator for the Sault Ste. Marie Tribe's Community Transformation Grant; Shannon Laing, program coordinator for tribal health and wellness in the Center for Healthy Communities at the Michigan Public Health Institute; and Sault Tribe planning and development director, Jeff Holt, who also chairs the Sault Ste. Marie Economic and Development Commission.

LEVERAGING GRANT DOLLARS ACROSS SECTORS FOR HEALTHIER, SAFER COMMUNITIES

Norkoli summarized the history of the Sault Tribe Community Transformation Grant (STCTG) initiative.[2] Its lead convening agency, the Sault Tribe Community Health Department, began a project in 2006 in Sault Ste. Marie with a small grant from the Steps to a Healthier Anishinaabe Project. In 2008 this work was broadened to include the communities of Munising, Manistique, and St. Ignace with funding from the Centers for Disease Control and Prevention as part of the Strategic Alliance for Health Project. In 2011 the tribe obtained a Community Transformation Grant allowing it to expand the work further into Kinross and Newberry. Since then, the initiative has partnered with other existing coalitions and partners to promote shared goals in communities across the entire seven-county service area.

The initiative is overseen by a tribal leadership team of decision makers who are instrumental in bringing policy, systems, and environmental changes to the tribal agencies where they work. Represented sectors include health, housing, transportation, economic development, enterprise (including casinos), early childhood, and youth education and activities. Among the challenges to be overcome are the broad geographic area and small population numbers, Norkoli said—as well as winters with a great deal of snow.

Norkoli highlighted three successful STCTG coalition-building strategies. The first entailed creating relationships with local public schools (because the tribe does not have its own schools). "When we first started this work, the tribe was kind of in isolation," Norkoli said. "The schools were in their own little silo, and local government worked on its own.

[2]For more information, see the STCTG website at http://www.up4health.org.

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Nobody really was collaborating, especially with the tribe." With funding in hand, the tribe organizers cautiously approached the local schools. "We were very careful not to say 'we would like you to improve your school lunches,' or 'we would like you to offer more [physical education] time,'" Norkoli said. Rather, the tribe offered some funding to help the schools build capacity and infrastructure to form coordinated school health teams and conduct assessments of their environments. The schools could create an action plan and tell the tribe what they wanted to do, Norkoli said. "We wanted to make sure that they owned the project." Five schools went on to develop action plans that included participating in the Safe Routes to School project, which aims to increase students' physical activity and get them walking and biking to school. The STCTG initiative has worked with 17 school districts across the region to implement some form of coordinated school health.

A second strategy involved approaching local governments on transportation issues. A major problem was that the largest employers of tribal members are casinos, but those businesses are connected to tribal housing sites and health centers only via "dangerous highways with a lot of fast-moving traffic," said Norkoli. The collaboration brought the tribal transportation planner together with city engineers, downtown development authority directors, and other stakeholders to look at transportation infrastructure, conduct walking audits and workshops, and create a nonmotorized transportation plan covering the seven-county service area. "A vision was created not just about increasing physical activity but how we could make walkable, bikeable, vibrant communities," a move that local governments saw as offering economic advantages, Norkoli said.

That success also led to partnerships with the Village of Newberry and the city of Manistique to promote healthy eating. The tribe started two farmers' markets in those communities and then added two others in smaller communities.

Norkoli and her colleagues worked hard to build sustainability into these efforts. Through workshops with the local governments, they worked to educate seven communities about the benefits of "complete streets" policies of the National Complete Streets Coalition in making streets safer and friendlier to pedestrians and bicyclists. The tribe provided some funding to local government agencies in implementing those policies by collaboratively creating nonmotorized transportation plans. For example, when the Sault Tribe gave one community $3,000, the village council matched the funding, drew up the transportation plan, and then used it to apply for additional state funding to put the plan into action. "That leveraged $230,000 for construction of sidewalks and shared-use paths and for the school to do some encouragement, education, and enforcement activities to promote walking and biking to school," Norkoli said. The local public school and the village

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used the funds to install a sidewalk and a crosswalk so that students could get to class safely.

During the discussion, panel facilitator Amelie Ramirez of the University of Texas in San Antonio asked about STCTG's future plans for expanding or scaling up. Norkoli said the organizers hope to expand their work into some of the more western areas of the service region. In addition, the Sault Tribe recently extended its work on improving nutrition and physical activity at tribal early childhood education sites to nontribal sites across the region through partnerships with Great Start Collaboratives.

BUILDING TRUST WITH TRIBAL LEADERSHIP TO MEASURE COMMUNITY HEALTH

Laing described how she and her colleagues have worked systematically to improve the way in which community assessment data are gathered. She leads the evaluation team that is tracking outcomes of the STCTG initiative.

Laing explained that STCTG is based on the community coalition action theory model (Butterfoss and Kegler, 2002), in which "there is significant effort invested in coalition building over the life span of the work" (see Figure 10-1). Dedicated employees work to recruit and mobilize community members, help establish infrastructure in local communities and build their capacity, plan and implement strategic plans, evaluate outcomes, and support the ongoing institutionalization of strategies.

"The community context is very important," Laing emphasized. For the Sault Tribe, contextual factors that have heavily influenced the successes and challenges of the STCTG initiative include the sociocultural and political environment, the local geography history, social norms, and the broader history that American Indians have experienced in the United States.

Essential to success, Laing said, has been the process of "putting data into action"—the collection, interpretation, and prioritization of data and their dissemination and translation into strategies. However, organizers initially faced many significant barriers to carrying out this process, such as the lack of reliable population-level data for obesity-related measures in the Sault Tribe. Available data showed wide disparities in the tribal community's overall health as compared with the state population, "but what we didn't know was whether disparities existed within the tribal population," Laing said. "We were afraid that health inequities could continue to exist, or could worsen, if we couldn't measure and monitor disparities with reliability and precision." However, she also noted that "sharing data can be difficult for tribes because data has historically been misused, misconstrued, or misrepresented." Thus, determining how to approach data collection for health indicators was critical; a participatory and respectful approach was key.

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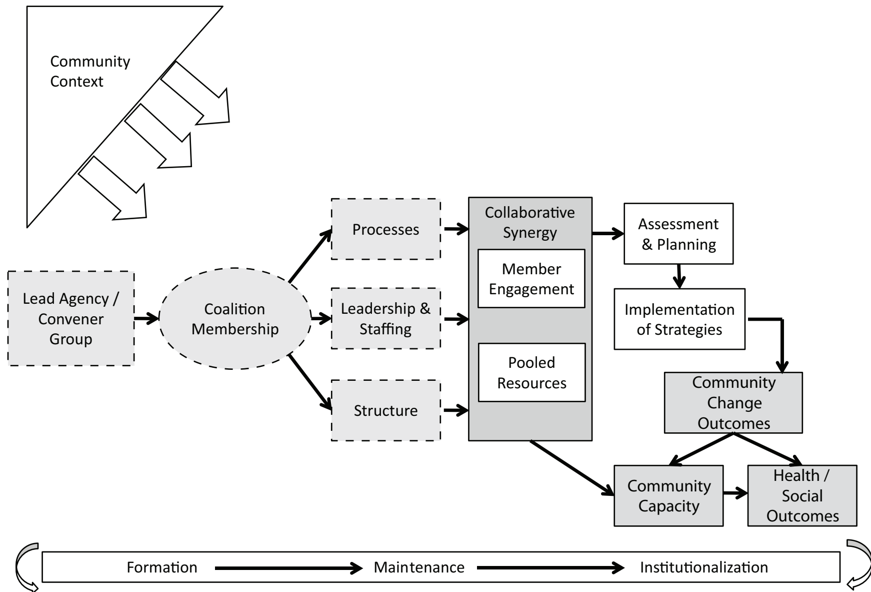

FIGURE 10-1 Community coalition action theory builds on the synergy of cross-sector collaboration.
SOURCE: Butterfoss and Kegler, 2002. Reproduced with permission of John Wiley & Sons, Incorporated, in the format republished in a book via Copyright Clearance Center.

Since 2008, more than 100 assessment tools in different sectors across the service area have shown positive increases in measures of the physical, built, and food environments. These data were integral to a participatory prioritization and action planning process that local coalitions have used on an annual basis, Laing said.

In 2013, the Sault Tribe completed a population health survey. This survey provided data that will allow the communities to tailor their strategies in a targeted way. The survey results showed that rural areas and urban "clusters" differ in their adult obesity rates, physical activity levels, and consumption of fruits and vegetables. The survey also provided representative data for the first time on tribal children's daily physical activity; screen time; and consumption of produce, junk food, and sugary beverages. This information is enabling the tribe to conduct long-term planning for obesity prevention by targeting modifiable factors in schools and early childhood programs, Laing said.

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A key achievement has been the ongoing support of the tribal leadership for measurement and evaluation efforts "when protections are put in place, when the work is done in a culturally sensitive way," Laing emphasized. In an unusual move, the Tribal Board unanimously approved a resolution that allows for the sharing of tribal health data to support the project's goals.

Core elements of STCTG that have been essential to its success include a strong cross-sectional leadership team, with champions who are "willing to stick their neck out to reach across sectors, to create those linkages, to build this synergy," Laing said. Also important has been carrying out well-designed and culturally sensitive assessment and formative evaluation activities on an ongoing basis, early and often. Good evaluation is necessary for strategic planning, Laing said.

To scale up and extend this work requires building community capacity, Laing noted. Dedicated, experienced staff who can provide technical expertise, support, guidance, and resources to help communities establish their own infrastructure and local leadership are crucial. Coaching and mentoring of these local teams are critical as well "to ensure that the early successes help build momentum and also long-term sustainability," Laing said.

TAKING A SEAT AT THE DECISION-MAKING TABLE

Holt offered a perspective on STCTG from the tribal Leadership Team, which he said has provided an essential connection to the communities in working across sectors and serving as a conduit for communication. One barrier that the initiative encountered involved "turf issues" across sectors. For example, Holt explained, "Leaders of one sector may ask, Why is health involved to lead a business or a transportation issue?" STCTG organizers learned that "it is important to engage all the partners in assessments, prioritization of needs, and decisions about what and how best to carry out the strategies and to address identified needs," Holt said. A collaborative process creates greater buy-in and commitment over the long term.

Other barriers included the usual red tape and limited resources of local governments. To break down those barriers, STCTG focused on taking its resources straight to key players to gain their support for creating action teams within their agencies, Holt said.

A driving motivation for the initiative was that in the past, the Sault Tribe often "did not have a seat at the table in a lot of the local communities," Holt said. Its needs were not being met, and not enough open communication and trust existed between tribal and nontribal entities. But the situation is different now. Whereas for many years the tribe lacked the budget to maintain staff in key positions, the federal community health grants made it possible to hire a grants project coordinator and four local community coordinators; around the same time, the tribe hired a transpor-

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tation planner. The tribe worked to create formal agreements with local governments, and tribal members provided more input for local decision-making processes by serving on committees and advisory boards. "Now that we are at the table, we can afford to speak up, and we are not afraid to," Holt said.

A decade ago, Holt observed, Sault Tribe leaders were the ones going to nontribal communities asking for help. Now the tribe itself can offer assistance, expertise, and leadership: "When we go into a community, we now expect the communities to collaborate with us," he said.

> *"No one entity has the resources to invest in a singular type of way to address the issue. No one. And so with that, everybody has to come together on this issue. It is solvable. It is solvable. It's complex, but it's solvable, and I believe that."*
>
> —Yvonne Cook of Highmark, Inc.

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11

Concluding Remarks

A recurring point raised across the case study presentations summarized in Chapters 6–10 was the extent to which the work on these initiatives is "a very human process of building community" and engaging people and establishing trust, commented David Fukuzawa, program director for health at The Kresge Foundation. He moderated a discussion session on the five cross-sector initiatives with all the workshop speakers, steering the conversation to points that had emerged throughout the day. Speakers focused on strategies for talking about health equity, means of building relationships in communities and across sectors, direct versus indirect approaches to addressing obesity, measurement and evaluation issues, and ways of sustaining the work of initiatives with the next generation of leadership.

STRATEGIES FOR TALKING ABOUT HEALTH EQUITY

Equity can be a difficult issue to raise, Fukuzawa said, whether it is around race, class, or people who are marginalized in a community. What possible actions did the speakers suggest for raising the equity issue in the process of building a community collaborative?

Mildred Thompson of PolicyLink replied that "when we think about equity, the words that we use matter." If the word "fairness" is used, everyone will likely agree that all people deserve to be treated fairly, but talking about race and class tends to make people feel concerned, she said. However, she suggested that "there is a way that we can talk about race without calling someone racist." If organizers of cross-sector projects are mindful of

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this and carefully consider their framing and terminology in entering into a conversation, they may encounter less defensiveness.

James Bloyd of Cook County PLACE MATTERS added that it may be easier to broach the topic of equity—particularly when disparities clearly align with income levels, neighborhoods, and racial/ethnic lines—by stating from the outset that the issue is not about individual responsibility or behavior. In his initiative, for instance, Bloyd shows people that neighborhood residential segregation in the 1930s was a root cause of many conditions leading to certain behaviors. But it is difficult for leaders at the local, state, and federal levels to shift from an individual focus toward a social determinants focus on those root causes, he said.

Keeping the focus on children is another way to navigate the equity issue, suggested Helen Riley of St. Michael's School in Delaware, because it is "easier for people to have some empathy for children." It helps to remind people "that every child is born with potential, every child is deserving of an opportunity," she said. "If we provide the resources, and we provide the training that they need, then everyone benefits."

Felipe Tendick-Matesanz of Restaurant Opportunities Centers United had a different perspective on the discussions around equity. The public health community often talks about poor people, but it shies away from talking "about the labor conditions they are in and how to improve those conditions, or even measure those conditions," he noted. "Nobody wants to talk about it," he said, perhaps because the subject gets into politics and questioning capitalistic models. He challenged the workshop participants to start having those conversations.

MEANS OF BUILDING RELATIONSHIPS IN COMMUNITIES AND ACROSS SECTORS

From the audience, Bob Grist of the Institute of Social Medicine and Community Health commented that the presented cross-sector initiatives illustrate a level of cooperation very different from the way society functions, with processes that can be more equitable and more responsive to human needs. Some health care companies, such as Kaiser Permanente and HealthPartners, and federal Community Transformation Grants are investing in these processes. Yet, he said, "I haven't heard any talk . . . about the potential of this process for transforming our health care delivery system that responds to all of these symptoms of inequality."

In reply, Susan Damour of the U.S. General Services Administration and the National Prevention Council spoke about the power of bottom-up collaborations that are taking place in communities. While the senior leaders of her agency in Washington, DC, say they must cut their budget and staff, Damour plans to keep doing what she is doing—building relationships

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with different partners on the ground to undertake projects together. "You do have people of passion in your communities," she told the workshop attendees. "People know what the problems are. Don't ask for permission. Go find them, and then find out what you want to work on. Make it reasonable, measurable, and achievable. Then just build from there."

Marna Canterbury of Lakeview Health in the St. Croix Valley added that a welcoming communication strategy—one that is positive, inclusive, and nonjudgmental—also is important in creating a movement toward better health. "We have a bunch of communication rules: no 'shoulds,' no 'healthy,' et cetera."

DIRECT VERSUS INDIRECT APPROACHES TO ADDRESSING OBESITY

Fukuzawa commented that in several of the case study initiatives, obesity was not actually the starting point. Organizers instead focused on larger themes such as population health or equity. Is obesity just a symptom of the places where we are living, as Bloyd pointed out, or is it the problem itself? he asked.

Donna Zimmerman of HealthPartners responded that in the St. Croix Valley PowerUp project, the Health and Wellness Committee was not interested in using the words "children's obesity initiative" because community members felt it was negative messaging that did not energize anybody. What energized people was a more open-ended mission of "Let's do something to let all children in the valley have an opportunity to be healthy." Obesity is in part a by-product of not being healthy or not having access to healthful food, Open Gyms, or other programs, she said.

For Bonnie Rateree, her collaborative work in Harvey, Illinois, is motivated by the 14-year difference in life expectancy between her neighborhood and northern Cook County. Many factors combine to cause that shorter life expectancy, including obesity and related chronic illnesses such as heart disease. Obesity became an issue for Rateree when she saw it in the young people around her. Her granddaughter is a smart, overweight child who spends most of her time on the computer. Compared with when Rateree was growing up, the community is not as safe for children to go out and play.

If one starts with where the community is and what it needs, benefits in countering obesity and improving public health will follow, suggested Debra Oto-Kent of the Health Education Council. All of the various factors involved are connected. For instance, addressing a problem with loose dogs on the streets makes it safer for people to be physically active in the neighborhood, Oto-Kent noted.

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MEASUREMENT AND EVALUATION ISSUES

Fukuzawa asked whether speakers had encountered any issues related to measuring progress in their prevention work other than those raised in the workshop presentations. For example, he noticed a Tweet that questioned whether Kaiser Permanente's concept of measuring "doses" of impact from health interventions was "medicalizing" the process.

Kaiser Permanente's Pamela Schwartz replied that her team tried changing the language they used many times, but it always came back to "dose" because that resonated for people, even if some thought it sounded too medical. "They get the concept of 'reach a lot of people, touch a lot of lives' with something that matters." However, she added, "there are so many barriers to building something that is more impactful in the time period that we fund." Also, having conversations about measuring dose and impact is difficult because "it can actually come across as insulting if we say your work, as it stands, is not impactful enough for what you signed up for," Schwartz said. Her team still has to work on its messaging.

Mary Kate Mouser, from Nemours in Delaware, said that the question of how best to carry out evaluation remains the topic of much discussion for her team, now 10 years into their initiative. Much of the focus at the workshop was on measuring such factors as physical activity and healthy eating, but Mouser believes it will be necessary to somehow combine all of those factors into one broader population health metric instead of looking at them separately. Evaluation "is a huge area to continue to learn and figure out," Mouser said.

WAYS OF SUSTAINING THE WORK OF INITIATIVES WITH THE NEXT GENERATION OF LEADERSHIP

A final question came from Bill Purcell of Jones Hawkins & Farmer, PLC: Who will carry on the work of these initiatives into the future?

Thompson responded that it is critical to create succession plans and groom the next generation, noting that PolicyLink has many bright, enthusiastic young people whom she tries to engage as much as possible. "We have a responsibility to share, and not hold onto, our knowledge and our experiences," she said.

Rateree said all the things she is working on now are on her "bucket list." She is looking to find 10 people to take up the torch when she retires. Last May, the PLACE MATTERS national team announced a partnership with The Children & Nature Network to improve community health through greater access to green spaces. This initiative includes a fellowship program for training young leaders to share the outdoor world with their communities, Rateree said. A young woman from Cook County partici-

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pated in that program and is now planning family nature activities in her community. "Hopefully, this young lady, and nine more people, will allow me to really retire," Rateree said.

"If the goal is to have a culture of health in America, that means we have to all come together because it is a benefit for all Americans to deal with the problems of childhood obesity."

—Dwayne Proctor of the Robert Wood Johnson Foundation

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A

Workshop Agenda

Cross-Sector Work on Obesity Prevention, Treatment, and Weight Maintenance: Models for Change
Solving Obesity: Everyone's Issue

SEPTEMBER 30, 2014

Auditorium, National Academy of Sciences Building
2101 Constitution Avenue, NW, Washington, DC
Hosted by the IOM Roundtable on Obesity Solutions

AGENDA

OPENING REMARKS

9:00 am **Welcome**
Bill Purcell, Jones Hawkins & Farmer, PLC, and Roundtable on Obesity Solutions Chair

9:05 am **Introduction and Orientation**
Nico Pronk, HealthPartners, Inc., and Workshop Planning Committee Chair, Roundtable Member

SESSION 1: OVERARCHING CONSIDERATIONS FOR WORKING ACROSS SECTORS

Moderator: *Nico Pronk, HealthPartners, Inc., Roundtable Member*

9:20 am **Health Equity:** *Mildred Thompson, PolicyLink*

9:35 am **Sustainability:** *Donald Hinkle-Brown, The Reinvestment Fund*

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9:50 am **Leadership:** *Debra Oto-Kent, Health Education Council*

10:05 am **Measurement:** *Pamela Schwartz, Kaiser Permanente*

10:20 am **BREAK**

10:45 am **Panel Discussion**
Facilitator: *Larry Soler, Partnership for a Healthier America, Roundtable Member*

11:15 am **Audience Discussion**
Facilitator: *Larry Soler*

11:45 am **LUNCH**

SESSION 2: CASE STUDIES OF CROSS-SECTOR WORK

Moderator: *Nico Pronk*
Each case study will feature a 20-minute presentation, followed by 20 minutes of discussion with the audience.

1:00 pm **The National Prevention Council**
Melissa Lim Brodowski, U.S. Department of Health and Human Services
Susan Damour, U.S. General Services Agency, Rocky Mountain Region
Jeff Levi, Trust for America's Health
Acting Surgeon General Rear Admiral (RADM) Boris D. Lushniak
Brigette Ulin, U.S. Centers for Disease Control and Prevention
Facilitator: *Sylvia Rowe, SR Strategy, LLC, Roundtable Member*

1:40 pm **A Statewide Strategy to Battle Child Obesity in Delaware**
Mary Beth French, Christina School District
Mary Kate Mouser, Nemours
Helen Riley, St. Michael's School and Nursery
Facilitator: *Debbie Chang, Nemours, Roundtable Member*

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2:20 pm **Cook County PLACE MATTERS (Chicago)**
James E. Bloyd, Cook County Department of Public Health, Chicago
Bonnie Rateree, Community Advocate
Felipe Tendick-Matesanz, Restaurant Opportunities Centers United
Facilitator: *Brian Smedley, National Collaborative for Health Equity, Roundtable Member*

3:00 pm **PowerUp in the St. Croix Valley (MN and WI)**
Marna Canterbury, Lakeview Health
Sue Hedlund, Washington County Department of Public Health and Environment, Minnesota
Donna Zimmerman, HealthPartners
Facilitator: *William Dietz, George Washington University School of Public Health, Roundtable Member*

3:40 pm **ACTIVE BREAK** (participate at your ability)

4:00 pm **Sault Ste. Marie (MI) Tribe of Chippewa Indians**
Jeff Holt, Sault Tribe Leader
Shannon Laing, Michigan Public Health Institute
Donna Norkoli, Sault Tribe Health Services
Facilitator: *Amelie Ramirez, Salud America!, Roundtable Member*

4:40 pm **Audience Discussion**
Facilitator: *David Fukuzawa, The Kresge Foundation, Roundtable Member*

CLOSING REMARKS

5:10 pm **Distilled Learnings**
Moderator: *Nico Pronk*
Russell Pate, University of South Carolina, Roundtable Member
Marion Standish, The California Endowment, Roundtable Member
Maha Tahiri, General Mills, Inc., Roundtable Member

5:30 pm **Adjourn Workshop**

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B

National Prevention Council Cross-Sector Case Study

Submitted by presenters
Acting Surgeon General Rear Admiral Boris D. Lushniak, Melissa Lim Brodowski, Susan Damour, Jeff Levi, and Brigette Ulin[1]

DESCRIPTION OF CROSS-SECTOR MODEL USED

The National Prevention Council (NPC), created through the Affordable Care Act and chaired by the U.S. Surgeon General, provides coordination and leadership among 20 executive departments and agencies with respect to prevention, wellness, and health promotion activities. Such high-profile involvement demonstrates an unprecedented commitment to coordinated federal action to address prevention and wellness. The NPC released the nation's first National Prevention Strategy in June 2011. The NPC engages leadership from across sectors to improve the health of the nation and advance the National Prevention Strategy's goal to "increase the number of Americans who are healthy at every stage of life." The NPC's work is informed by the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health and by partners across the country working to advance the National Prevention Strategy. The Strategy's vision is to move the nation from a focus on sickness and disease to one based on prevention and wellness.

NATIONAL PREVENTION STRATEGY FRAMEWORK

The National Prevention Strategy guides our nation in identifying the most effective and achievable means for improving health and well-being. It prioritizes prevention by integrating recommendations and actions across

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multiple settings to improve health and save lives. Since many of the strongest predictors of health and well-being fall outside of the health care setting, the Strategy envisions a prevention-oriented society where all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for all Americans.

The National Prevention Strategy identifies four Strategic Directions—the foundation for all prevention efforts—and seven targeted Priorities designed to improve health and wellness for all Americans (see Figure B-1). It provides evidence-based recommendations for each Strategic Direction and Priority and supports *Healthy People 2020*, a 10-year set of science-based national health objectives.

In June 2012, the NPC released the National Prevention Council Action

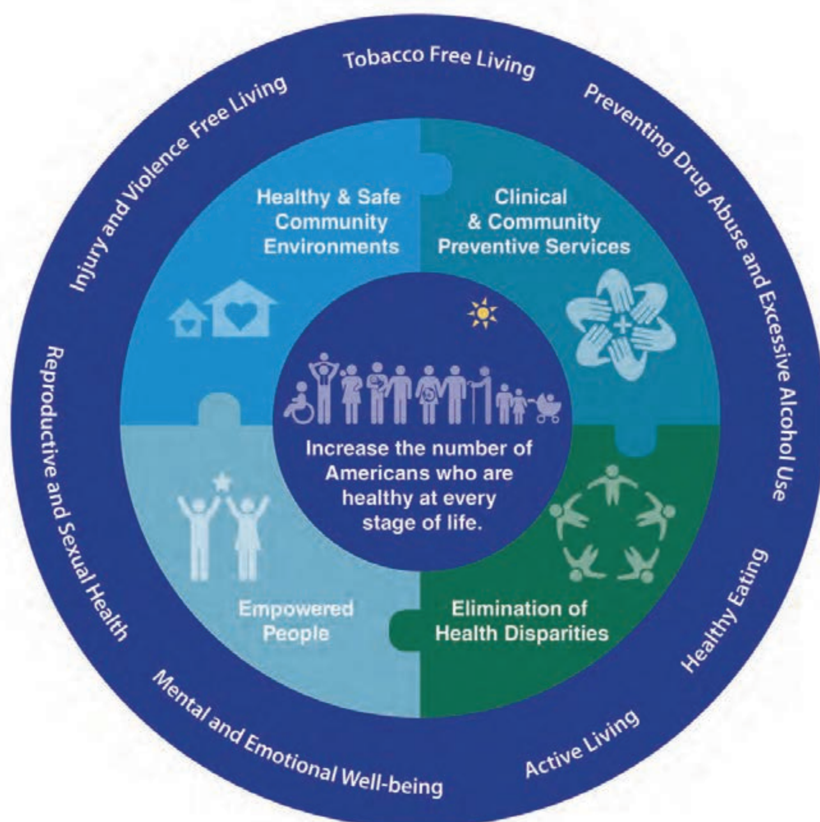

FIGURE B-1 National Prevention Strategy Framework.

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BOX B-1
National Prevention Council Commitments

→ Identifying opportunities to consider prevention and health within National Prevention Council departments
→ Increasing tobacco-free environments within National Prevention Council departments
→ Increasing access to healthy, affordable food within National Prevention Council departments

And encouraging partners to do so voluntarily as appropriate.

Plan, which demonstrates how departments are implementing prevention efforts in line with their respective missions and identifies three shared commitments to accelerate prevention through the high-impact efforts of all National Prevention Council departments (see Box B-1). The NPC continues to advance its commitments by integrating health and wellness into policies, practices, and programs to achieve better health for all Americans. For more information, visit http://www.surgeongeneral.gov/initiatives/prevention/index.html.

SECTORS INCLUDED

On June 10, 2010, the President signed an Executive Order (http://www.whitehouse.gov/the-press-office/executive-order-establishing-national-prevention-health-promotion-and-public-health) creating the NPC within the Department of Health and Human Services. Council members are cabinet secretaries, chairs, directors, or administrators from these departments:

Department of Health and Human Services (HHS)
Department of Agriculture
Department of Education
Federal Trade Commission
Department of Transportation
Department of Labor
Department of Homeland Security
Environmental Protection Agency
Office of National Drug Control Policy
Domestic Policy Council

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Department of the Interior
Department of Justice
Corporation for National and Community Service
Department of Defense
Department of Veterans Affairs
Department of Housing and Urban Development
Office of Management and Budget
General Services Administration
Office of Personnel Management

LESSONS LEARNED FROM THE INITIATIVE

The most recent achievements of the NPC are included in the 2014 Annual Status Report—delivered to the President and members of Congress and posted online on July 1, 2014—demonstrate the nation's progress and highlight the collective impact of the federal government and its partners to improve the health and quality of life for individuals, families, and communities. Highlights from the report include:

- The NPC is working to integrate the Health and Sustainability Guidelines into federal food concessions and vending operations as appropriate. These guidelines are the result of collaboration between HHS and GSA with the goal to increase healthy food and beverage choices and sustainable practices at federal work sites. Eighty-six percent of cafeterias in GSA-managed buildings now provide healthy food choices. By applying the Dietary Guidelines for Americans 2010 to food service operations, the Health and Sustainability Guidelines demonstrate HHS's and GSA's commitment to promoting a healthy workforce.
- The Department of Defense's Healthy Base Initiative (HBI) aims to identify best-practice efforts in reducing obesity and tobacco use, while improving fitness. In a recent survey at one HBI site, 93 percent of employees said the initiative is helping change their behaviors, including eating habits and physical activity. The Environmental Protection Agency's (EPA's) Healthy Heart program (which complements HHS's Million Hearts initiative) educates people—in particular, individuals with heart disease—about the health risks of air pollution and how to reduce exposure through the EPA-supported Air Quality Index.
- HHS is collaborating with the Department of Education to promote Birth to 5: Watch Me Thrive!, an initiative that encourages healthy child development through universal developmental screening for children.

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BARRIERS TO ESTABLISHING THE INITIATIVE

Because of the diversity of the missions and priorities for each Department, the NPC recognizes that Department-specific actions to advance these shared commitments will vary. This variation presents opportunities and challenges. Identifying strategic opportunities to integrate prevention and health within the various Departments requires ongoing engagement and constant communication amidst changes in leadership and agency priorities.

Metrics are important to the NPC's work because they can be used to measure how activities that serve an agency's core mission also promote health. The 2014 Annual Status Report includes national data from a variety of sources including those managed by Centers for Disease Control and Prevention such as the National Health and Nutrition Examination Survey and the National Health Interview Survey, and the National Vital Statistics. Other data sources include the U.S. National Toxics Release Inventory from the EPA, the Monitoring the Future Survey from the National Institutes of Health, and the National Survey on Drug Abuse and Health from Substance Use and Mental Health Services Administration. Currently indicators are aligned with *Healthy People 2020* (as appropriate), which creates efficiencies in data reporting at the national level. However, more comprehensive data sources are needed across the various indicators and longitudinal data will need to be available in timely and user-friendly format to allow the NPC and state and local stakeholders to truly measure the collective impact of the prevention work across sectors.

WHAT IS NEEDED TO ACCELERATE MOVEMENT FORWARD IN YOUR CROSS-SECTOR WORK?

National, state and local leadership is critical to creating a prevention-oriented society. The NPC will continue to prioritize prevention by collaborating across multiple settings. The National Prevention Strategy recognizes that policy, systems, and environmental changes can support healthy choices. Health and wellness are influenced by the places in which people live, learn, work, and play. Communities—including homes, schools, public places, and work sites—can better support well-being and make healthy choices easy and affordable. We need innovative approaches such as rethinking community design to improve community walkability and promote physical activity, and increasing availability of affordable, healthy food and drink options to support a nutritious diet.

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C

Delaware Cross-Sector Case Study

Submitted by presenters
Mary Beth French, Mary Kate Mouser, and Helen Riley[1]

DESCRIPTION OF CROSS-SECTOR MODEL USED

Nemours Health & Prevention Services (NHPS), headquartered in Wilmington, Delaware, works with families and communities to help children in Delaware grow up healthy, both physically and emotionally. It is a division of Nemours, a nonprofit organization dedicated to children's health and health care that provides hospital and clinic-based specialty care, primary care, prevention and health information services, as well as research and medical education programs to improve the lives of children and families throughout the Delaware Valley and Florida. NHPS was created to expand Nemours' reach beyond clinical care to consider the health of the whole child within his or her family and community.

NHPS uses a population health approach, beginning with the establishment of clear outcomes for a geographic region, to work with community partners across sectors to make policy, systems, practice, and environmental changes in the places where children live, learn, and play. We build sustainable capacity within our partners by providing tools, training, and technical assistance in evidence-based practices. We also include a focus on evaluation from the onset of initiative design and provide data to our partners that they can use to drive their decision making and action. Through policy, advocacy, and capacity-building in and across organizations, we support partners to invest resources in creating and sustaining environments in which children have the opportunity to make healthy choices,

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practice healthy behaviors, and, ultimately, achieve improved health outcomes. Social marketing was utilized to accelerate early policy and practice changes. To date, NHPS has focused on initiatives related to obesity prevention, asthma, and emotional and behavioral health.

SECTORS INCLUDED

NHPS works with other health care organizations; schools; child care providers; local, county, and state governments, including the state agencies that provide public health, Medicaid, education, social service, child welfare, and child mental health services; youth-serving and other community nonprofit organizations; faith community; universities and colleges; and businesses. We serve as an "integrator" that works intentionally and systematically across sectors to improve the health and well-being of children.

LESSONS LEARNED FROM OBESITY PREVENTION INITIATIVES

- Focus on child well-being outcomes, including but not limited to, increasing the percentage of Delaware children, birth through age 17, in a healthy weight range, for a specific population and intervene early to focus on primary prevention;
- Coordinate programs and connect services so that program silos are eliminated and children are better served;
- Be opportunistic in determining which policy, systems, and environment changes to drive at which time, balancing a portfolio of reactive and proactive engagements and shorter- and longer-term implementation horizons;
- Develop a shared measurement system across silos to ensure joint accountability for improving child and family outcomes related to obesity prevention;
- Consider sustainability at the front end and throughout the life of the project;
- Reach children where they live, learn, and play;
- Create policy and systems change/development to impact populations with sustainable change—essential elements of a comprehensive children's system in addition to practice changes;
- Be intentional about harnessing and leveraging lessons learned to inform spread, scale, and sustainability; and
- Identify the champion integrators and stakeholders for obesity prevention and support them to get state and local buy-in and to spread and sustain the work.

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BARRIERS TO ESTABLISHING THE INITIATIVE

- Workforce Development—developing a workforce, both internally and with our partners, that is capable and empowered to utilize a population health approach. For example, child care providers, teachers, etc., need to be trained in how to integrate this work into their daily priorities for sustainability. Also a workforce that is able to work cross-sector—speak the different languages, make multiple compelling arguments for involvement, etc.—is critical for implementation and sustainability.
- Telling Our Story—gleaning the anecdotal and statistical data and packaging it effectively to tell the story of the accomplishments and impact of implementation to reach various strategic audiences who can create buy-in and interest in implementation.
- Sustainable Revenue Generation—identifying and mobilizing grants and identifying and maximizing other funding streams.

WHAT IS NEEDED TO ACCELERATE MOVEMENT FORWARD IN YOUR CROSS-SECTOR WORK?

- Strengthen targeted partners to enhance spread, intensity, and sustainability among diverse populations by building their capacity in the ways that are most helpful to our partners in their environments.
- Place more emphasis on building comprehensive, integrated systems of care for children and their families.
- Continue work on leadership development and leveraging resources among our partners and in community coalitions toward shared outcomes related to obesity prevention.
- More targeted evaluation and performance measurement to ensure that we are measuring the most relevant indicators to demonstrate progress and impact for all sectors.
- Continue to work on incorporating an equity approach in all work, to assure that all children have equal opportunities to optimal health.

WHAT ARE THE CORE FEATURES OR ELEMENTS OF YOUR INITIATIVE THAT ARE NECESSARY FOR SCALE AND SPREAD?

- Build trusting relationships and capacity across sectors, including determining policy, systems, and environmental changes to spread and sustain within the context and environments of the partners and communities.

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- Mobilize resources with partners in which responsibilities are clearly defined and shared so that the partners are actively engaged and understand their role in meeting shared outcomes.
- Use data to drive decisions, including mining existing or conducting community needs assessments, researching the best evidence of what works, and designing evaluations to produce the information necessary to drive action.
- Work with partners to share decision making on planning and implementation.
- Identify an integrator to take responsibility for advancing the shared and agreed upon policy and practice change agenda that can be adopted by multiple sectors.
- Communicate openly on what is working, what is not, and how to make improvements.

WHAT ARE THE FEATURES THAT NEED TO REMAIN FLEXIBLE TO ALLOW FOR LOCAL ADAPTATION?

Adaptation can lead to spread outside of the initial area of implementation as well as deeper implementation in the original geographic area.

- Determine the readiness of partners and communities to embrace the policy, systems, and environmental changes that are being recommended and be flexible to move through the change process at the pace that the partners or communities are comfortable with, focusing on the policy and practice changes in a targeted fashion to take advantage of the knowledge gathered.
- Adapt methods of the intervention to what is feasible in the local context based on the local needs with the resources available.
- Determine the best sectors and adopters with whom to partner.

For more information, please contact: Nemours Health & Prevention Services, 2200 Concord Pike, 7th Floor, Wilmington, DE 19803, Kelli Oliver Thompson, kothomps@nemours.org, (302) 298-7638 or (302) 298-7600.

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D

Cook County PLACE MATTERS Case Study

Submitted by presenters
James E. Bloyd, Bonnie Rateree, and Felipe Tendick-Matesanz[1]

DESCRIPTION OF CROSS-SECTOR MODEL USED

PLACE MATTERS is an initiative of the National Collaborative for Health Equity. Cook County PLACE MATTERS (CCPM) is 1 of 21 teams in the United States, designed to build the capacity of local leaders and communities around the country to identify and address social, economic, and environmental factors that shape health inequities. The vision of CCPM is to build a health equity movement that works to eliminate structural racism and creates the opportunity for all people of Cook County to live healthy lives. The name reflects the phenomenon of "accumulation of negative conditions in certain communities" as a result of "larger social forces and injustices within American society," according to three of the founders of the initiative—Gail Christopher, Vincent LaFronza, and Natalie Burke.[2]

CCPM raises awareness about the existence and root causes of health inequities in the Chicago area; works to increase the power of communities where people are sicker and die sooner; and takes action to promote healthy public policy. In order to address its desire to change existing power relations that constrain community change while being aware that it is at

[1]Reprinted as submitted by the presenters.

[2]Christopher, G., Lafronza, V., and Burke, N. 2010. Place matters: Building partnerships among communities and local public health departments. In *Tackling health inequities through public health practice: Theory to action a project of the National Association of County and City Health Officials* (2nd ed., pp. 458-474). New York: Oxford University Press. P. 458.

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the same time deeply embedded in those power relations,[3] CCPM is guided by leaders from multiple institutions and backgrounds, in order to work toward an ideal of increased democratic control and accountability, while limiting dominance of any one institution. Therefore, the Cook County Department of Public Health does not "control" or make decisions for CCPM, despite providing key staff support for the team.

At a press conference in July 2012 at the release of "PLACE MATTERS for Health in Cook County: Ensuring Opportunities for Good Health for All," Cook County Board President Toni Preckwinkle thanked the CCPM team for the report and observed that "it is shameful that we live in one of the wealthiest countries in the world and that a person's life can be cut short by more than a decade because of factors outside her or his control. People living in areas with a median income greater than $53,000 per year have a life expectancy that is almost 14 years longer than people living in areas with a median income below $25,000 per year."[1]

[1]http://youtube/GYmtREA3Lkc.

Sectors included CCPM focuses on grassroots communities and labor in the food system, in order to reduce poverty and income inequality, which are at the heart of the obesity epidemic according to researchers Adam Drewnowski and Kate Pickett.

Lessons learned from initiative are that the distribution of resources for an equitable distribution of quality social determinants of health (SDH) is highly political; challenging structural racism is key; and the individual behavior and risk factor model of health is the common perspective.

Barriers to establishing the initiative include a lack of understanding of the SDH and policy implications; a dependence on volunteer and in-kind staff.

Accelerating this cross-sector work will require recognition of the value of alliances with social movements of low-wage workers in racialized, gendered workplaces; specific statements and actions from public health leaders at the federal, state, and local levels that support this work; and prioritizing relationship building with residents of neighborhoods affected by unjust and preventable health inequities.

A **core element needed for spread** is resources and technical assistance at the national level, while **features needed to allow for local adaptation** include local decision-making on policy and strategy; organizational struc-

[3]Please see Himmelman, A. T. 2001. On coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment. *American Journal of Community Psychology* 29(2):277-284.

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ture and leadership fitting the local context; and recognition of the potential of "non-health" sectors initiating new projects.

The partnership of CCPM with south suburban Harvey, Illinois, resident Bonnie Rateree exemplifies CCPM's commitment to community sector work toward assuring an equal distribution of high-quality education. Ms. Rateree uses urban gardening as a community activity promoting education, organizing and nutrition. Schools in Harvey and nearby suburbs, where a majority of the population are people of color, are challenged to provide adequate financing in the face of a reliance on local property taxes. Illinois ranks worst among the states in this reliance, which has lead to what Ralph Martire at the Center for Tax and Budget Accountability judges to be "structural racism" in which black and Latino children are selected for low-quality education.

CCPM's partnership with Restaurant Opportunities Centers (ROC) Chicago exemplifies the understanding that food justice includes the struggle for justice by low-wage "back-of-the-house" workers in Chicago's expanding restaurant industry. According to research by ROC Chicago, income, working conditions and career advancement opportunities are systematically limited and structured along lines of race/ethnicity and gender.

ROC United is the only national nonprofit dedicated to improving wages and working conditions for the country's more than 10 million restaurant workers. It is a member-based national workers center with more than 10,000 members with local offices in 12 major cities. ROC United's innovative approach to system change has three major components: research and policy, workplace justice, and promotion of the high road to profitability.

Through participatory-based research guided by strong academic alliances ROC United is able to produce high-quality data outcomes that can guide policy recommendations.

Through strong supportive structures that educate workers on workplace rights as well as allow space for organizing efforts ROC United is able to help workers produce positive changes that improve working conditions at both restaurant unit and corporate levels.

Through industry training programs that promote career ladders for those most disenfranchised, building business alliances for shared prosperity, supporting and promoting the ethical consumer market, and showcasing and developing new business models for shared prosperity ROC United is able to provide a human rights framework and foundation in the restaurant industry.

Additional information about Cook County PLACE MATTERS is available at http://www.facebook.com/ccplacematters and @ccplacematters, and http://www.youtube.com/ccplacematters.

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E

PowerUp in the St. Croix Valley (MN/WI) Case Study

Submitted by presenters
Marna Canterbury, Sue Hedlund, and Donna Zimmerman[1]

PowerUp is a community-wide initiative to make better eating and active living easy, fun and popular, so that youth can reach their full potential. PowerUp focuses on children ages 3 to 11, and adults who influence their food and physical activity choices. The initiative reflects a 10-year commitment by HealthPartners and Lakeview Health (Lakeview Hospital; Lakeview Health Foundation; Stillwater Medical Group) to work in partnership with the community to improve population health in the St. Croix River Valley region (Minnesota/Wisconsin).

DESCRIPTION OF CROSS-SECTOR MODELS USED

The PowerUp Community Initiative Framework illustrates a multi-level, community-based approach. It is a simplified model that is accepted and clear among all stakeholders. It reflects that multiple levels of intervention are necessary for a comprehensive approach, based on a foundation of community leadership and engagement for success and sustainability. The levels of the framework represent (see Figure E-1):

- Community: Working collaboratively with and in the community
- Environment/Engagement: Community-level change and larger reach
- Programs/Clinical: Individual-level change and smaller reach
- Engage and Transform Zones: Relationship building across levels/ sectors

[1]Reprinted as submitted by the presenters.

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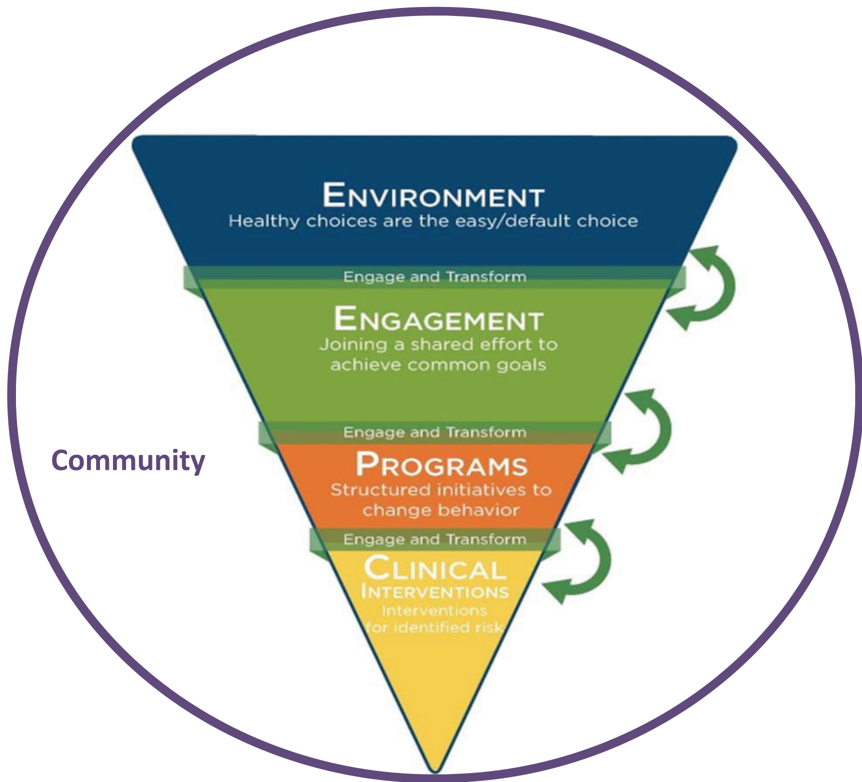

FIGURE E-1 PowerUp Community Initiative Framework.
SOURCE: HeathPartners, Inc., 2013. Reprinted with permission.

The PowerUp Framework is influenced by models focused on:

- Authentic community partnerships/Collaborative Leadership: Leaders and followers act as peers. Leaders have the credibility and integrity to set a direction, motivate and align people to work together toward a common purpose and goal.
- Community influences on behavior/The Social-Ecological Model
- Relevant messages/Social Marketing: Marketing approaches to reach the target audience and community.

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SECTORS AND STAKEHOLDERS INVOLVED

PowerUp involves more than 130 community advisors, including both individual and organizational stakeholders. Community advisors initially developed the focus, vision statement, and advisory structure for the initiative. Through committees, workgroups and individual input, the number of advisors continues to grow. Advisors lead and guide the effort, support strategy development, set priorities, and hold PowerUp accountable for results. Community advisors live and/or work in the target communities, sharing a passion for the well-being of kids. Advisors are also key agents for change and advocates for PowerUp as they create opportunities to do what is "best for kids" in their areas of influence. Advisors represent multiple sectors including:

- Health care: Clinics; hospitals
- Government: Local health departments in Minnesota and Wisconsin; local and state government agencies
- Schools: District administration; schools; Parent Teacher Association/Parent Teacher Organization; afterschool programs; teachers/staff; booster clubs
- Early childhood: Preschools; early childhood programs; child care providers
- Businesses and worksites: Local employers; grocers; banks; restaurants; manufacturing
- Community organizations: Nonprofits; youth programs; food shelves; Rotary; Chambers of Commerce
- Faith-community: Parish nurses; child/family education
- Community leaders and members: Parents; other community residents

KEY LESSONS LEARNED

- A strong and collaborative lead organization is needed to convene the community, provide guidance and expertise and help leverage resources. A commitment by the lead organization to ongoing collaborative planning and decision-making is essential. Dedicated staff is essential to partner with a core group of community leaders to launch and sustain the initiative.
- The community shares leadership from the beginning and ongoing. Community advisors and HealthPartners/Lakeview trust and embrace a collaborative leadership process. This includes sharing power, decision-making authority, and recognition.

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- Community advisors live and/or work in the community and are committed to and passionate about PowerUp goals. A core group provides essential continuity and momentum across sectors. Each advisor may be involved in a variety of ways, including partnerships, committees and workgroups and in advocating for change.
- A wide range of stakeholders, sectors and roles increase both innovation and sustainability. Many of the most innovative PowerUp ideas come directly from the community. Advisors may also offer specific skills as individuals (such as marketing), but may not necessarily represent a particular sector. Local health departments have provided leadership and contribute local health data. Partnerships with nonprofit organizations and schools help reach low-income populations.
- Authentic relationships, partnerships and collaborations take time. Adequate upfront time to develop a shared vision, purpose, roles and expectations is needed. Partnership development is people-intensive work, and a long-term commitment allows partnerships to grow and become sustainable.
- Smaller changes in institutional practices may precede and drive policy change. Changes in the food/physical activity environment at one school carnival, classroom or department are influencing change on an institutional policy level by demonstrating the positive effects to policy decision-makers.
- A strong, targeted communications strategy, including a community "call to action" is needed. PowerUp includes a communications campaign that resonates with the target audience, including kids and the "adult influencers" (parents, youth leaders, etc.). "PowerUp Countdown" messages are consistent with national 5-2-1-0 messages to magnify all efforts. Messages are positive, solution-based and invitational. The community call to action "We PowerUp" is well-received and PowerUp tells a "new story" about norms for kids in our communities.
- Practical evaluation methods are needed at the start in order to sustain over time with available resources. Gaining consensus on realistic expectations for short- and long-term measures of change is critical.

BARRIERS TO ESTABLISHING THE INITIATIVE

- Competing possibilities for action/priorities—Stakeholders needed to reach initial consensus on which community priority to address (chronic illness vs. prevention). PowerUp continues to set priorities

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and resources based on balancing the evidence of "what works" with the perspectives and insights of the community.

- Breaking through community perceptions—Initial perceptions were that PowerUp was a just a short-term program, "another collaborative," or a funding source for existing projects. Therefore, PowerUp approaches partnerships with the question, *"How can we work together to do what is best for kids?"* PowerUp and partner organizations are each expected to bring resources, expertise, and time to the effort in contrast to a funding relationship.
- Navigating "turf" in partnerships—Determine shared objectives and where to work in parallel to other organizations.

WHAT IS NEEDED TO ACCELERATE MOVEMENT FORWARD IN YOUR CROSS-SECTOR WORK?

- Define what "success" looks like and communicate results: Practical evaluation models, methods, and measures are needed to evaluate progress, including documenting systems, environment and policy changes, marketing, education, and collective impact of multiple efforts in one region. Effectively communicating results to diverse stakeholders and the broader community is essential.
- Build capacity of current community advisors: Attaching and maintaining diverse representations to advise and lead the initiative. Development of more community members to fill leadership roles and be community spokespersons for the initiative. Increase effective provider engagement strategies.
- Involve/engage new stakeholders and sectors: Increased involvement from local governments and businesses as well as health care providers in the initiative.

WHAT ARE THE CORE FEATURES OR ELEMENTS OF YOUR INITIATIVE THAT ARE NECESSARY FOR SCALE AND SPREAD?

- Shared leadership and ownership with communities served.
- Communications include call for community-level change (not just individual-level change).
- Local, institutional change in practices and policies.
- Leverage learnings and resources from similar initiatives for collective impact.
- Evaluate, continually improve and share results.

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WHAT ARE THE FEATURES THAT NEED TO REMAIN FLEXIBLE TO ALLOW FOR LOCAL ADAPTATION?

Shared leadership with community and welcoming new stakeholders and sectors continually strengthens community involvement and engagement. Flexibility is needed to change the structure, representation and priorities as community conditions and interests evolve and to respond when readiness/resources are present, which may be at unpredictable times.

For more information, visit http://www.powerup4kids.org.

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Sault Ste. Marie Tribe of Chippewa Indians Cross-Sector Case Study

Submitted by presenters
Jeff Holt, Shannon Laing, and Donna Norkoli[1]

DESCRIPTION OF CROSS-SECTOR MODEL USED

The Sault Tribe Community Transformation cross-sector work follows the Community Coalition Action Theory model (Butterfoss and Kegler, 2008), and is characterized by a network of action-oriented coalition partnerships focused on accomplishing a broad set of common goals, one of which is reducing obesity. This collaborative health improvement initiative began over 10 years prior to the Centers for Disease Control and Prevention's (CDC's) Community Transformation Grant (CTG) and has been evolving over time. As the lead convening agency, the Sault Tribe Community Health Department began this work focusing on just one community in 2006. A strategic approach, including analyzing the problem; gathering data and assessing need; developing an action plan with identified solutions; implementing solutions; achieving outcomes; and creating social change was used to address selected priority health issues. Using the momentum generated through participation in a CDC-supported community health promotion program, Sault Tribe expanded this model to four of its communities in 2008. At this time, Sault Tribe staff and coalition leaders strategically fostered partnerships and built upon programmatic successes to move toward using strategies that would maximize population-wide health improvement, such as policy, systems, and environmental changes that support healthy lifestyles. With the award of the CDC CTG cooperative agreement in 2011, Sault Tribe strategically expanded the initiative again

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into a network of coalitions covering the Tribe's entire seven-county service area. Sault Tribe Community Transformation has invested significant time and effort into coalition building over the lifespan of the initiative, with dedicated staff to work on recruiting and mobilizing members, establishing structure, building capacity, planning and implementing strategies, evaluating outcomes, and supporting institutionalization of strategies. Contextual factors, such as the sociocultural and political environment, geography, history of collaborative work, and social norms have heavily influenced the success of the initiative.

The Sault Tribe Community Transformation initiative is overseen by a tribal Leadership Team that steers the direction of the initiative and action planning that covers the entire tribal service area. In addition, Sault Tribe facilitates a Tribal Food Sovereignty Collaborative and five local coalitions in communities across the service area. Finally, Sault Tribe Community Health partners with various other local community coalitions to promote shared goals among initiatives.

SECTORS INCLUDED

Sault Tribe Community Transformation coalition partners represent diverse sectors, organizations, and constituencies. Sectors represented on the Leadership Team include: tribal transportation, tribal housing, tribal enterprise (i.e., casinos), tribal insurance department, tribal government, tribal health system (health care, public health, and rural health program), tribal economic development and planning, tribal early childhood programs, tribal elders, and tribal youth programs. In addition, tribal nutrition programs, tribal U.S. Department of Agriculture food program, tribal farmers and growers, tribal elders program, and Michigan State University Extension are represented on the Sault Tribe Food Sovereignty Collaborative.

Sectors included in the local community coalitions include: local transportation, local government, higher education institutions and cooperative extension, school districts, farmers and growers, Food Hubs, downtown development authorities, local health departments, local hospitals, county commissioners, YMCA, early childhood advocates (i.e., Great Start Collaboratives), local media outlets, regional planning and development commissions, food co-ops, area agencies on aging, community economic development, parks and recreation departments and others.

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LESSONS LEARNED FROM THE INITIATIVE

- Health equity:
  - The Sault Tribe now has a "place at the table" with local government and in decision-making processes that affect tribal members (who live in non-tribal community settings); tribal staff serve on committees and advisory roles; local government includes tribal issues on meeting agendas for ongoing collaboration.
  - Our coalitions used a balance of evidence-based strategies, community wisdom, and innovative interventions that addressed the root causes of health disparities as determined through community assessment.
- Sustainability:
  - Each sector contributes what they are able since all partners have a stake in the game.
  - Inclusive of shared priorities: there is a shared focus on creating healthier communities, and conditions that support health. These coalitions don't focus only on obesity. This broad focus gets more people involved, creates more shared benefits and brings more resources to the table to support obesity work. Partners capitalize on anything and everything partners can bring to the table.
  - The Sault Tribe CTG Project has implemented cross-cutting strategies: Safe Routes to School, Complete Streets, and Non-motorized Transportation Planning to bring cross-sector partners together. This maximizes impact and shared benefits, increases support for each other's efforts, and increases the ability to leverage funds for partners from a variety of sources.
  - The Project uses social support strategies and concrete supports (funds, signage, staff, etc.) in combination with policy, systems, and environmental changes to promote and sustain positive changes in community environment and to bring about lasting changes in community norms.
- Leadership:
  - The Sault Tribe CTG Project developed a strong Leadership Team and used staff with expertise in coalition building, strategic planning and implementation of policy, systems, and environmental change to facilitate coalition functioning, pooling of resources and engagement of community partners.
  - The project fostered shared leadership and bridge building between coalition members and the community.

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- Measurement:
  - Good-quality, tribal-level population health data empower Sault Tribe to tailor the strategies in their action plans to priority groups and sub-populations.
  - Community assessment data show positive increases in measures of the physical and built environment and the nutrition environment.

BARRIERS TO ESTABLISHING THE INITIATIVE

- Health equity:
  - The Sault Tribe has not traditionally been a partner with local government or schools and there was a "trust" barrier to overcome on both sides.
- Sustainability:
  - Changes in federal funding (end of Strategic Alliance for Health, sequestration) delay progress or decimate infrastructure to sustain staff support and coordination of coalition activities.
  - Staff turnover and need for training of new staff to develop community organizing skills has been a barrier to sustainability of the initiative.
- Leadership:
  - Turf issues have arisen. Why is health involved in or trying to lead a (business, transportation, human resources, etc.) issue?
- Measurement:
  - There was no existing population-level data on obesity-related health measures for tribal members.
  - Sharing data publically has historically been a concern for Tribes due to misperceptions and misuse or abuse of data by external stakeholders. Data-sharing agreements, internal capacity, and models for appropriate data use and management were limited.
  - Evidence of population-level outcomes from this cross-sector work was limited for a number of reasons; the most obvious being that population change may take years or even generations to occur. Although they frequently require them, funding streams traditionally were not designed to support measurement of outcomes over this length of time, and priorities for data collection focused solely on meeting requirements. A flexible vision for long-term strategic planning and investment in evaluation and population-level health surveillance (aligned with changing funding requirements) was needed.

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WHAT IS NEEDED TO ACCELERATE MOVEMENT FORWARD IN YOUR CROSS-SECTOR WORK?

- Health equity:
  - Organizational and personal relationships need to continue to be strengthened and stand the test of time for real equity to be achieved.
  - Assessment, evaluation, and surveillance data collection needs to be culturally sensitive and rigorous to identify subpopulation disparities for prioritization.
- Sustainability:
  - Funding for initiatives needs to come from a variety of sources to reduce dependency on one source of funding.
- Leadership:
  - Leadership needs to engage partners in assessments, prioritization of needs, and decisions regarding implementation of strategies to address the needs. Shared responsibility creates greater buy-in.
- Measurement:
  - Adequate resources to support rigorous local (tribal-specific) data collection and continued focus and priority on high-quality, population-based data for assessment and evaluation.

WHAT ARE THE CORE FEATURES OR ELEMENTS OF YOUR INITIATIVE THAT ARE NECESSARY FOR SCALE AND SPREAD; WHAT ARE THE FEATURES THAT NEED TO REMAIN FLEXIBLE TO ALLOW FOR LOCAL ADAPTATION?

Core Features Necessary for Scale and Spread

- The creation of infrastructure and capacity building at the local level is critical to ensure sustainability and successful pilot projects that can be replicated across communities.
- Partnerships are most effective when technical assistance and support are available to provide guidance, resources, and expertise to community leaders. This is especially true when coalitions are conducting key processes and activities during the implementation phase.

Core Features to Remain Flexible

- The strategies and initiatives selected may differ in each local community so we must let the local partners decide the need and move

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forward. For example, the CTG project had allocated funding for sub-awards to local municipalities to develop non-motorized transportation plans. In one community the local leaders met with CTG staff and explained that in their small community they had a non-motorized section in their recreation plan so could they use the funding to implement one of the priorities from their plan, which was creation and promotion of a historic walking route through the town.

Additional information about Sault Tribe Community Transformation is available at: http://www.up4health.org.

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Acronyms and Abbreviations

ACA	Patient Protection and Affordable Care Act
BMI	body mass index
CANFIT	Communities, Adolescents, Nutrition, and Fitness
CATCH	Coordinated Approach to Child Health
CCPM	Cook County PLACE MATTERS
CDC	U.S. Centers for Disease Control and Prevention
CDFI	Community Development Financial Institution
CFPA	California Food Policy Advocates
CHI	Community Health Initiative
CTG	Community Transformation Grant
DAHPERD	Delaware Association for Health, Physical Education, Recreation, and Dance
EIS	Epidemic Intelligence Service
EPA	U.S. Environmental Protection Agency
EVS	Exercise as a Vital Sign
FDA	U.S. Food and Drug Administration
FQHC	Federally Qualified Health Center
GSA	U.S. General Services Administration

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HBI	Healthy Base Initiative
HEAL	Healthy Eating, Active Living
HEC	Health Education Council
HHS	U.S. Department of Health and Human Services
IFIC	International Food Information Council
IOM	Institute of Medicine
JDRF	Juvenile Diabetes Research Foundation
NCHE	National Collaborative for Health Equity
NDI	New Detroit, Inc.
NHPS	Nemours Health & Prevention Services
NIOSH	National Institute for Occupational Safety and Health
NPC	National Prevention Council
OSG	Office of the Surgeon General
PHA	Partnership for a Healthier America
RADM	Rear Admiral
ROC	Restaurant Opportunities Centers
RWJF	Robert Wood Johnson Foundation
SCHIP	State Children's Health Insurance Program
SDH	social determinants of health
STCTG	Sault Tribe Community Transformation Grant
TFAH	Trust for America's Health
TRF	The Reinvestment Fund
USPHS	U.S. Public Health Service

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Speaker Biographical Sketches

James E. Bloyd, M.P.H., is a member of a team responsible for leading a community health improvement and planning process at Cook County Department of Public Health. He has worked in local public health departments in Los Angeles County, California, and in Lake and Cook Counties in Illinois. His background includes work in tobacco prevention, school health, prevention and treatment of sexually transmitted infections, health equity, and collaborative staff development. In 2009, Mr. Bloyd was chair of the Food and Nutrition Section of the Illinois Public Health Association. He is presently a member of the School Network of the Illinois Caucus for Adolescent Health and a fellow in the Public Health and Equity Cohort of Human Impact Partners. He is a member of the Health Equity & Social Justice Strategic Direction Team of the National Association of County and City Health Officials. In 2011, he presented "A Strategic Assessment of the Illinois Fresh Food Fund: Working Towards an Ideal National Initiative" at the 139th Annual Meeting of the American Public Health Association. Mr. Bloyd was drawn to public health because of its underlying value of social justice. He is committed to eliminating large and unfair health inequities by building strong relationships between public health and residents of communities of color and low-income communities. He holds a degree in Spanish from San Francisco State University and an M.P.H. from the University of California, Los Angeles, which he received in 1990. He is writing his dissertation for the Dr.P.H. degree at the University of Illinois School of Public Health.

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Melissa Lim Brodowski, Ph.D., M.S.W., M.P.H., is currently on detail as acting senior advisor for policy and outreach with the Office of the Surgeon General (OSG) at the U.S. Department of Health and Human Services (HHS). In this role, she supports the implementation of the National Prevention Strategy and other related OSG initiatives. Prior to this assignment, she was a senior child welfare program specialist at the Children's Bureau within the Administration for Children and Families at HHS. She has overseen several grant programs, technical assistance, and research and evaluation activities related to early childhood, prevention, and child welfare services, and supported various federal and nonfederal interagency initiatives. Dr. Brodowski has more than 22 years of experience working in the field of child welfare and human services at the local and national levels. She received her master's degrees in social welfare and public health from the University of California, Berkeley, and her Ph.D. from the University of Maryland, Baltimore, School of Social Work.

Marna Canterbury, M.S., R.D., is director of community health at Lakeview Health Foundation. She brings more than 25 years of experience in community health leadership, nutrition programs, and health message design to her leadership role with the Lakeview Health Foundation, part of the HealthPartners family of care in Minneapolis, Minnesota. As director of community health, Ms. Canterbury leads the development, implementation, and evaluation of PowerUp, a long-term, community-wide initiative designed to make better eating and physical activity easy, fun, and popular so that youth can reach their full potential. She works in partnership with multiple community stakeholders through numerous community health advisory groups and collaboratives. Ms. Canterbury also provides leadership for Lakeview's Community Health Needs Assessment and Implementation Plan. Her previous experience includes leadership and development of health improvement efforts for health plans, clinics, nonprofits, schools, hunger relief organizations, and chronic disease prevention. Her previous roles also include community nutrition manager at HealthPartners, executive director of United Way, health communications consultant for the General Mills Foundation, and senior wellness consultant at UCare Minnesota. Ms. Canterbury received her bachelor's degree in nutrition and biology from Concordia College in Moorhead, Minnesota, and completed her training as a registered dietitian at the University of Iowa. She received her master's degree in community health from Minnesota State University, Mankato.

Debbie I. Chang, M.P.H., is enterprise vice president of policy and prevention and a corporate officer for Nemours, an operating foundation focused on children's health and health care. Nemours is a founding member of the

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Partnership for a Healthier America and the National Convergence Partnership, a unique collaboration of leading foundations focused on healthy people and healthy places. Ms. Chang works to leverage Nemours' expertise and experience to spread what works through national policy and practice changes to improve the health and well-being of children nationwide. She co-directs Moving Health Care Upstream, a national collaborative network whose mission is to test, develop, and spread innovative population health strategies. She was founding executive director of Nemours Health & Prevention Services, an operating division devoted to using a comprehensive multisector, place-based model to improve children's health in Delaware. Ms. Chang serves on the Institute of Medicine's (IOM's) Board on Children, Youth, and Families and the IOM Roundtables on Population Health Improvement and on Obesity Solutions, the University of Michigan Griffith Leadership Center Board, and the Winter Park Health Foundation Board. She has more than 27 years of federal and state government and private sector experience in the health field. She has held key government positions including deputy secretary of health care financing at the Maryland Department of Health and Mental Hygiene, with oversight for Maryland's Medicaid program and national director of the State Children's Health Insurance Program (SCHIP) when it was first implemented in 1997 at HHS. Her work on population health, child health systems transformation, Medicaid, SCHIP, and Nemours' prevention-oriented health system including its Centers for Disease Control and Prevention (CDC) Pioneering Innovation award-winning statewide childhood obesity program has been widely published. Ms. Chang holds a master's degree in public health policy and administration from the University of Michigan and a bachelor's degree in chemical engineering from the Massachusetts Institute of Technology.

Susan B. Damour, was appointed regional administrator for the U.S. General Services Administration's (GSA's) Rocky Mountain region, effective October 26, 2009. As regional administrator, she oversees all of GSA's activities in Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming, including management of federal real estate and a wide range of acquisition support. She is responsible for an inventory of 165 government-owned buildings and 491 active leased buildings that house nearly 50,000 federal employees. More than $350 million in procurements, primarily for the U.S. Department of Defense, pass through her region every year. In her current role, Ms. Damour serves as GSA's representative on the President's National Prevention Council, an organization comprising 20 federal agencies that promotes wellness nationwide. She is a founding member of the West Metro Sustainability Partnership, a collaborative effort dedicated to sharing sustainable practices throughout the community. Participating organizations include GSA, the U.S. Department of Energy's National Renew-

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able Energy Laboratory, the City of Lakewood, and Red Rocks Community College. Previously, Ms. Damour served as regional administrator for the Rocky Mountain region from 1998 to 2001, at which time she helped coordinate the then-largest wind energy purchase by federal agencies to celebrate the 30th anniversary of Earth Day. Before returning to GSA this time, she worked with the Rocky Mountain Climate Organization, where she led stakeholder outreach and expanded statewide membership as director of outreach. Ms. Damour holds a bachelor's degree in liberal arts from Colorado Woman's College.

William (Bill) H. Dietz, M.D., Ph.D., is a consultant to the IOM Roundtable on Obesity Solutions and director of the Sumner M. Redstone Global Center on Prevention and Wellness at the Milken Institute School of Public Health at George Washington University. He was director of the Division of Nutrition, Physical Activity, and Obesity in the Center for Chronic Disease Prevention and Health Promotion at the CDC from 1997 to 2012. Prior to his appointment to the CDC, he was a professor of pediatrics at the Tuft's University School of Medicine and director of clinical nutrition at the Floating Hospital of New England Medical Center Hospitals. Dr. Dietz has been a councilor and president of the American Society for Clinical Nutrition and president of the North American Association for the Study of Obesity. From 2001 to 2003, he served as a member of the Advisory Board to the Institute of Nutrition, Metabolism, and Diabetes of the Canadian Institutes for Health Research. Dr. Dietz has received numerous awards and honors, including the William G. Anderson Award from the American Alliance for Health, Physical Education, Recreation, and Dance, as well as recognition for excellence in his work and advocacy by the Association of State and Territorial Public Health Nutrition Directors (2000); honorary membership in the American Dietetic Association and the Holroyd-Sherry Award for his outstanding contributions to the field of children, adolescents, and the media (2002); the George Bray Founders Award from the North American Association for the Study of Obesity (2005); the Nutrition Award from the American Academy of Pediatrics for outstanding research related to nutrition of infants and children (2006); the Oded Bar-Or Award from the Obesity Society for excellence in pediatric obesity research (2008); and a Special Recognition Award from the American Academy of Pediatrics' Provisional Section on Obesity and the Outstanding Achievement Award from the Georgia Chapter of the American Academy of Pediatrics (2012). Dr. Dietz is the author of more than 200 publications in the scientific literature and the editor of 5 books, including *Clinical Obesity in Adults and Children*, and *Nutrition: What Every Parent Needs to Know*. He received his B.A. from Wesleyan University in 1966 and his M.D. from the University of Pennsylvania in 1970. After completing his residency at Upstate

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Medical Center, he received a Ph.D. in nutritional biochemistry from the Massachusetts Institute of Technology. Dr. Dietz is a member of the IOM.

Mary Beth French, M.Ed., is a physical educator and district physical education and health content chair for the Christina School District in Delaware. She is currently vice president of physical education for the Delaware Association for Health, Physical Education, Recreation, and Dance (DAHPERD) and is in her third year chairing the DAHPERD State Conference Planning Committee. She continues to serve on the Christina School District Wellness Committee while also chairing the Wellness Committee of her school, Brader Elementary. Brader is in its sixth year of participating in Nemours Health & Prevention Services' (NHPS's) Make School a Moving Experience. Brader Elementary has been awarded the Delaware State Pilot Program, Safe Routes to School Grant. It was recognized by the Alliance for a Healthier Generation, Edith Vincent Award Committee and received the Healthier U.S. Schools Challenge Award for its work in creating a healthy school environment for its students. Ms. French earned a B.S. degree in physical education at the University of Delaware and an M.S. degree in curriculum and instruction at McDaniel College.

David D. Fukuzawa, M.Div., M.S.A., is program director for health at The Kresge Foundation. Mr. Fukuzawa has more than 20 years of experience in philanthropy, with a special focus on vulnerable children and youth. His experience as a youth worker and community organizer in Detroit and Chicago taught him that health and well-being are profoundly affected by the condition of the communities, schools, and environments in which people live. Those lessons have informed the efforts he has led to re-envision and redesign Kresge's approach to health grantmaking. In 2002, Mr. Fukuzawa helped develop and then manage the Special Opportunities Initiative. This initiative focused on building the capacity of high-impact organizations that reached underserved populations but were uncompetitive in Kresge's bricks-and-mortar challenge program. From 1990 to 1999, Mr. Fukuzawa was a program officer at The Skillman Foundation in Detroit, where he focused on child and youth health. He was responsible for a major initiative addressing the lack of safe and accessible out-of-school opportunities for Detroit youth, a major factor in the city's high incidence of violence, delinquency, substance abuse, and teen pregnancy. He also helped develop Michigan's first statewide childhood immunization registry. Before his career in philanthropy, Mr. Fukuzawa served as director of human needs at New Detroit, Inc. (NDI), where he was responsible for policy analysis and development, particularly in the areas of welfare reform and health care reform. He drafted NDI's policy statement for health care reform and was NDI's liaison to the Michigan Legislature regarding liability/tort

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reform and its effect on physicians in Detroit. Mr. Fukuzawa also administered a Robert Wood Johnson Foundation grant that established the first school-based health centers in the Detroit public schools. A Yale University graduate, he also holds a master of divinity degree from Catholic Theological Union in Chicago and an M.S. degree in administration from Central Michigan University.

Sue Hedlund, P.H.N., M.A.L., retired in June 2014 as deputy director of the Washington County Department of Public Health and Environment, Stillwater, Minnesota. She is a current member of the Lakeview Foundation Board and chair of its Health and Wellness Committee. Ms. Hedlund has 31 years of experience in local governmental public health work as a public health nurse and administrator. She holds a degree in nursing from Gustavus Adolphus College, St. Peter, Minnesota, and an M.A. degree in leadership from Augsburg College, Minneapolis, Minnesota.

Donald Hinkle-Brown is president and CEO of The Reinvestment Fund (TRF), a national leader in rebuilding America's distressed towns and cities through the innovative use of capital and information. With more than 20 years of experience in the Community Development Financial Institutions (CDFI) industry, Mr. Hinkle-Brown is widely recognized as an expert in developing new programmatic initiatives, raising capital, and creating new products to meet market demand. He previously served as president of community investments and capital markets at TRF, leading the Fund's lending during a period in which it lent or invested more than $1.3 billion. Mr. Hinkle-Brown also has provided his underwriting and capitalization expertise to many community development loan funds and organizations, including the Hope Enterprise Corporation, Opportunity Finance Network, and the Low-Income Investment Fund, and as adjunct faculty at the Center for Urban Redevelopment Excellence at the University of Pennsylvania and University of New Orleans. He serves as the Community Development Trust's founding board member and until recently was on the board of the Housing Partnership Network and its affiliated CDFI. Mr. Hinkle-Brown also has served as adjunct faculty in Temple University's Geography and Urban Studies program and the University of Pennsylvania's City Planning department. He holds an M.B.A. in real estate and urban planning from the Fox School at Temple University, as well as a B.A. in economics.

Jeff Holt has been involved in economic and community development for more than 20 years. His past accomplishments include financing, contract management, and construction management for two community health facilities, totaling $7.5 million. He has been project lead in the creation of a multi-million dollar housing site, designed and created from 300 acres of

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farm land. Mr. Holt is responsible for annual funding for road projects in excess of $1 million annually. He is also active in economic relations with Canada. He was appointed by the governor of Michigan to a Workforce Investment Board. Mr. Holt serves as chairman of the Sault Ste. Marie Economic Development Commission and the Eastern U.P. Dispute Resolution Center as a state-certified mediator. He is a board officer for Michigan Works and for the Eastern Upper Peninsula Planning Commission, as well as a board advisor for the U.S. Department of Agriculture's Farm Service Agency.

Shannon Laing, M.S.W., is program coordinator for Tribal Health and Wellness in the Center for Healthy Communities at the Michigan Public Health Institute. Over the past 10 years, she has designed and coordinated more than 25 projects with tribal communities. Her work focuses primarily on supporting tribes and tribal organizations carrying out community health assessment, population health surveillance, community health improvement, and culturally tailored evidence-based interventions through community-based and participatory evaluation, training, technical assistance, and facilitation. Currently, Ms. Laing serves as local evaluation team lead for multiple tribal organizations working on CDC-funded projects implementing policy, systems, and environmental change interventions to improve community health. She is also project coordinator for a Robert Wood Johnson Foundation Public Health Services and Systems research study exploring the organization and capacity of tribal public health systems. Ms. Laing holds a master of social work degree in organizational and community practice from Michigan State University. She is trained and experienced in applying technology of participation facilitation methods and strategic planning through the Institute of Cultural Affairs.

Jeffrey Levi, Ph.D., is executive director of the Trust for America's Health (TFAH), where he leads the organization's advocacy efforts on behalf of a modernized public health system. He oversees TFAH's work on a range of public health policy issues, including implementation of the public health provisions of the Patient Protection and Affordable Care Act (ACA) and annual reports assessing the nation's public health preparedness, investment in public health infrastructure, and response to chronic diseases such as obesity. TFAH led the public health community's efforts to enact, and now defend, the prevention provisions of the ACA, including the Prevention and Public Health Fund and the new Community Transformation Grants. In January 2011, President Obama appointed Dr. Levi to serve as a member of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, which he chairs. Dr. Levi is also professor of health policy in George Washington University's School of Public Health, where his research

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has focused on HIV/AIDS, Medicaid, and integration of public health with the health care delivery system. In the past, he has served as associate editor of the *American Journal of Public Health* and deputy director of the White House Office of National AIDS Policy. Beginning in the early 1980s, he held various leadership positions in the lesbian, gay, bisexual, and transgender and HIV communities, helping to frame the early response to the HIV epidemic. Dr. Levi received a B.A. from Oberlin College, an M.A. from Cornell University, and a Ph.D. from George Washington University.

Rear Admiral (RADM) Boris D. Lushniak, M.D., M.P.H., is acting surgeon general of the United States. He also oversees the operations of the U.S. Public Health Service's (USPHS's) Commissioned Corps, comprising approximately 6,800 uniformed health officers who serve in locations around the world to promote, protect, and advance the health and safety of the nation. RADM Lushniak served as deputy surgeon general from November 2010 until July 17, 2013, when he assumed the duties of acting surgeon general. He began his USPHS career in 1988 as a lieutenant, entering as part of the CDC's Epidemic Intelligence Service (EIS), and initially was stationed with the CDC's National Institute for Occupational Safety and Health (NIOSH) in Cincinnati, Ohio, where he conducted epidemiological investigations of workplace hazards. In 1990, he was accepted for the CDC's long-term training program and completed a 3-year residency in dermatology at the University of Cincinnati, after which he established an occupational skin disease program at NIOSH. During his time at the CDC, RADM Lushniak also served on special assignments and disaster response activities in Bangladesh, Kosovo, Russia, and St. Croix, and was part of the CDC/NIOSH team at Ground Zero (World Trade Center) and the CDC team investigating the anthrax attacks in Washington, DC. In 2004, he transitioned from the CDC to the U.S. Food and Drug Administration (FDA) as chief medical officer of the Office of Counterterrorism. In 2005, he was appointed FDA assistant commissioner, counterterrorism policy and director of the Office of Counterterrorism and Emerging Threats within the Office of the Commissioner. While at the FDA, he was deployed after Hurricane Katrina to serve as HHS representative in San Antonio and served as FDA deputy incident commander for the 2009 pandemic response. RADM Lushniak is a member of many professional organizations and has received numerous USPHS awards. In addition, he has received the American Medical Association's Dr. William Beaumont Award in Medicine and the Association of Military Surgeons of the United States Sustaining Member Lecture Award, as well as HHS Secretary and FDA Commissioner awards. RADM Lushniak completed his B.S. degree in medical sciences in 1981 and obtained his medical degree in 1983. In 1984, he received his master of public health degree from Harvard University. He

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completed a residency in family medicine in 1987 at St. Joseph Hospital in Chicago and a residency in dermatology at the University of Cincinnati in 1993. RADM Lushniak maintains board certifications in dermatology and preventive medicine (occupational). He served as a staff physician in dermatology at the National Naval Medical Center in Bethesda and is adjunct professor of dermatology at the Uniformed Services University of the Health Sciences.

Mary Kate Mouser, M.S., is operational vice president of Nemours Health & Prevention Services (NHPS), an operating division of Nemours, one of the top pediatric health care systems in the nation. NHPS is focused on population health and has been recognized nationally for pioneering work in prevention of childhood obesity and for innovation in linking clinical practice and community-based prevention. Ms. Mouser joined Nemours in 2011, bringing 20 years of expertise in advocacy, government and community relations, and communication, most recently with the Monroe Carell Jr. Children's Hospital at Vanderbilt. Her background also includes extensive experience in strategic planning and capacity building for nonprofit organizations, as well as work in fundraising, market research, product development, and financial management. At NHPS, Ms. Mouser is responsible for the administration of the overall operation, including personnel communications, marketing, and public relations; 60+ employees; and an annual operating budget of $12 million. She currently serves as principal investigator on major grants awarded to NHPS by the CDC and the Center for Medicare & Medicaid Innovation. Ms. Mouser also oversees NHPS's partnership engagement strategy to foster alliances with external partners, in addition to working with other Nemours operating divisions to support an integrated approach to achieving the goal of optimal health for all children in Delaware. Ms. Mouser has a long history of personal engagement in community activities, having served on a wide variety of boards and committees focused on health, children's issues, and human services. She holds an undergraduate degree from the University of Kentucky and an advanced degree in human and organizational development from Vanderbilt University.

Donna Norkoli, is project coordinator for the Sault Ste. Marie Tribe of Chippewa Indians' Community Transformation Grant project. She has worked in public health for 19 years, coordinating regional efforts to promote physical activity, healthy eating, and tobacco-free lifestyles, as well as developing and implementing programs designed to increase active transportation. Ms. Norkoli holds a B.S. degree in public health education and health promotion from Central Michigan University and is a national certified health education specialist.

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Debra Oto-Kent, M.P.H., has been executive director of the Health Education Council (HEC), which is dedicated to providing access, education, advocacy, and training to empower individuals toward a healthy life, for more than 20 years. Ms. Oto-Kent founded the HEC in 1991 after working for more than 13 years in the nonprofit health sector. Her two primary areas of interest and expertise are coalition building among diverse stakeholders; reaching consensus on common goals; and public health education, with an emphasis on reducing health disparities among underserved populations, including communities of low socioeconomic status and diverse ethnic populations. She has written and spoken extensively on the latter topic. She has served on boards and committees of local and statewide health and research organizations including the California Tobacco-Related Disease Research Program and the Breast Cancer Research Program. She continues to serve on Communities, Adolescents, Nutrition, and Fitness (CANFIT) and the External Advisory Board for the National Center for Reducing Asian American Cancer Health Disparities, and is founding board member of the Capitol Health Network. Under Ms. Oto-Kent's leadership, HEC has developed model programs focused on increasing access to health and education resources and reducing health disparities in preventable causes of death.

Russell R. Pate, Ph.D., is professor of exercise science at the Norman J. Arnold School of Public Health, University of South Carolina, Columbia. Dr. Pate's research interests and expertise focus on physical activity measurement, determinants, and promotion in children and youth. He also directs a national postgraduate course aimed at developing research competencies related to physical activity and public health. Dr. Pate is involved in the CDC-funded Prevention Research Center at the University of South Carolina. His research includes studies on preschoolers' physical activity levels and how schools can influence these levels, as well as multicenter trials on the promotion of physical activity among girls of middle and high school age. Dr. Pate was a member of HHS's Physical Activity Guidelines Advisory Committee and served on the 2005 Dietary Guidelines Advisory Committee. He is a past president of both the American College of Sports Medicine and the National Coalition on Promoting Physical Activity. Dr. Pate served as a member of several IOM obesity-related committees, including the Standing Committee on Childhood Obesity Prevention, and was chair of the Committee on Fitness Measures and Health Outcomes in Youth. He received a Ph.D. in exercise physiology from the University of Oregon.

Nico Pronk, Ph.D., is vice president for health management and chief science officer for HealthPartners, Inc. Dr. Pronk is also a senior research

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investigator at the HealthPartners Institute for Education and Research; adjunct professor for social and behavioral sciences at the Harvard School of Public Health; visiting research professor in environmental health sciences at the University of Minnesota, School of Public Health; member of the Task Force on Community Preventive Services; and founding and past-president of the International Association for Worksite Health Promotion. His research expertise lies in the areas of population health improvement, the role of physical activity in health, and the impact of multiple health behaviors on health outcomes. Dr. Pronk is particularly interested in improving population health in the context of the employer setting; the integration of health promotion with occupational safety and health; and the integration of health promotion, behavioral health, and primary care. He is senior editor of the American College of Sports Medicine's *Worksite Health Handbook*, 2nd ed. (2009), and author of the scientific background paper for the U.S. National Physical Activity Plan for Business and Industry. Dr. Pronk received a Ph.D. in exercise physiology from Texas A&M University and completed postdoctoral studies in behavioral medicine at the University of Pittsburgh Medical Center and the Western Psychiatric Institute and Clinic in Pittsburgh.

Bill Purcell, J.D., is an attorney in Nashville, Tennessee, and an adjunct professor of public policy at Vanderbilt University. While he was serving as mayor of Nashville (1999 to 2007), his accomplishments as a civic leader earned him Public Official of the Year honors in 2006 from *Governing Magazine*. Elected to five terms in the Tennessee House, he held the positions of majority leader and chair of the Select Committee on Children and Youth. After retiring from the General Assembly, Mr. Purcell founded and became director of the Child and Family Policy Center at the Vanderbilt Institute of Public Policy Studies. From 2008 to 2010, he served as director of the Institute of Politics at the Harvard Kennedy School of Government. He was then appointed special advisor and co-chair of the Work Team for Allston in the Office of the President at Harvard University. Mr. Purcell has previously served in various capacities on IOM obesity-related committees, including as a member of the Committee on an Evidence Framework for Obesity Prevention Decision Making, as vice chair of the Committee on Accelerating Progress in Obesity Prevention, and as a member of the Standing Committee on Childhood Obesity Prevention. He graduated from Hamilton College and Vanderbilt University School of Law.

Amelie Ramirez, Dr.P.H., M.P.H., is director of Salud America! and professor of epidemiology and biostatistics at the University of Texas Health Science Center at San Antonio, where she also is founding director of the Institute for Health Promotion Research. In addition, she co-directs the Can-

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cer Therapy & Research Center's cancer prevention and population science research program. Over the past 30 years, Dr. Ramirez has directed many research programs focused on human and organizational communication to reduce chronic disease and cancer health disparities affecting Latinos, encompassing cancer prevention and risk reduction, obesity prevention, healthy lifestyles, and more. She directs two national research networks, including Salud America! The Robert Wood Johnson Foundation (RWJF) National Research Network to Prevent Obesity among Latino Children, which is building an evidence base, creating bilingual multimedia content, developing the field of researchers, and empowering communities to reverse the obesity epidemic among Latino children. Among several honors is her 2007 election to the IOM. She also is a member of the board of directors for the Lance Armstrong Foundation, C-Change, and the RWJF Health & Society Scholars Program, as well as a member of the San Antonio Mayor's Fitness Council, which has overseen the implementation of healthy lifestyle programs that have lowered local obesity rates.

Bonnie Renée Rateree is a community advocate for Cook County PLACE MATTERS (Chicago). She was born in the working class community of Harvey, Illinois (a suburb of Chicago), where she still resides. She received her education in Public School District #147, where she serves as an elected school board member and vice president of the board. A lifetime of volunteer service has given Ms. Rateree an opportunity to witness inequities in educational and health opportunities for women and people of color. Her professional work as director of a nonprofit community organization, regional director for an international social change organization, and assistant to the mayor of the City of Harvey has kept her in close touch with the people most affected by unfair social policies. As a master gardener with the University of Illinois Extension and an environmentalist, Ms. Rateree has dedicated her life to collaborative work with her local governmental and community organizations to bring about systemic change through open, honest dialogue that includes the voices of those most affected by national and local policies. Ms. Rateree is vice president of the West Harvey/Dixmoor Board of Education; a member of the National School Board Association; and the Native American, African American, and Hispanic Caucuses. She also is acting director of the Human Action Community Organization serving the south suburbs of Chicago. Her involvement with the Cook County PLACE MATTERS team has proven to her that place really does matter and that the inequities she has witnessed in her neighborhood are not only a reality but by design. Ms. Rateree's philosophy can be summed up in two phrases: "work hard/stay humble" and "think globally/act locally." The Harvey of her childhood, where there were at least two jobs for every household, is now a place where half of

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the housing stock is vacant. She often compares her hometown to a Third World country.

Helen Riley is executive director at St. Michael's School and Nursery in Wilmington, Delaware. A recognized expert and visionary in the early education industry, Ms. Riley often is called upon to be a spokesperson for young children's issues. She has been a driving force for legislation and effective regulations covering early childhood academics, health, and safety. Professionally, she was a kindergarten teacher for 18 years at St. Michael's School before becoming executive director in 1988. Founded in 1890, St. Michael's is widely acknowledged as a trailblazer in innovative and exemplary early childhood education for children from birth through age 8. During his recent visit to the school, U.S. Secretary of Education Arnie Duncan called St. Michael's a model for the nation. The school holds the highest attainable designation, Level 5, in the DE STARS quality rating program. It has won the Governor's Award for Excellence in Early Education and the Delaware Academy of Medicine's Public Health Award in recognition of its outstanding contribution to the health and well-being of the community and its children. St. Michael's was the pilot site for the first Nemours Health & Prevention Services (NHPS) project in Delaware and has been a partner ever since. More than 70 percent of St. Michael's children receive help from the school's private financial aid program; nearly $1 million must be raised annually to provide these scholarships. Next year, the school, which is one of the oldest in the United States, will celebrate its 125th anniversary. Ms. Riley is a graduate of the University of Delaware, where she pursued studies in education and psychology.

Sylvia Rowe, M.A., is currently president of SR Strategy, providing communications and management consulting on a broad range of health, nutrition, food safety, and risk issues. Ms. Rowe also is an adjunct professor at the University of Massachusetts, Amherst, and the Tufts Friedman School of Nutrition Science and Policy. Previously, she served as president and chief executive officer of the International Food Information Council (IFIC) and IFIC Foundation in Washington, DC. IFIC's programs are supported primarily by the broad-based food, beverage, and agriculture industries. Ms. Rowe's leadership resulted in national public–private partnerships and coalitions between IFIC and preeminent government agencies and health organizations committed to developing science-based consumer communications on healthful lifestyles. Ms. Rowe's background in media and expertise in issues management are reflected in her professional history as a producer and on-air host of several television and radio talk shows covering social, political, economic, and consumer issues. She also previously held positions in public relations, marketing, and membership development

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for several diverse associations. Ms. Rowe is a distinguished Institute of Food Technologists speaker and contributing editor of *Nutrition Today*. She has served on numerous boards and advisory committees. She also is a member of the International Women's Leadership Forum and the National Press Club, among other professional groups. Ms. Rowe received a bachelor's degree from Wellesley College and a master's degree from Harvard University.

Pamela Schwartz, M.P.H., joined Kaiser Permanente in 2001 and became part of its Community Benefit Program in 2007 as director, program evaluation. In that capacity, she directs multiple cross-site evaluations of Kaiser Permanente's Community Benefit efforts, including the Community Health Initiative, a national initiative to improve health in Kaiser Permanente communities through multisectoral, place-based efforts focused on environmental and policy change. This initiative is a critical element of Kaiser Permanente's comprehensive approach to preventing obesity and obesity-related diseases. Ms. Schwartz also directs Kaiser Permanente's Thriving Schools evaluation effort, aimed at documenting the impact of a key component of Kaiser Permanente's Total Health strategy. The Thriving Schools initiative is intended to improve the health of students, teachers, and staff, primarily through improvements to the school environment within communities served by Kaiser Permanente. In addition, Ms. Schwartz leads a program-wide strategy aimed at supporting and improving Kaiser Permanente's needs assessment processes and products and increasing effective use of needs assessments in Community Benefit decision making. Prior to becoming part of Community Benefit, Ms. Schwartz led the cross-site evaluation of The California Endowment's Partnership for the Publics Health, a $40 million initiative partnering 39 communities with their local health departments throughout California. Before coming to Kaiser Permanente, she directed a 5-year evaluation of a substance abuse and pregnancy prevention project for adolescent girls at Boston University's School of Public Health and a multi-million-dollar longitudinal research project studying adult children of alcoholics at Arizona State University. She has worked abroad in Guatemala with indigenous populations and in Israel with Ethiopian populations and studied in Mexico and Spain. In addition, she has held various positions with Planned Parenthood. Ms. Schwartz holds a master's in public health degree and has 20 years of experience in public health and evaluation, and is the author of several journal articles. She is also a graduate of Kaiser Permanente's Executive Leadership Program at Harvard Business School.

Brian Smedley, Ph.D., M.A., is co-founder and executive director of the National Collaborative for Health Equity, a project that connects research,

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policy analysis, and communications with on-the-ground activism to advance health equity. In this role, Dr. Smedley oversees several initiatives designed to improve opportunities for good health for people of color and undo the health consequences of racism. From 2008 to 2014, Dr. Smedley was vice president and director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC, a research and policy organization focused on addressing the needs of communities of color. Formerly, he was research director and co-founder of a communications, research, and policy organization, The Opportunity Agenda, which seeks to build the national will to expand opportunity for all. Prior to helping launch The Opportunity Agenda, Dr. Smedley was a senior program officer in the IOM's Division of Health Sciences Policy, where he served as study director for various reports on diversity in the health professions and minority health research policy. Dr. Smedley came to the IOM from the American Psychological Association (APA), where he worked on a wide range of social, health, and education policy topics in his capacity as director for public interest policy. Prior to working at the APA, he served as a congressional science fellow in the office of Rep. Robert C. Scott (D-VA), sponsored by the American Association for the Advancement of Science. Dr. Smedley has received several awards and distinctions, most recently the American Public Health Association's Cornely Award for social activism (2013). He holds an undergraduate degree from Harvard University, as well as an M.A. and Ph.D. in clinical psychology, both from the University of California, Los Angeles.

Lawrence Soler, J.D., is president and chief executive officer of the Partnership for a Healthier America (PHA). Prior to joining PHA, Mr. Soler was chief operating officer for the Juvenile Diabetes Research Foundation (JDRF). He oversaw the bulk of JDRF's activities, including all fundraising and local chapters, marketing and communications, information technology, government relations, and international development. Mr. Soler originally joined JDRF in 1998 as a senior legislative counsel. Among his signature accomplishments at the Foundation, he is credited with leading efforts that resulted in securing $1.75 billion in mandatory federal funding for research on type 1 diabetes, the only disease that receives such funding. He also created and chaired the Coalition for the Advancement of Medical Research, an organization comprising 100 nationally recognized patient groups, universities, scientific societies, and foundations that successfully overturned a pending federal ban in a leading medical research area. Additionally, Mr. Soler served as executive sponsor of JDRF's Artificial Pancreas Project, an ambitious effort to accelerate the development of closed-loop insulin pumps and glucose monitoring systems, which impacted reimbursement policy, regulatory policy, research strategy, and industry partnerships.

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As part of his responsibilities with the project, he negotiated joint product development deals with several companies to create cutting-edge devices and new pharmaceutical solutions for treating type 1 diabetes. Mr. Soler previously worked for 8 years in federal relations positions at the Association of American Universities, focusing on education, health, and immigration issues. He received a B.A. with honors from Clark University and his J.D. from George Washington University. He is a member of both the Maryland and Washington, DC, Bar Associations.

Marion Standish, J.D., is senior advisor in the Office of the President at The California Endowment, where she leads the foundation's multiple philanthropic partnerships, provides strategic guidance for the Health Happens Here Campaigns, and provides programmatic support to Impact Investing activities. Ms. Standish serves as lead officer for many of the Endowment's funding initiatives including the Partnership for a Healthier America, the First Lady's Let's Move Campaign, the National Convergence Partnership, Let's Get Healthy California Task Force, collaboration among California's Community Transformation Grant recipients, and the newly formed international Global Alliance on the Future of Food. Before assuming her role as senior advisor, Ms. Standish was director of community health for the Endowment, a role in which she created and managed multiple grantmaking initiatives focused on addressing health disparities and environmental factors that contribute to the poor health of underserved communities. In that capacity, she created the Partnership for the Public's Health, a 5-year program designed to build strong, effective partnerships between government public health agencies and the communities they serve, including projects focused on reducing environmental triggers for asthma among school-aged children and on supporting local and regional community coalitions in developing and implementing policies and programs to reduce obesity. In 2012, Ms. Standish served as a loaned executive to the Public Health Institute and the State of California for the launch of CA4Health, the state's 42-county Community Transformation Grant program. Before joining the Endowment, she was founder and director of California Food Policy Advocates (CFPA), a statewide nutrition and health legal, research, and advocacy organization focused on federal food programs and improving access to nutritious food for low-income families. Before launching CFPA, she served as director of the California Rural Legal Assistance Foundation, a statewide advocacy organization focused on health, immigration, housing, education, and labor issues facing farmworkers and the rural poor. She began her career as a staff attorney with California Rural Legal Assistance, a federally funded legal services program. Ms. Standish is the recipient of numerous public service awards, has published articles on health disparities, and is a regular speaker at state and national conferences.

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She currently serves on the board of directors of the Food Research and Action Center, and is a member of the Advisory Board of the San Francisco Community Boards Program, focused on dispute resolution and mediation. She received her J.D. from the University of San Francisco School of Law and both her M.A. and undergraduate degrees from New York University.

Maha Tahiri, Ph.D., is chief health and wellness officer at General Mills, Inc., and heads the Bell Institute of Health and Nutrition. Dr. Tahiri leads a group of dedicated nutrition and food scientists, dietitians, and public health nutritionists whose mission is to excel at nourishing the world. The Bell Institute integrates nutrition science, regulatory expertise, and communication skills to deliver strategic innovation in health and nutrition for all of General Mills' businesses globally. Her professional experience is in the food industry, developing global health and nutrition innovation strategies for a variety of food companies covering several regions, including Europe, Asia, the Middle East, and North Africa. Dr. Tahiri serves on the Executive Board of Directors of the International Food Information Council and on the Board of the European Food Information Council. She is an active member of the International Life Science Institute and a member of the IOM Food Forum. She holds a Ph.D. in human nutrition from the National Institute of Agricultural Research, France.

Felipe Tendick-Matesanz, M.S., is national high road programs coordinator at Restaurant Opportunities Centers United, where he is tackling the challenge of creating a sustainable food economy in the United States. He is a public health scientist focused on building participatory and community-driven sustainable food systems. He also works with various academics in the fields of occupational and environmental health sciences, urban planning, engineering, and public health on the topics of environmental health, complex systems evaluation, and occupational health and safety. Mr. Tendick-Matesanz has presented at various conferences and lectured on such topics as the current state of food deserts; labor equity in sustainable food systems; justice for food service workers; and negative effects of genetically modified organisms and pesticides on food safety, biodiversity, and human health. His overarching philosophy emphasizes cooperative collaboration over isolation-driven individualism. Mr. Tendick-Matesanz holds a B.A. degree in Spanish literature and international business and an M.S. degree in environmental and occupational health sciences.

Mildred Thompson is senior director and director of the PolicyLink Center for Health Equity and Place, where she leads the organization's health team, whose work focuses on access to healthy food, improving the built environment, and the systemic integration of health equity. A significant component

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of her work involves exploring community factors that impact health and identifying effective solutions. Prior to joining PolicyLink, she was director of community health services for Alameda County's Public Health Department, director of Healthy Start, and director of the San Antonio Neighborhood Health Center. Ms. Thompson holds degrees in nursing, psychology, and social work. She has taught at Mills College and San Francisco State University, and also worked as an organizational development consultant. She is a frequent speaker on topics related to health equity and serves on several boards and commissions, including the Zellerbach Family Foundation, and she is co-chair of the IOM's Roundtable on the Promotion of Health Equity and Elimination of Health Disparities.

Brigette Ulin, M.P.H., is director of the Office of the National Prevention Strategy in the CDC's Office of the Associate Director for Policy. In this role, she coordinates the activities of the National Prevention Council across 20 federal departments and the implementation of the nation's first National Prevention and Health Promotion Strategy. Authorized by the Patient Protection and Affordable Care Act of 2010, the National Prevention Strategy envisions a prevention-oriented society in which all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for all Americans. Previously, Ms. Ulin worked in the CDC's National Center for Chronic Disease Prevention and Health Promotion; National Center for Injury Prevention and Control; National Center for HIV, Viral Hepatitis, STD, and TB Prevention; and National Center for Infectious Diseases. A significant focus of her research and work has been planning and evaluating community-based prevention initiatives, behavioral and health education initiatives, national campaigns, and health education curricula. She began her career at the CDC in 1997 as a presidential management fellow. During her tenure at the CDC, she has served as the civil servant representative of the Public Health Service's Scientist Professional Advisory Committee, co-chairperson of an institutional review board, member of the National Advisory Board for Outreach Prevention, member of the Community Health Education Team of the Emergency Communication System, member of the Emergency Anthrax and SARS Prevention and Control Teams, and chairperson of the Behavioral and Social Science Workgroup. Ms. Ulin holds a master's in public health degree in behavioral science from Emory University and a bachelor's degree in neurobiological science from the University of Florida.

Donna Zimmerman, M.P.H., is senior vice president of Government and Community Relations for HealthPartners, Inc., a nonprofit, consumer-governed health care organization in Bloomington, Minnesota. HealthPartners, Inc., provides health care coverage to 1.5 million members and health

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care services for more than 1 million patients each year. Ms. Zimmerman is responsible for developing and managing federal and state public policy and regulatory relationships, community affairs, and community partnerships to improve population health. She works in all areas of government and reform product strategy, encompassing Medicare, Medicaid, and individual products. She was previously director of government programs, with responsibility for the health plan Medicare and state public programs. Her background is in community health administration and policy, with leadership and executive experience in the public and nonprofit sectors. She holds a master's in public health degree from the University of Minnesota and a bachelor's degree in nursing from St. Olaf College, Minnesota.

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