Weight of the Nation:

CDC's Inaugural Conference on Obesity Prevention and Control

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Focusing State Health Departments On Obesity Prevention

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DR. VICTOR SUTTON:

During the course of this conference, we have heard some innovative strategies to address this complex issue of obesity prevention and control around a built environment, work site health promotion, school health, access to affordable fresh fruits and vegetables in every community, policy and environmental changes, opportunities in the medical care setting, and opportunities to apply what we have learned from the tobacco control efforts such as price, exposure, and image.

We also understand the impact of social determinants such as housing, education, and income has on your health. State health departments have historically been excellent insurers of protecting and promoting public health. However, unlike TB, the flu and some other communicable diseases, there is no shot or vaccine for obesity. State health departments are uniquely petitioned to continue to paradigm shift to address this epidemic.

Let me quote a famous Mississippi native: "I am sick and tired of being sick and tired." Mississippi would not be bringing up the rear much longer. We are not going to be last much longer. We have some very innovative programs and partnerships taking place. In Mississippi, the task of creating that culture of wellness is already taking place and the pendulum is swinging. City leaders and mayors are aware, engaged in promoting health as you heard from our good Mayor Chip Johnson from Hernando. We must continue to build evidence towards addressing this complex issue around obesity prevention and control.

Mississippi has accepted the challenge but it takes time to turn this Titanic obesity ship around. So I have the distinct pleasure to introduce our panel.

Dr. Monroe is the Indiana State Health Commissioner. She's president of the Association of State and Territorial Health Officials, and serves on the Board of Directors for the Public Health Accreditation Board. She is focused on health promotion and prevention, quality improvement, health reform, and preparedness during her tenure as health commissioner. We also have Ms. Laura Hutton. Ms. Hutton is the lead evaluator for the Center for Health Promotion, chronic disease, and risk reduction unit in the Minnesota Department of Health. And we also have Dr. William H. Dietz. Dr. Dietz is the director for the Centers for Disease Control Division of Nutrition, Physical Activity and Obesity.

DR. JUDY MONROE:

Hello. I am a middle child but, you know, state public health, we are the middle child of the public health enterprise between federal, state and local and many times that's kind of where we feel. In the position of a state health official, we certainly play a significant role in moving forward the Governor's agenda, policy development, and we can certainly be in a position to deliver a trusted message to the legislators and to the public. And that's really where I think state health officials need to be.

Governor Daniels is an example with the initiative that we have with INShape Indiana that has built a whole trail system that we will have in Indiana. State health officials also have the ability to leverage both physical and human resources across multiple programmatic areas and policy areas rather than funding one at a time. That can be challenging; but as the state official, you have some ability to do that. And we have the ability to bring comprehensive systems together, a comprehensive system approach to obesity prevention. So, I think it's important that we educate our state health officials as they come in. And I commend the Robert Wood Johnson Foundation for the State Health Leadership Initiative.

So, when we look at the role and in my own experience, setting priorities is something that the state health official can do for the state health agency. And setting those priorities is important because the state wants to know what the priorities are. I have been really amazed at how powerful that is to come in, say these are the priorities, stick with those priorities, and there is a problem because, as soon as you set a priority, somebody is not on the list and they are upset. Other program areas are upset, right? But if everything is a priority, then nothing is a priority. So we really do need to define what that is.

Now, I was fortunate in Indiana because Governor Daniels really wanted from the get-go to have something around health. He understands the economic impact of poor health. And so in 2005, INShape Indiana was launched and our priority right off the top was improve nutrition, physical activity and tobacco. And those three really, to me, need to be national priorities and be priorities in every state, and then you can have maybe two or three others. You know, you can't have a whole litany of priorities. But when you are out there with those priorities and you've set them, what I've been amazed at in Indiana is I've had universities say, "How can we help?" We are so glad to hear that the State has priorities, and we want to be part of that. Because there are so many folks they want to be part of helping the State.

Businesses have come to the forefront. We have had a number of businesses that have stood up and said: You know, we are going to help. We are going to make a difference. We are going to promote that work-site wellness and do what we can do. So, they have gotten the message. Our hospital association last summer, their board of directors, they invited me to come to give a presentation on where the State was. And with me present, they voted on six priorities that were consistent with the State's priorities in terms of what they were going to do and leverage funding and leverage resources around and in alignment with the State. So, it can be very, very powerful.

One thing that just happened in Indiana that was just a true honor to be part of, we have the Peyton Manning Children's Hospital in Indiana. Peyton Manning and his dad, Archie, are involved as well with the Peyton Manning Children's Hospital and other partners have launched what's called "Project 18" in Indiana. Project 18 -- there are going to be public service announcements throughout Indiana with Peyton being the messenger to the kids. Ball State University created a curriculum that will be available to all the schools, so the health curriculum has been a part of this. Schools can ask and receive the curriculum, no charge and some services come with that.

And then Moore Supermarkets is an early partner who has come in, and they are going to have Project 18 foods identified throughout the supermarket. So, they have already been assessed for their nutritional value so that the families and kids might gravitate to the Project 18 foods. But that was a really exciting thing. But this is the kind of thing that we are seeing in Indiana as we have stuck to the message, and we have stayed very consistent with here's the priority, this is what we need do.

The result for us, it takes time, but we, for the last four years now running that we have plateaued. We stopped the rise. And we had been well on the rise. And that's changed our state ranking, but it's no consolation because other states have continued to increase their obesity rates. So, we haven't reversed it statistically yet. But we know we have to stop that. So, some efforts are making a difference.

State health officials can also be the face and the voice of public health; and when it comes to the media and so forth, I think it's really important to have a consistent voice. When folks see that person, they know what the message is. They know what that's all about.

Now, that can get you into trouble a little bit. A couple of years ago we had been on an Indianapolis monthly magazine. They wanted to come to my home to do a photo op. And I thought, oh, how nice. Well, they didn't want me or my family, they wanted the inside of my refrigerator. At which point, my middle son, who has always been the character was scheming how the night before they came he would empty the refrigerator and fill it with Taco Bell and beer because he thought that would be really cool. And then my oldest son, who is extremely health conscious, happened to be home -- it was kind of the holidays and they identified -- where I had identified some of the foods, I had to tell them what was in there and who bought them. And so when it came out in the magazine, full page, full-page picture of my refrigerator in the magazine, telling everybody what was in it and one of the circles was Egg Beaters. And it said this is her son, he is a health nut. And at that point, my son was like, mom, this health commissioner thing has gone way too far.

So you've got to engage the family and make the kids a little bit crazy with this if you are going to take on that role. But the leadership of the state health official and the state health agency and having folks is just critical and it's powerful. And it's the power to be able to convene and coordinate and optimize resources, support local communities. Again, that consistency of messaging and modeling those desired behaviors is important. But like I say, it can get you into trouble. You really do have to walk the talk if you are going to get out there, no question about it.

The other thing that a state health official can do at the state health agency is get the right people on the bus, because we need leadership at all levels. Clearly one person can't do it. It's powerful when you're governor. It's the CEO of the state is saying it would be wonderful if nationally every governor had started there and every governor said obesity is a priority and nutrition and physical activity, and then the state health officials have the freedom to really carry that message in a powerful way.

But we need everyone else. We need all levels throughout the state health agency and then across the whole system to do that. And that is challenging work sometimes because we have got to get the right

people on the bus and get them in the right seats. And so it does mean personnel changes sometimes if you can't get the alignment.

What I have found in my fifth year now is that I really feel like I know the state well and State Health Officials also get to know the communities well. You know which ones are struggling. You know which are ready for change and would be those that you can perhaps fund and get programs started if you are piloting something and so forth.

And we just did a study at ASTHO. Thirty of our state health agencies either directly provide all or some of the local public health services to 50 - 55 percent of the population. So, there are some direct services too, not just the role as the big bad state.

We have data and we have expertise. And the agencies can and should serve then as examples for work-site wellness. So, that's the other thing that we can do. In fact, at ASTHO, serving as president of ASTHO this year, we started something new -- and since I was president, I could do this. I put out a challenge to all state health officials to really look hard at their work-site wellness within their state health agency and start there, and then we are going to align the President's award this year around what's been done in the state agencies. So, there are opportunities there. And then, of course, you know, funding can drive action too depending on where the funding sources come from.

I wanted to just briefly go over a little bit what we have done in Indiana with "INShape Indiana" to give some of the successes that we have accomplished. When we launched this, we started a website. We actively communicate right now with about 85,000 citizens in every county across the state. So 85,000 communicate with us by e-mail. We have now gotten into social marketing. We have Facebook. We have Twitter. So, we are using all of those resources. I know CDC has started to get out there and do this as well.

The website has a social networking component that allows individuals to form groups and then do their share information and encourage them to challenge one another and those kinds of things. We have short-term programming that we found to be quite successful. You know, attention spans are only so long, right? So, we have done some things like every January we do a ten-and-ten challenge, and we challenge folks to lose those 10 pounds that they've lost over the holidays, and do it in the next ten weeks. We give them tips and, you know, we highlight folks, and we put a face to it.

We have started "INShape 150." It's a new eight-week program encouraging Hoosiers to engage in at least 150 minutes of physical activity per week. And then as an example this year, new partnership is with Red Gold tomatoes at the State Fair. So, this is the year of the tomato if you didn't know, or at least it is in Indiana. And so they are going to have a passport to health that folks can get and it's a promotion, and they can sign up and I think there are going to be some prizes along with it and, of course, healthy messages and so forth. The "INShape Indiana" services include a clearinghouse for information, and that's been critical to us. And of course, we have lots of partners at local communities.

We also serve as the cheerleader, cheering folks on. I think that's a role that the state can play and, as we know, which communities are doing a great job. One of the things that we have done is we will be conducting now our fifth annual statewide summit. And this is an interesting story. They got really popular. The first one focused on just obesity. We had folks from CDC help us out in that first one. The second year we kind of added the tobacco message. Our third one we decided to go to Purdue University and focus on worksite wellness and really call upon our employers. Well, once we open the door to go in one university, now we have a competition. The next thing we knew, IU wanted to hold one, and then Indiana State wanted one, and then Ball State wanted one. And that's kind of the exciting thing to see that from the state level we can help promote activities like this at the community level.

We have established a work-site wellness partnership that was started after the Purdue meeting where Eli Lilly, Anthem, Kroger Supermarkets, have all come together. They are leading the way for smaller employers around worksite wellness, and they meet on a quarterly basis to share Best Practices.

So, what we do is just kind of get them together, launch them, challenge them, and then we go pat them on the back when they have done a great job or give them the high five. And so that's a way when you don't have a lot of resources, it's that leadership at all levels.

Our second component - and we kind of started with "INShape Indiana" and now we are one of the states that currently has CDC funding for obesity, and we were very happy to be funded last year. And so we have a healthy weight initiative at the state. We are going to focus on policy and environmental change, looking at the larger population. We have a task force of 140 members statewide. Looking at all those things you've heard about here in the conference: Public health, education, industry, transportation, government, et cetera. And then they have broken into workgroups focusing on the different areas like breastfeeding and so forth.

We also have some legislation that passed. One thing that happened in Indiana two years ago, we passed a cigarette tax and every penny went to health, and that was a big win in Indiana. And that was certainly due to the leadership of the Governor in this message that was so strong and powerful. Some of that funding went to what I guess is still the only one of its kind in the nation. We have a small employer worksite wellness tax credit for worksite wellness. So that if a small employer, less than a hundred employees, and they have to go through criteria so that we know that they have got an evidence-based program and if they meet the criteria, then they will get 50 percent in a tax return. 50 percent of the cost of that wellness program back in a tax return. And so that was unique legislation that passed.

We have lactation support in the workplace. Some legislation that passed that in the law in 2008 that we are very proud of; and it requires, for employers, 25 employers or more or if you are the state -- if your state or political subdivision, you are required to give paid breaks for lactation, and then obviously a place to store breast milk as well. So, that's been real positive in our state as well. So, we can certainly see, you know, policy change at different levels take place as we engaged health officials.

Just now to talk a little bit about the focus of state health departments. You know, yesterday I got called a lot because we had had our third death in Indiana for H1N1 influenza. And state health officials have been pulled a lot to that health issue. And currently that's a national priority. Our focus is to limit the spread of H1N1, align those efforts across federal, state and local, and then bring in all our partners. So, I guess I would leave you with this - doesn't obesity prevention deserve the same? Thanks.

MS. LAURA HUTTON:

I am going to tell you about our Statewide Health Improvement Program, SHIP. I want to thank the SHIP staff because of all of their hard work and the work of over a hundred people at the Health Department, including the unit I work in and across the State Department of Health and all of our partners. All of their hard work made this happen.

So, what in the world is a Statewide Health Improvement Program? It is a state-funded program that was passed by the legislature to prevent obesity and tobacco use by working at the local and tribal government level. It is modeled after the CDC funded Steps Program. It is funded for $47 million over two years. The Commissioner of Health then needs to find an alternative funding source after the two years. The funding starts this summer.

SHIP has funded 39 competitive grants at the local public health and tribal government level, and that covers virtually every local public health and tribal government in the state. So, we are really happy about that. The grantees need to address physical activity, healthy eating and tobacco use in four settings: Community, school, worksite and healthcare. Grantees get to choose from a menu of interventions that are evidence-based and focused on policy systems and environmental change.

SHIP will be evaluated. I am not the evaluator of the SHIP program, but I always want evaluation. And so Sapna Swaroop of the SHIP staff will be evaluating this project at the state and local level to ensure progress is made towards measurable outcomes that's in the plan.

So, how in the world did we pass SHIP at this time through the Legislature? Well, it started in 2007. We are lucky we had an advocate at the Legislature who said, we really want a comprehensive plan for health improvement, statewide health improvement. So, the Department of Health please write that plan. So, the plan was developed in consultation with our local public health offices and with our executive office. And we incorporated expert knowledge from the state and local level. And at the same time, we were working our state obesity plan. So, while the plan for this health improvement is based on STEPS, it's also based on our state obesity plan. So, in the fall of 2007, this plan has been developed, and the Governor is interested in healthcare reform and the Legislature is interested in healthcare reform. So everybody wanted to hear about this plan. And this plan, this SHIP plan, got into the Governor's healthcare reform recommendations.

Now, what was in this plan? What made it useful for healthcare reform? Well, we had details of evidence that connected the dots between obesity, tobacco, chronic disease and the rising cost of healthcare. We also talked about cost effectiveness of prevention. It was very helpful to have our health economics people present there. Now, if you reduce obesity by X percent, healthcare costs will be decreased by Y percent. That was a very persuasive argument. So, that was helpful. And then we had examples of state and local policies in this plan.

So, the plan was passed in the Healthcare Reform Bill, and it was just one element of the Healthcare Reform Bill. Some of the other elements included healthcare homes, payment reform, electronic health records, insurance coverage and other things. So this $47 million that's going to go to local public health and tribes is coming from that Minnesota Healthcare Access Fund, and that has several funding sources, including a tax on physicians, hospitals and healthcare providers, a gross premium tax, premiums from the enrollees of health plans and a federal matching dollars.

So, healthcare reform was passed in 2008 when the budget was in a nicer place than it is in 2009. But SHIP didn't start until 2009. So, we kind of held our breath because you know the legislature -- one legislative session can't tie the hands of another legislative session. So, was it still going to be happening in 2009? So, the 2009 legislative session started, and we sat and we waited. And wonderful things happened -- it was still a high priority. It's still a high priority. Healthcare reform in general is a high priority in the Legislature -- this is one of her high type priorities. It really helps to have the health commissioner and the governor and legislators go into bat for you. And the funding stayed.

It also helps that the funding comes from a different source than the general state fund. It also helps that healthcare, health improvement was not a separate item. It was part of a whole Healthcare Reform Bill talking about we want to reduce healthcare costs. That's very powerful.

So, we are going to do it. It's going to start this summer with the grants. We can hardly wait. Watch us change the world, you know, like you are doing yourselves. So, just sort of in summary points -- we started early on with key legislators interested in prevention, plus an interest in healthcare reform, making

an evidence-based case that connected obesity and tobacco to chronic disease to healthcare costs and becoming a bigger part of having obesity prevention and tobacco prevention be a bigger part of a Healthcare Reform Bill. And that's the way we did it in Minnesota.

DR. WILLIAM DIETZ:

One of the things that I think has been invisible at this conference is the CDC's role in supporting state programs. And I want to focus on eight functions to share with you briefly about how we support state programs. The first is funding. We fund 25 states. That total funding is at the level of about ten to 15 cents per person per state. So, it's pretty small compared to what the estimates are of the costs required for tobacco control, which are in the $5 - $7 range. And, furthermore, 25 of our states are not funded. That's a serious barrier to progress. But we see states as our principal partners in our efforts to improve nutrition, physical activity and obesity.

The second major function is surveillance. You are all familiar with Behavioral Risk Factor Surveillance System. We also support the Pediatric Nutrition Surveillance System, which was the data set, which demonstrated a plateau in the prevalence of early childhood obesity among two to five-year-olds. And one of our most recent surveys is the maternity practice survey which is designed to tell us what the breastfeeding rates are and efforts to support breastfeeding at the state level. And just around the corner is a fruit and vegetable report card to assess how states are progressing on fruit and vegetable consumption.

In the wings are several gaps, namely, how do we assess progress around obesity prevention and control in communities, in worksites, and childcare. And, furthermore, how do we particularly assess the progress among those disparate populations in special need of support.

A third area is the development of guidelines and recommendations. The first physical activity guidelines to partner with the dietary guidelines in the United States. Our division was deeply involved in the abstracting process and provided the scientific support for that effort. Many of you are also familiar with the community guide recommendations which has been a substantial investment for our division over time and produced, not only the sound evidence base that underlies physical activity interventions, but is increasingly going to focus on the six target behaviors which we have established as the target behaviors necessary to prevent and control obesity. Those are physical activity, breastfeeding, fruit and vegetable consumption, energy density, sugar-sweetened beverages and television viewing. And we have moved from simply establishing those as target behaviors to beginning to focus on what are the strategies necessary to reverse or improve those behaviors.

And the Measures Project. And I wanted to just share in more detail what those measures are because it really is the first effort to identify community measures and community strategies necessary to prevent and control obesity.

The first effort was to develop an expert panel to begin to review and think about what those measures ought to be. And they use the following criteria: They used BRFS. What percentage of the target population is likely to be addressed by this particular strategy? What is the likelihood that this strategy can be implemented at the community level? And, furthermore, how generalizable is it? Can it be implemented in communities at different size and resources and demographics? What's the effect size? What's the potential magnitude of the health effect for this strategy, and can it be sustained?

So, I just wanted to outline some of those for you. They fall into six arenas. The first being, promote the availability of healthy foods and beverages. There are six strategies to do that. These include: Promote the availability of healthy foods and beverages in public service venues, make them affordable in public

service venues, improve the geographic availability of supermarkets, other strategies that you've heard throughout this conference.

Strategies to support choices of healthy foods and beverages. There are four. I am not going to share all of these with you, but I just want to give you a sense of how we are now employing these strategies. So, these include restricting less healthful foods in public venues or offering smaller portion sizes in public venues, or discouraging the consumption of sugar-sweetened beverages.

Increasing support for breastfeeding is another category. Encouraging physical activity or limiting sedentary behavior through requiring physical education or increasing the amount of physical activity in physical education.

A fifth category is creating safe communities that support physical activity, such as, improving access to outdoor recreation facilities or enhancing the infrastructure for bicycling or walking.

And, finally, encouraging communities to organize for change, that is, to develop and participate in coalitions and partnerships.

Now, I mentioned these six target behaviors. These are ways to begin to implement those behaviors. And in addition to those strategies which I've just outlined, we are in the process of developing guidance documents, a review of policies and strategies beyond those which I've just articulated for addressing physical activity, breastfeeding, fruit and vegetable consumption, energy density, sugar-sweetened beverage and television viewing.

A fourth area is research. One was our collaboration with Eric Finklestein to update the obesity costs that was just published in Health Affairs. And as you've heard, obesity costs now account for nine percent of our Federal budget spent on medical care and account for about $147 billion per year. That's a huge number and one which is already influenced the discussion of health reform.

Fifth, we convene and we catalyze efforts. The precursors for this conference, for example, where last summer we convened the public health law and obesity conference to begin examining legal authorities around obesity. We brought together 24 communities that were active in obesity to begin to understand what those community needs were so that it would inform our program development, and in part led to the strategies which I just mentioned.

And, finally, that culminated with this meeting and work on this meeting began a year ago with a very deliberate focus on progress in the prevention and control in obesity, not a subject which people have talked about before. But with also a very deliberate focus on policy and environmental interventions across a variety of sectors.

The sixth area is translation. We need to move what we know from the research field into actionable strategies in communities. A good example of this is the Lean Works, an online tool for small-to-medium size businesses to help them understand the cost of obesity in their work force and to begin to implement nutrition and physical activity strategies. Additional translation documents that already exist or will appear include our research-to-practice series - material for consumers and state health departments that translate research and things like energy density or sugared-sweetened beverages to more actionable strategies which are going to be very substantially augmented by translation of the guidance documents which I mentioned earlier.

The seventh area, which is a new investment for us but a vital one, is evaluation. We need to understand what works. And we have already established an early assessment project to begin to identify

projects which are worthwhile for a full-fledged evaluation, and we've begun to invest in the evaluation of some of the most promising practices. But if we are going to grow the evidence base for action, we need to understand practice-based evidence and evaluation as a critical element of that.

The final area of our activities are our partners. And we see all of you and all of the organizations in this room as potential partners. This is what's going to be necessary to move this forward and the extent to which we can, not only foster these partnerships at the federal level, but also implement these partnerships at the state and local level will be a major factor in our success. So I am very pleased to be a part of this panel, and because these are the people that are making things happen at the state level. And we see our job as augmenting and supplementing those efforts.

DR. VICTOR SUTTON:

The first question is from a national perspective. How can the Centers for Disease Control and Prevention use its influence to help state health departments overcome programmatic silos and move states forward in addressing obesity control and prevention?

MS. LAURA HUTTON:

Sure. I'll take a shot at that. So, I am just going to mention three quickly. I really would love getting a glossary of how to talk to state folks -- how do you talk to planners? How do you talk to transportation people? How do you use their words to partner so that our health issues also become their issues, that they can see how it works for them too. I would love something like that. We have loved the community guides. We are eagerly waiting for the community guide for nutrition.

And the last thing is, if CDC could help produce the economic cost piece more farther than down than what we have already got, I mean, so what are the cost savings if we have safe streets? Can we talk about cost savings? Or can we talk more about the economic pieces of obesity? And, you know, dare I ask while I am asking, state level estimates for economic costs? Anyway, these are my dreams, and so I'll mention those three.

DR. JUDY MONROE:

Well, you know, I don't know what happens at CDC, but, I mean, I think it starts there with the different programs, certainly at the state level. I mean, one of the things I found as state health commissioner is sometimes I just need to bring everybody in the room and start talking about what the priorities are and making sure they understand. I mean, we have heard the figures, the cost is tremendous. This has such an impact across our nation, and it certainly seems like we do need, all hands on deck at some level helping us. And so breaking down those silos would certainly help the states if the message started coming from CDC.

So, I know at the state level sometimes folks are calling their project officer, and they will get one answer on one thing and one on other another. And I hear that from different things. So it's alignment starting at CDC would be helpful.

DR. WILLIAM DIETZ:

I think the challenge for us is finding the right balance between being prescriptive and allowing state innovation, because the tobacco analogy would tell us that a lot of innovation is at the state and community level.

And as Larry Green has repeatedly said, that in order to build more evidence-based practice, we need more practice-based evidence. And that comes from activities across a variety of settings. And we depend on our state programs to help us understand those.

QUESTION:

Hello, my name is Genoveva Islas-Hooker, and I am regional program coordinator for the Central California Regional Obesity Prevention Program. We are a partnership between public health departments locally and community-based organizations as well as grassroots community members. And many of the success stories that you've heard about we can relate to and share in creating healthier environments.

But our work has been largely a success because of the engagement with grassroots community members and empowering them to be the leaders in driving the work. So, I would like to know what formal or informal channels of grassroots community engagement you have at your various levels that is informing the obesity prevention work.

DR. JUDY MONROE:

I couldn't agree with you more that engagement at the local level, at the community level is essential. We have got to have that engagement. I've seen it happen on various levels in Indiana. Sometimes it will happen because of a local leader or a charismatic leader at a local level that takes on a cause and becomes passionate. Sometimes they just left a national meeting and they are inspired or a state meeting, and they go back and they begin to mobilize.

The other thing that I've seen one of the mechanisms we have used for community engagement is reaching out and working in close partnership with Purdue extension. So, it's our extension officers, that's one of their engagement is one of their big pieces. So I've seen it happen at that level.

In Indiana, we have a program that we have done statewide called our Public Health System Quality Improvement Project; and as part of that, it's actually getting us in some ways ready for accreditation in public health. And so we have been using -- and I know a lot of states have done this, they have used at the local levels as well as state, and I know boards of health are beginning to use the CDC's performance standards program. I have firsthand seen some rational engagement. And so when they start going through their questions, they are going to start pulling and tugging and saying, well, this question may not apply to us, and what exactly does this mean. And then very rapidly they begin to shift to this incredible engagement and starting to raise higher-level questions about their community or about their function. I just saw it happen with our state board of health, the executive board for the Indiana State Department of Health. I've witnessed this particular tool being an incredible engagement tool and all of a sudden they want to have a retreat and they want to really evaluate what their role is and how they should function as a board and how they can be more effective.

So, our local communities in Indiana - we have got about 30 different counties that have come together using this tool. And then they have some leadership training together and some root cause analysis and some common training. And then from there, they have a project charter based on a problem that they have identified. And a lot of our counties are doing obesity. They have selected childhood obesity, particularly as that. So, that's another mechanism we have used in Indiana.

MS. LAURA HUTTON:

The SHIP program is going through what CDC has for a model for engaging in a good evaluation. But starting with needs assessment and going out there and talking to people about, so what do you care

about? What do we need? Where is our gaps? What can we do? Who is already doing this? Where can we partner?

But that's the way we are doing engagement in the SHIP project. We are doing it by making sure we first start with, who is doing what already, where are the gaps, where are our needs, where is the political will, where is the interest, let's get going. And then from there, we will choose this intervention because that's where we are ready to go.

DR. WILLIAM DIETZ:

And I will just add to that, at the CDC level, we are very interested in what works and that's what we are trying to develop. And as we learn that and what we have already learned is posted on our web page and hope that that's helpful as you plan locally.

QUESTION:

My name is Pam Eason and I serve as the Title V director for the Maternal Child Health Bureau and just happen to be the project officer for the states of Indiana and also Minnesota. One thing I would like to know is, for your state obesity plans, does that include children with special healthcare needs, and also is there any evaluation component?

DR. JUDY MONROE:

Our Indiana expert actually is Joie Brazell. I think that probably the first step that we are taking at this time is to integrate all our programs. So, we actually created a new commission; and in that commission, we pulled in maternal and child health, WIC, DMPA, chronic disease, Office of Women's Health. So, we are just now starting those steps to integrate the children's program with us, and so it's early but we recognize that that has to be done.

MS. LAURA HUTTON:

The Minnesota state obesity plan, especially in our breastfeeding program is working with WIC and women and we are going to do focus groups on women going back to work, race ethnicity, to figure out where the barriers are, where the challenges are. We are also going to do a clinician survey to find out what they are telling women. And then from the focus groups, we will kind of find out what they are hearing and seeing what's going on to encourage breastfeeding and find out where the challenges and the barriers are.

The special needs. I'm sad to say that's not directly mentioned in our plan. I'm glad you said that because now I am going to go back and make sure that we engage them in figuring out what's going to work for them, what piece should we be leveraging so that we can address the issue.

How could I forget the other issue, evaluation. Why, yes, we are going to evaluate. Now, having said that, we have intermediate and long-term outcomes, and there will be no surprise. They are based on their surveillance systems we already have in place like, bless your heart, BRFS. You know, we have a Minnesota student survey, that kind of thing. And we have noticed when there are gaps. In fact, one of the gaps has been what's happening at the local level on communities. And that's where we are excited because we are pilot testing the community managers so that we actually have a way to measure when things change at the local level, you know, the policy systems environmental change, what's going on.

So, we are very excited about that because we are going to help fill that particular surveillance and evaluation gap through the community measures.

Statewide, we are still struggling. How do we do it at the state level? How do we have a system that sort of automatically gets at that? And so we will still be working on the evaluation plan has not been fully developed but we are in the process.

QUESTION:

Hi, I am Elizabeth Byrd with the Montana Nutrition and Physical Activity Program. And the commissioner mentioned the ten and ten, losing 10 pounds in ten weeks starting in January. And I know that the CDC's orientation has been primarily policy and environmental change. And I think that that's a major innovation. But I have recently been reading a book called "The Intuitive Eating." And it really documents the dangers for increased obesity of diet programs and dieting.

And I am curious whether any of the states or localities are trying to institute weight-loss programs that maybe go, back down from the policy and environmental level to the programmatic level that really take into account the problems with diet programs and try to figure out other ways to help people beyond the five-a-day sort of thing and beyond increasing physical activity for focusing on actually weight loss.

DR. JUDY MONROE:

You know, I mean let me respond first to this ten-and-ten challenge. What it's kind of focused on is that holiday weight gain. And I will have to read the book that you are talking about there. But it inspired actually a lot of friendly competition among like, one law firm would challenge another. And so it was friendly competition. But the guidance we were giving -- we would give guidance every day about, you know, this is how much physical activity you should have, and this is how you should eat. And we have actually some remarkable success stories where people started with that and then went on to change their behavior, and we have got some folks that have reported weight loss of a hundred pounds or more without bariatric surgery. And, you know, they did it over several months because they were inspired with this particular program. So, I guess we will have to take a look at the evaluation piece on that.

But our message through "INShape Indiana" is that people get updates and they can come to the website and its clearinghouse and so forth, all of that is really meant for folks to have better education, to have support and to begin to change their behaviors. Not focused on dieting per sè, but really just increasing their steps. We do a lot around the pedometers and the steps and making sure they connect with their local communities. Because that's the other thing INShape does with the website is that folks can go out and find out what's happening in their county and connect to their local communities, maybe resources they haven't known about and maybe the local communities haven't been able to have the resources to promote as well as we might be able to do. So, that's kind of the approach that we have taken.

DR. WILLIAM DIETZ:

I would just challenge the premise of that book. Because there's been substantial literature on weight loss and what happens with weight regain. And it's true, that after people lose weight, many regain to a level above where they started but not at a level that's different from the rising weight that occurs with age.

And the other comment is that I think we commonly focus on weight loss to the exclusion of weight maintenance because people are losing weight all the time. What they are not doing is sustaining that weight loss. And our focus is on how do we build the supports necessary to sustain people at a healthy weight prior to weight gain as well as the healthy weight after weight loss.

QUESTION:

I'm from the New York City Health Department. And I wanted to actually make a couple of comments related to the very first question that the moderator had posed. I think the speaker from Minnesota had talked about the need for perhaps some documents or guidance around speaking to design professionals, architects, planners, et cetera. And I just wanted to let the group know that in New York City we have a document called the "Active Design Guidelines" that will be coming out this fall that has been co-written in conjunction with our Department of Design and Construction who are primarily architects. Our Departments of Transportation and City Planning who are a combination of architects, urban design professionals and planners. And we have also done this in conjunction with academics, Craig Zimring, Gail Nicoll, who are our architects and belong to the School of Architectures, and Reed Ewing, who is an academic planner.

And I think other communities, rather than necessarily replicating the process, might be able to take them and, you know, adapt them to their context. And we have actually had a workshop for practicing architects and planners to utilize those guidelines in design exercises, and they seemed to have worked. So, we are hoping that these will be finalized and available later this year.

And I think the other comment that I had briefly that I made earlier as well was I think the important role of actually having staffing in communities to carry out all of these activities that I think are being raised at this conference. So, if the panel has any sort of comments on how we take these things forward, that would be great. Thanks.

MS. LAURA HUTTON:

The funding for SHIP when we think about implementation -- so they first do planning. But when we think about implementation, they are getting $75,000 as a base, and then $3.89 per capita, which is the mid-line cost projection provided by CDC to achieve measurable improvement in the behaviors and health of individuals. And in that is a requirement of having a SHIP coordinator because we know at the community level sometimes what you really need is one person making sure they are pulling everybody together. One person paid to do that. It really moves things forward.

DR. VICTOR SUTTON:

Thank you. I want to wrap up this panel and say thank you for the panelists.