



CityMatCH CityLights

Promoting communication and collaboration to improve the health of urban women, children and families

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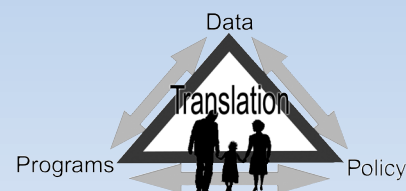
Summer 2005

Promoting Healthy Weight: Local Health Departments Take Action

Rates of overweight and obesity in the U.S. are fast rising and crosscutting, without respect for age, gender, race, culture, ethnicity. Adverse impacts linked to overweight and obesity suggest a public health approach is needed. CityMatCH membership concurs: the most recent membership assessment verified that healthy weight is a top priority for their health departments.

In this Summer 2005 edition of *CityLights*, CityMatCH addresses the issue of healthy weight. To do this, we consider strategies for achieving healthy weight, with specific attention paid to approaches that are applicable to urban health departments. Throughout this issue, the CityMatCH Data Use triangle is used as a framework for analysis. The Triangle, developed by CityMatCH, promotes translation of data to action. The three corners—*data, policy and program*—represent the three core domains of effective data use, all of which must be equally represented to translate data effectively into action.

In the data portion of this issue, analytic work done by the Los Angeles County Department of Health Services to enhance programs and policies designed to improve nutrition and increase physical activity is featured. In the policy portion, strategies, recommendations and a review of current U.S. policy efforts related to overweight and obesity are highlighted. This issue also features two programmatic stories: first, you will read how the Detroit Department of Health and Wellness Promotion planned and implemented healthy weight changes from within. Second, you will read about how state and local health departments in Colorado enacted a coordinated effort to address low birthweight resulting from inadequate weight gain during pregnancy. We invite readers to become familiar with local trends related to achieving and maintaining a healthy weight across the life span, and encourage you to find utility in these stories of effective data, policy and programmatic strategies.



Inside This Issue...

<i>CityView</i>	2
<i>CityRoundtable</i>	3
<i>CityData</i>	2, 4
<i>CityPolicy</i>	6
<i>CityProgram</i>	8
<i>CityMatCHNews</i>	11

Making Sense of the Data: Local Strategies for Healthy Weight

In the past two decades, rates of overweight and obesity in the United States have increased so dramatically that many investigators have suggested the onset of a national epidemic. See page two, "Why Healthy Weight?" for national data illustrating this problem and selected evidence-based impacts of obesity. An effective public health

(Continued on page four)

Evidence-Based Policies Are Critical to Achieving Healthy Weight in the United States

An Ancient Swahili Proverb reads, "How do you eat an elephant? One bite at a time." However, public health leaders have long recognized that bite-by-bite approaches will never stem the obesity tide. We cannot emphasize focusing on carbohydrates or fats; children or adults; physical

(Continued on page six)

Urban Health Department Programs Meet Healthy Weight Challenges

*"If Detroit is to grow and thrive as a city,
we must be a healthy city."*

These words, from Detroit's Mayor, Kwame Kilpatrick, launched the "Movement for Life" initiative to improve the health and physical fitness of those who live in Detroit. Health data from Detroit

(Continued on page eight)

Weighing In....



Mary Balluff, MS, RD
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Recently, I was tasked with solving a programmatic issue for the department.

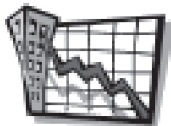
I found myself seated in a small conference room with four lawyers, a student intern and a data analyst. I arrived with a single sheet of paper and my best pen, confident that by the end, I would be able to log the singular solution with the supporting argument for that solution.

Over the next two and a half hours, I marveled at the volume of information exchanged through the lively volley of theory and experience. The gentle breeze created by the constant flutter of reference pages, law books and data tables assured me that we were looking at all the possibilities. Then, suddenly, the books were closed, partners rose from their chairs, each wished me "good luck" and thanked me for the "insightful meeting." Filled with inspiration, I checked my trusty paper only to find I had written absolutely nothing down. In many ways, that may be what happens when we think about healthy weight. We have seen the data, heard the stories, read the articles and even talked to the experts, but when we are back in our offices deciding what to do next, our sheet of paper is blank.

Using the DaTA Institute triangle helps us balance our approach between data, policy and programs. This issue of *CityLights* gives us a glimpse at how our counterparts across the country are writing first steps on that blank sheet of paper. CityMatCH has given us many tools to measure the size and shape of the step that works for us.

As we take that first step, we feel a nagging sense of dread and begin to recount all those barriers: political will, competition, resources or expertise. Leaf through this issue and find the common thread. These programs all started with one thing, opportunity in the form of an interested county supervisor, a new state initiative, a dedicated partnership, a persistent staff member or an old program that needed retooling. Indeed, the best initiatives often begin with an opportunity. When you are done reading this issue, take out that blank piece of paper again. This time instead of writing down a singular solution, create a list of opportunities and call your partners, or if you are already well on the road, write down your success story and celebrate with your partners. The next time the call goes out for model programs, each of us should be ready to answer.

Data Speaks: Why Healthy Weight?



According to the 1999-2002 National Health and Nutrition Examination Survey (NHANES), almost 65 percent of the population is overweight or obese, with the prevalence being higher for minority groups. Obesity is now present in 31 percent of the adult population and overweight in 34 percent.¹ The percentage of young people who are overweight has more than tripled since 1980. Additionally, among children and teens aged 6-19 years, 16 percent (over nine million young people) are considered overweight. One of the national health objectives for 2010 is to reduce the prevalence of obesity among adults to less than 15 percent. Given the current well-documented upward trend of obesity in the nation, this goal will not be met.

Defining Healthy Weight: A healthy weight is that which is associated with the best opportunity for health and well-being. Overweight and obesity are both labels for ranges of weight greater than what is generally considered healthy for a given height. The Body Mass Index (BMI) is an accepted measure of body weight adjusted for height for most individuals and has been found reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. BMI ranges are based on the effect body weight has on disease and death, such that as BMI increases, the risk for some diseases and conditions (premature death, cardiovascular disease, high blood pressure, osteoarthritis, some cancers and diabetes) also increases.² For adults aged 20 years or older, BMI falls into one of the following categories: underweight (BMI below 18.5), normal (BMI of 18.5 to 24.9), overweight (BMI of 25 to 29.9), or obese (BMI of 30 or higher).

According to the CDC, BMI is used differently with children than it is with adults. In children and teens, BMI is used to assess underweight, overweight and risk for overweight. Children's body fatness changes over the years as they grow. Also, girls and boys differ in their body fatness as they mature. BMI for children, also referred to as BMI-for-age, is gender- and age-specific. BMI-for-age is plotted on gender-specific growth charts. These charts are used for children and teens 2-20 years of age. For the 2000 CDC Growth Charts and additional information, visit CDC's National Center for Health Statistics at www.cdc.gov/growthcharts.

Health Consequences of Obesity and Overweight: Being obese increases the likelihood of illness and early death. Obesity has been defined as a chronic, relapsing, stigmatized and neurochemical disease.³ It is a major cause of preventable illness and death in the U.S. Overweight and obesity are associated with hypertension, Type 2 diabetes mellitus, hypertension, dyslipidemia (high total cholesterol or high levels of triglycerides), coronary heart disease, stroke, heart failure, certain kinds of cancers (endometrial, breast and colon), gallbladder disease, osteoarthritis, sleep apnea, respiratory problems and earlier mortality.^{4 5}

Obesity is associated with four of the ten leading causes of death, including coronary heart disease, cancer, stroke and Type 2 diabetes.⁶ Obesity and overweight are estimated to cost society billions each year in medical expenses and lost productivity. According to *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, the cost of obesity in the United States in 2000 was more than \$117 billion (\$61 billion direct and \$56 billion indirect). Between 1987 and 2002, private spending on obesity-linked medical problems grew from \$3.6 billion, or two percent of all health spending, to \$36.5 billion or 11.6 percent of spending.⁷

¹ Flegal, KM. Prevalence and Trends in Obesity. JAMA 2002; 288:1723-1727.

² HHS, CDC. Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion. Overweight and Obesity: Contributing Factors. Retrieved June 2005 at http://www.cdc.gov/nccdphp/dnpa/obesity/contributing_factors.htm

³ Bray GA. Obesity Is a Chronic, Relapsing Neurochemical Disease. Int J Obes Relat Metab Disord. 2004;28:34-38.

⁴ P-Sunyer FX. Medical Hazards of Obesity. Ann Intern Med. 1993;119:655-660.

⁵ HHS, CDC. Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion. Overweight and Obesity: Contributing Factors. Retrieved June 2005 at http://www.cdc.gov/nccdphp/dnpa/obesity/contributing_factors.htm

⁶ HHS, CDC. Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion. Overweight and Obesity: Contributing Factors. Retrieved June 2005 at www.cdc.gov/nccdphp/dnpa/obesity/contributing_factors.htm

⁷ Thorpe, KE, Florence, CS. The Rising Prevalence of Treated Disease: Effects On Private Health Insurance Spending. Health Affairs Web Exclusive, June 27, 2005. Retrieved 6/05 at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.317>

E-Roundtable: MCH Leaders Talk About Local Strategies for Healthy Weight

CityMatCH members, through the 2004 Membership Assessment, indicated that issues related to overweight/obesity and achieving a healthy weight are clear current and future priorities for urban health departments. To better provide a framework for discussions and to help shape the focus of this edition of *CityLights*, the following "E-Roundtable" was fielded this summer to selected CityMatCH Member Representatives. Highlights of their responses follow:

What is the role of your health department in promoting healthy weight?

Karen Ayala: Our health department has not adopted a formal role; however, programs within the department have assumed leadership roles in community efforts. Specifically, we have representation on two obesity task forces within our county: an Obesity Task Force which is a collaboration between OSF-Health System, Rockford Public Schools, YMCA and Health Department representatives; the CATCH program—a school-linked health clinic at an elementary school. In addition, our WIC program, which serves about 40 percent of the births in our county, promotes breastfeeding as a program strategy to encourage healthy weight from birth. We also have a staff member who serves on our State's Region Two Task Force for Childhood Obesity and provides recommendations to the Illinois Department of Human Services to incorporate organizational procedures.

Nina Burford: Healthy weight is now a priority of this health department. Each division is involved in some way—The Nutrition Division provides the WIC program to tens of thousands of women each year, promoting its goals and working to promote breastfeeding. This division is developing a breastfeeding peer support program and is involved with a state organization addressing childhood obesity prevention. They are also developing a plan to utilize responses to a state nutrition services survey indicating the needs of many women seen by the WIC registered dietician to have additional visits.

The Nursing Division has tied promoting healthy weight to identified MCH goals and objectives, assuring that all women seen through our perinatal services receive education and case management including healthy weight information.

The Environmental Health Division

is involved with urban planning toward healthier communities.

The Epidemiology, Planning and Information Division recently coordinated an assessment of agency activities around chronic diseases, many of which are related to weight and activity levels.

Additionally, healthy weight information is available on the web site at www.tchd.org.

Phyllis Elkind: Approximately four years ago, the County of San Diego, Health and Human Services Agency (HHSA), Maternal, Child and Family Health Services (MCFHS) initiated the Coalition on Children and Weight - San Diego. With support from the previous Chair of the Board of Supervisors and eventually with participation from several hundred professionals, community organizations and consumers, the Coalition identified and began working on key priorities. MCFHS staff led monthly meetings and workgroups until an elected board evolved. MCFHS now provides staff support for meetings, houses the web site, distributes updates and meeting notices and hosts meetings.

About a year ago, HHSA/MCFHS was asked to assist in hiring a consultant to bring the community together in the development of a childhood obesity strategic action plan. The Health Officer and a leader from a community-based organization chair the group, and MCFHS staff provide support for this six-month planning process that is currently underway. This process is being accomplished with strong support, including financial support, from two of our Board of Supervisors.

What is the difference between your health department's healthy weight initiatives now and three to five years ago?

Ayala: In the past three to five years, our Winnebago County Department of Health (WCDH) supervisors have attended and graduated from the Illinois Maternal Child Health Leader-

What is an E-Roundtable?

Simply put, an E-Roundtable is a series of questions that are developed and sent out to a select group via E-mail. Over the years, this proven tool has effectively facilitated virtual conversations by tailoring issue-based questions and targeting a cohort of respondents (in this case, a geographical cross-section of CityMatCH member representatives). Responses have been edited for publication in *CityLights*.



Participants

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ship Institute. Their leadership projects focused on healthy weight initiatives. One supervisor has implemented her project—an afterschool program designed to introduce fruits and vegetables to attendees. In addition, this project publishes a newsletter that provides a healthy recipe, exercise encouragement, simple nutrition tips and introduces a family fun activity. The newsletter is distributed to all elementary school-aged children and their families within the school district. Previous to these efforts, little attention was given to healthy weight initiatives.

Through our Health Council, the community has participated jointly with a neighboring community in the "Race to the Moon," a contest designed to encourage walking. Another project, not yet fully realized is establishing a bike path in one of the smaller communities adjacent to Rockford. This community was similar to those that research has found to be at risk for childhood obesity issues/risks—isolated and suburban. This project was also drawn from the Leadership Institute; its purpose was to increase children's physical activity levels and to promote safety.

Burford: Healthy weight is more of a priority now, and data are available

(Continued on page ten)

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response is needed and will require the successful translation of data to action at the local level where those affected by obesity live. "Why Healthy Weight?" provides a framework for why action is needed by presenting national data on overweight and obesity, including associated health risks and costs ascribed.

As you read this page and the next, you will walk through local examples—all drawn from Los Angeles (LA), County, CA—of data strategies to address healthy weight. Two brief stories below give highlights of strategies the LA County Department of Health Services employed to either directly effect change through the use of data or to positively influence community groups to advocate for needed policy changes in their locale. The third, and more exhaustive story of this data sequence gives a more in-depth, chronological accounting of steps that have been taken to address healthy weight locally. It is our intent that readers will find both inspiration and local application for what they read next:

1. Utilizing Existing County Health Survey to Monitor Healthy Weight Trends:

The LA County Health Survey, a population-based telephone survey conducted by the health department, collects information on sociodemographic characteristics, health status, healthy behaviors and access to health services among adults (8,167 surveyed) and children (5,995 surveyed) in the county. The relatively large sample size allows users to obtain health indicator data for large demographic subgroups and across geographic regions of the county, including Service Planning Areas and Health Districts.

This data is then used to monitor trends, including those related to obesity, overweight, consumption of fruits and vegetables, amount of physical activity, breastfeeding, perception of safe neighborhoods and use of local parks.

The Office of Health Assessment and Epidemiology takes the data, develops and then disseminates periodic briefs highlighting health issues and community solutions. In the third story



of this two-page sequence, you will read how these briefs have been used to persuade and promote positive changes related to healthy weight.

2. Localizing Data for Advocacy:

The California Center for Public Health Advocacy used Geographical Information Systems (GIS) to display overweight/underfit children by legislative district. They linked data to California Assembly Districts to successfully demonstrate that eight of the nine worst Assembly Districts in the State were located in Los Angeles County.

This "data-to-district" linkage had a powerful effect when reviewed by California policymakers and resulted in the Baldwin Park Healthy Foods Resolution, a city ordinance ensuring that only healthy foods and beverages are sold in youth facilities in the city of Baldwin Park (located in LA County and with a population of 75,837). This is the first ordinance of its kind in the state.

3. Translating Data into Action:

In the story that follows, Cynthia Harding, Director, MCAH Programs at the Los Angeles County Department of Health Services and CityMatCH Board Member, shares a three-year process of translating data into programs, policies and ultimately lessons learned.

Harding describes struggling to find a way to address the problem of overweight children and adults, when she came across an article in the LA Times, entitled: *Supervisor Zev Yaroslavsky gets the Religion of Good Nutrition*. The article described how one LA County Supervisor had recently been diagnosed with Type 2 diabetes, and further said that Yaroslavsky felt our children would be condemned to poor health and a shorter life span unless prompt action in schools, communities and the health sector was taken. Harding called the Supervisor's office and let them know that

MCAH wanted to be a partner in solutions. The Supervisor implemented a Blue Ribbon Task Force on Children and Youth - Physical Fitness, chaired by Dr. Francine Kaufman, a pediatric endocrinologist, past president of the American Diabetes Association and author of the recently released book "Diabetesity." MCAH staff provided support for this Task Force. Community forums were held and a 2002 report produced with six key recommendations for action. (For the full report, see: <http://lapublichealth.org/mch/reports/Recommendations%20Report.pdf>)

Actions were rooted in data and informed by conversations with diverse community partners. MCAH took the lead in implementing the recommendations, forming a new Physical Activity and Nutrition Task Force. Quarterly meetings encouraged information exchange, promoted advocacy and legislative activity and provided updates on the work to implement the Supervisor's initial Blue Ribbon Task Force Recommendations. However, without adequate resources to do this work, little was accomplished.

In 2003, the California State MCH Branch provided LA County with a one-time grant to provide outreach to MCH populations eligible for food stamps and to provide nutrition education and services. MCAH staff worked with the LA County Office of Health Assessment and Epidemiology and the Nutrition Program to release a brief from LA Health Survey data on the relationship between food security and obesity. The root causes of obesity are not new (see box on page five), yet the relationship to food insecurity is troubling and was surprising to many. The survey found that 22 percent of low income households (400,000 homes) experienced food insecurity with more than a third of them (141,000 households) also experiencing hunger, a severe form of food insecurity.

This report sparked action by the LA Collaborative for Healthy Active Children, a partnership of community and county entities working together to promote good nutrition and increase physical activity. The Collaborative released a companion brief on the role a healthy breakfast plays in healthy weight management and food security.

This timeline is intended to be thought-provoking and is in no way offered as a comprehensive sequence of events. Sources are listed on page nine.

	<p>Healthy Weight in the U.S.: A Social/Cultural Timeline of Events</p>	<p>1944</p> <p>Researchers at the University of Minnesota found that "yo-yo" dieting could damage health.</p>	<p>July 5, 1945</p> <p>Lewis Reard, a Paris fashion designer, invented the bikini.</p>	<p>1951</p> <p>Campaign against obesity taken up by U.S. government and medical establishment.</p>	<p>1954</p> <p>Though not the inventors of the "TV Dinner," Swanson launched a massive advertising campaign for their product in 1954. They also coined the phrase "TV Dinner," which helped transform their frozen meals into a cultural icon.</p>
		<p>-----</p>			

At the Root of the Problem

(Derived from a report of the Los Angeles Collaborative for Healthy Active Children: Taking a First Step with a Healthy Breakfast)

The LA Collaborative identified factors that may contribute to American's growing overweight epidemic. For Children in Los Angeles County facing food insecurity issues some of the prime problems include:

- ◆ Heightened affordability of calorie dense, nutrient-light foods;
- ◆ Ready access to poor food choices and limited access to healthy alternatives;
- ◆ Limited availability of fresh, attractive and affordable fruits and vegetables;
- ◆ Fast-paced lifestyles that put a premium on convenience at the expense of smart nutrition;
- ◆ Limited nutrition education or understanding of how to make nutritional choices;
- ◆ Aggressive marketing of what is most frequently the least healthy food choices;
- ◆ Neighborhoods that discourage or prevent physical activity; and
- ◆ Increased portion sizes.

* Food Insecurity, Los Angeles, CA: Los Angeles County Department of Health Services, Public Health. Office of Health Assessment and Epidemiology, March 2004.

Specific recommendations were made for parents and families, school districts, state and federal policymakers, community-based organizations, the county and its cities, the medical community, managed care, health industries and the private sector. A media campaign promoting a healthy breakfast on billboards (see box on page four) was deployed in areas where obesity and food insecurity overlapped.

The LA Collaborative sought not only education and promotional efforts but also fundamental changes in the policies, systems and environments not actively supporting breakfast consumption.

The Health Department's partnership with the Nutrition Program continued, and the California Food Policy Advocates were invited to address barriers

to food stamp use and to help develop training on food stamp enrollment with the local LA County Department of Public Social Services (DPSS). Trainings were offered to regional food banks to encourage them to enroll clients in the food stamp program, and the health department worked with DPSS to eliminate barriers to food stamp use.

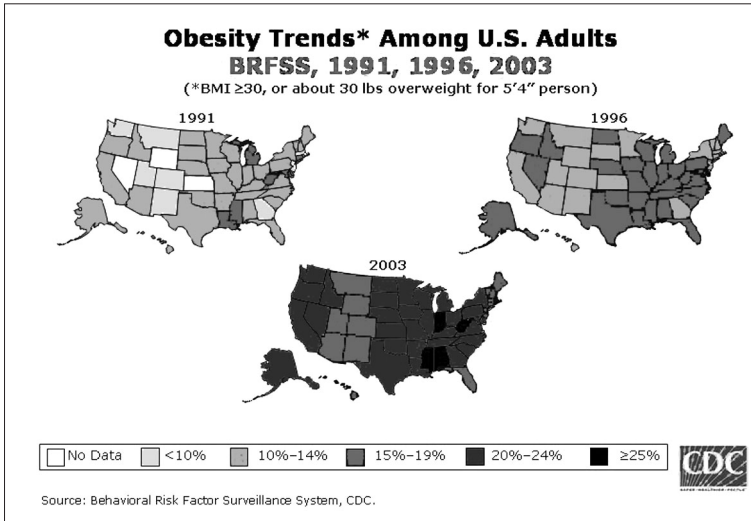
Policy Changes Influenced:

The Healthier Food and Beverage Policy states that by the Year 2010 all county-contracted food and beverage vending machines within county facilities and offices, all fund-raising activities held during work hours on county sites, and all county-sponsored meeting and events shall adhere to guidelines promoting good nutrition and healthy environments to prevent obesity and associated diseases.

As data was translated into community action and policy development, it was understood that as the largest employer in Southern California, LA County DHS needed to "walk the talk" and to help employees become effective family role models and improve their own health, by establishing policies and environments supportive of healthy eating, physical activity and breastfeeding.

Other LA County Policy/Programs currently being developed include:

- ◆ Food Policy for LA County mandates a minimum of 50 percent of items sold in vending machines be healthy (and provides a definition for this), and provides guidelines for foods sold as part of charitable giving and for foods offered at county-sponsored meetings.
- ◆ Diaper bag and curriculum for parents taking family leave for a newborn or newly adopted baby (including information on breastfeeding promotion, child health safety, healthy nutrition and interconception care).
- ◆ Lactation rooms support women



returning to work who want to continue breastfeeding.

◆ Specific Employee Wellness Training Programs are to be provided by health insurance carriers including: pedometer distribution, wellness classes and clubs, decreasing portion size, bringing one's lunch to work, stretching and incorporating exercise breaks into the workday.

Key Lessons Learned:

- ◆ Seek participation from all stakeholders in the development of recommendations, as it may be difficult to get buy-in from those not originally involved.
- ◆ Public health should take the lead in the comprehensive approach required, convening diverse stakeholders comprising public health, urban planners, community development organizations, parks and recreation staff, restaurant owners, transportation authorities and other county departments.

◆ Public health should lead efforts to monitor, advocate and ensure data is translated into action. Implementing the social norm changes needed to institutionalize good nutrition and promote physical activity require ongoing pressure, persistence and leadership.

For more information, contact Cynthia Harding, LA County Department of Health Services by phone at 213-639-6400 or via E-mail at charding@ladhs.org

For more information on the LA Collaborative see: http://lapublihealth.org/nut/LACOLLAB_Files/lacollab.html

1956	1956	1960's	May 1963	1966	program Late 1960s
The Jack LaLanne show premiered on television, making "fitness" a household word.	The President's Council on Physical Fitness and Sports was formed under President Eisenhower.	British fashion model, Twiggy, represented the new rail-thin ideal, revitalized more recently in the 1990's, by supermodel Kate Moss.	After deciding to commercialize a food plan that helped her shed 72 pounds, Jean Nidetch, a Long Island housewife with a lifelong weight problem, launched Weight Watchers International.	The President's Council on Physical Fitness and Sports started the Presidential Physical Fitness Awards	"Aerobics" was added to the English language and listed in Webster's Dictionary.

(Continued from page one)

activity or nutrition; behavior change or environmental change. This one-or-the-other approach (which often becomes one-then-the-other) is too narrow and likely will not produce real change. Public health professionals must use comprehensive, policy-driven strategies to end this epidemic. CityMatCH offers the following perspectives from two national experts, Dr. Michael McGinnis and Amy Winterfeld, JD, related to policy changes that must take place for our nation to achieve goals associated with healthy weight. We encourage our readership to review the strategies provided and consider possible applications in their local communities

Ten Strategies for Change

In 2004, during his tenure as Counselor to the President at the Robert Wood Johnson Foundation, Dr. Michael McGinnis wrote a piece for Expert Voices, the newsletter of the National Institute for Health Care Management, entitled, "Obesity: An American Public Health Epidemic; Strategies to Better Understand It, and to Change American's Behaviors." McGinnis theorized that multifactorial, sustained and comprehensive strategies are needed to make the cultural and social changes necessary to reverse the current trends.

Said McGinnis, "Obesity does not fit comfortably into our cultural and medical notions of an epidemic. Unlike an infectious disease outbreak

that surges suddenly onto the scene, the increasing girth of Americans—and the disability it carries has gradually accumulated over decades. If we don't act to counter these trends, we run the risk of raising the first generation of children that is sicker and dies younger than their parents.

Obesity is not primarily a matter of personal choice. Personal responsibility, for what we eat and do, enters into the equation. But make no mistake, this epidemic is the product of convenience technology and engineering, food production and marketing patterns, and powerful cultural forces that have shaped our communities, our lifestyles and ultimately our bodies.

We are fatter because our lives are more sedentary, the meals we choose are bigger, our snacking is more constant, and what we eat—both the food product supply and the choices we make—are higher than they should be in fats and higher than they ever have been in sweets and refined grains. At the same time, our children are spending more time in cars and in front of one sort of video screen or another, and less time walking or playing outside than ever before."

Clearly, the cultural and societal changes needed to reverse this epidemic will require a strategy that is multifaceted, sustained and comprehensive. Dr. McGinnis gave CityMatCH permission to reproduce his strategies for change, summarized below:

1. Get the message straight and get it out. Consistent

messages about calorie requirements, food choices, exercise/activity incorporating the HHS/USA Dietary Guidelines, the Food Guide Pyramid, and nutrition labels on foods.

2. Ensure accurate point-of-choice information. Readily accessible, practical and user-friendly information at point of purchase, including restaurants, public notices of calories expendable by walking stairs versus elevators, etc.

3. Make sure public investments enhance the nation's health. School meals, food stamps and food supplements such as WIC should be all part of a sustained effort to improve the nation's nutrition. Physical activity in school is another area of importance, as is consideration of physical activity when funding transportation, community development and education.

4. Seed local initiatives. Actions must arise locally and can be enhanced and promoted at the national level via support, leadership, technical assistance and the development of tools to help measure progress.

5. Enlist doctors and other health providers as full participants. Improve health provider competencies relative to nutrition and physical activity, and also link reimbursements for Medicare and Medicaid to engage the diet and exercise patterns of recipients. Add BMI assessments to pediatric visits.

6. Specify expectations for the key players and hold them accountable. Stakeholders may include parents, schools, health care institutions, employers, industry, media, and advertising, all of which are critically important, and from whom clear expectations for behavior, codes of conduct, measurable goals and performance measures must be expected.

7. Develop and test models for potential economic incentives. McGinnis suggests that clear incentives are both well-warranted and a powerful means for change.

8. Invest in research. Strategies must be evidence-based and supported by research. This is an area of growth, and significant research on interventions, differential impacts on various populations, etc. is warranted.

9. Monitor the progress. Regular reports of both the status of the problems and the progress being made should be provided. McGinnis suggests reports of eating patterns, activity experiences and BMI profiles by risk group. He feels regular monitoring of stakeholder practices (see above) on food labeling, sales, marketing, healthy school profiles, employee programs and provider practices is indicated.

10. Use the bully pulpit. From the Cabinet and Congress, to the President, Surgeon General and Secretary of Health and Human Services, visible leadership is important if progress is to be made.

For more information, and to access the complete article, visit the National Institute for Health Care Management website at: www.nihcm.org/ExpertV6.pdf. E-mail Dr. McGinnis at: mmcginn@rwjf.org.

Michael McGinnis



Dr. Michael McGinnis' commitment to healthy weight is well-documented. He was instrumental in the creation of the first Surgeon General's Report on Nutrition and Health in 1988; the U.S. Preventive Services

Task Force's Guide to Clinical Preventive Services, now in its third edition; the first HHS/USDA Dietary Guidelines for Americans, now in its fifth edition; and the Healthy People national health goals process.

As Assistant Surgeon General and Deputy Assistant Secretary for Health with responsibility for coordinating health promotion and disease prevention activities throughout the Carter, Reagan, Bush and Clinton administrations, McGinnis has consistently advocated for healthy weight for all.



1972	1970's	July 1982	February 4, 1983	1988	1994
"Dr. Atkin's Diet Revolution" by Robert C. Atkins became a best seller.	Major food companies began using partially hydrogenated fats, believing it to be a healthier alternative.	The aerobic exercise craze began with the publication of "Jane Fonda's Workout Book."	1970's pop singing idol Karen Carpenter died of heart failure caused by chronic anorexia nervosa, and brought national attention to the eating disorder.	Richard Simmons released "Sweatin' to the Oldies."	American Society of Plastic and Reconstructive Surgeons reported 51,072 liposuction procedures were conducted in 1994.

State Policy Efforts Related to Overweight and Obesity



Across the United States, obesity has gained recognition as a major public health issue. Both a growing number of obese Americans and a growing awareness of the costs and long-term health consequences of obesity are making it a concern for policy makers.

Legislators are taking an interest in policy options that can help provide children and adults with nutritional choices and incorporate physical activity into daily living.

Policy options that legislators considered in 2005 legislative sessions to facilitate healthy eating and a more active lifestyle included legislation in the general categories of putting obesity on the public agenda, school nutrition, physical activity, diabetes screening and management, insurance coverage and school wellness policies.

Putting Obesity on the Public Agenda: By 2004, at least six states had enacted obesity task forces, commissions, or studies: Arkansas, Maine, New York, Texas, Rhode Island, and Washington. Similar bills were introduced in five states in 2005, including Kansas, New Mexico, North Carolina, Virginia, and West Virginia.

Several states already have worked to raise awareness of obesity and its public health impact through legislators' efforts to set an example themselves. Colorado legislators participated in 10,000 Steps to Better Health and created Colorado Walking Wednesday to urge parents and children to walk to school together. Wisconsin legislators resolved to "Lose a Ton." Not everyone agrees that obesity is a topic for public responsibility. Legislators in many states have enacted legislation prohibiting lawsuits against the food industry for obesity-related health claims or weight gain, based on the idea that healthy weight is a personal responsibility.

Nutrition: Nutrition Standards in Schools: At least 38 states considered or enacted school nutrition legislation as of August 2005. This includes 16 states in which legislation has been enacted (Arizona, Arkansas, Colorado, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas, and West Virginia), one state in which a resolution was sent to the lieutenant governor (Utah), and one state in which legislation was vetoed by the governor (Connecticut). At least 20 other states considered or are considering school nutrition legislation in 2005.

Measurement of Student Body Mass Index (BMI): In 2003, Arkansas was the first state to implement universal measurement of student body mass index with confidential reporting of results to parents. Two additional states—Tennessee and West Virginia—enacted BMI legislation in 2005. Student BMI legislation was also introduced in eleven states. Legislation was also introduced in Arkansas to repeal the reporting requirement but it failed to pass.

Nutrition Menu Information for School Foods: School nutrition information requirements were considered in 2005 in California, Illinois, Massachusetts, and New York. Such requirements were enacted in Colorado and West Virginia.

Physical Activity: State assemblies also considered various bills to promote physical activity among youth. Cost (related to facilities and personnel) is often a barrier to expansion of physical education (PE) in schools. Implementation of daily recess is considered a lower-cost option.

Physical Education (PE) or Physical Activity in Schools: Currently, 49 states require PE in schools, but the scope of the requirement varies. About 60 percent of states require schools to follow national or state PE guidelines; 80 percent require adapted or mainstream PE for students with special needs. Illinois requires daily PE for grades K-12, but some exemptions are allowed. Alabama requires daily PE in grades K-8.

As of June 2005, eight states had enacted or strengthened PE requirements: Arizona, Colorado, Connecticut, Kansas, Kentucky, Montana, South Carolina, and Texas. An additional 25 states introduced legislation to implement or strengthen PE requirements.

Diabetes Screening and Management: Non-invasive screening of school children for diabetes risk was enacted

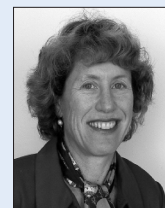
in California and Illinois in 2003. It was considered in New York and Pennsylvania in 2004 and again in Pennsylvania in 2005. Legislation to permit at-school treatment and training of school personnel in diabetes management passed both chambers of the Hawaii legislature in 2005 and was considered in Texas. In 2004, similar bills were considered in seven states. California enacted a law in 2005 to promote diabetes awareness in schools.

Insurance Coverage for Obesity Prevention and Treatment: Currently only one state—Maryland—requires health insurance companies to offer coverage for obesity prevention and treatment. An additional three states—Georgia, Indiana and Virginia—require health plans to offer an option (with an additional premium) for this coverage. Legislation was considered in eight states in 2005 to either create such requirements or strengthen existing law.

School Wellness Policies: Under the 2004 Federal Child Nutrition and WIC Reauthorization Act, local school districts participating in national school lunch or breakfast programs are required to establish local wellness policies by the start of the 2006-2007 school year. Wellness policy legislation was considered in 2005 in California, Ohio, Rhode Island, and Tennessee, enacted in Colorado and passed both chambers in Illinois.

For more information, contact: the author, Amy Winterfeld, JD, National Conference of State Legislatures by phone at 303-364-7700, or via E-mail at amy.winterfeld@ncsl.org

Amy Winterfeld



Amy Winterfeld, JD, is a Program Principal in the Health Program at the National Conference of State Legislatures (NCSL) where she manages the Obesity Prevention Health

Project. She covers state-level legislation and policy on school nutrition, physical activity, childhood obesity, and other selected chronic disease and public health topics. Winterfeld holds a B.A. in History from Brown University and a law degree from the University of Colorado. Prior to joining NCSL, she worked for over 12 years in the child welfare field. The National Conference of State Legislatures (NCSL) is a bipartisan organization serving the legislators and staffs of the nation's 50 states, its commonwealths and territories.

1996	1996	1999	July 10, 2002	July 2002
National Association of Anorexia Nervosa and Associated Disorders estimated that eight million Americans, mostly young Caucasian women, suffer from either anorexia or bulimia, or both.	Body Mass Index (BMI) emerged as the standard measurement of obesity.	30% of the \$101.8 billion in direct costs linked to heart disease are attributed to obesity.	The Institute of Medicine reported that trans-fatty acid consumption should be as low as possible when consuming a nutritionally adequate diet because of an increased risk of cardiovascular heart disease.	A New York Attorney filed lawsuits against four major fast food restaurants: McDonald's, Burger King, Wendy's and KFC, suggesting their fatty foods were responsible for his client's obesity and health-related problems.

Detroit Accepts the Challenges of Achieving Healthy Weight

(Continued from page one)

has revealed that the city has disproportionately high rates of the major medical conditions associated with obesity. Death rates from cardiovascular disease, cancer, stroke and diabetes are higher than the rates in Michigan and the nation. A national fitness magazine recently ranked Detroit as one of the "Fattest Cities." Although the study was not rigorously scientific, the publication acted as a community bellwether for Detroit.

Through the Mayor's "Movement for Life" initiative, the Detroit Department of Health and Wellness Promotion (DHWP) was given the charge of educating residents and city employees on increasing physical activity, achieving healthy weight and incorporating a healthy diet into their lifestyles. Through community and health care system partnerships and health promotion activities, the DHWP has provided leadership to engage residents in healthy living activities with health fairs, educational seminars, exercise events and a website (www.ci.detroit.mi.us). The "Movement for Life" initiative was just one of several actions undertaken by DHWP over the past two years to address alarmingly high rates of obesity. The DHWP is convinced that Detroit must be a place that provides people with the ability to lead a healthy lifestyle in order to develop a strong local economy attractive to businesses and potential residents.

In 2005, the Detroit Department of Health formally became the Detroit Department of Health and Wellness Promotion (DHWP). The name was changed to reflect a new orientation: engaging healthy decisionmaking, being proactive and focusing on prevention. The Department's new identity was crafted to restore public confidence and empowerment, and to instill citizen/employee credibility in Detroit's public health system. The DHWP also unveiled a new mission statement and logo to enhance residents' connection to the roles of the public health department and the use of our services. The mission reads: "The Detroit Department of Health



and Wellness Promotion assists in achieving and sustaining the highest levels of health and healthy communities throughout the City of Detroit and to provide public health services that promote health and well being, and prevent disease."

An Office of Health Promotion and Worksite Wellness has been created. This Office, along with the Director, established a Health and Fitness Center within the Department, open from 7:00 am-7:00 pm daily for employees to exercise and improve personal levels of activity. The DHWP is "walking the physical activity talk" by offering lunch-and-learn health promotion and nutrition classes, personal trainers, inline-skating training, a "Cardio Bootcamp" and even kick-boxing instruction.

The DHWP operates "The Village Health Workers (VHW) Partnership" that is coordinating an initiative, "Promoting Healthy Eating in Detroit" (PHED) that aims to increase access and use of healthy foods. The PHED/VHW staff facilitate mini-markets, selling at-cost fruits and vegetables in communities with limited fresh food retailers, facilitating healthy cooking demonstrations that promote nutritious foods and healthy food preparation.

The Healthy Connections project, another DHWP/VHW initiative, conducts "House Parties" (organized gatherings of women) that provide screenings for Diabetes and Cardiovascular disease at churches, community organizations, neighborhoods or homes. These are implemented by Healthy Connections Advocates. Advocates disseminate information to the community about diabetes prevention, screening management and encourage women to increase their physical activity and eat healthier by increasing their daily intake of fresh fruits and vegetables. Also, DHWP is collaborating with the REACH Detroit Partnership to promote and refer residents to walking clubs, community dance classes and healthy eating sup-



port groups, and the Healthy Mothers on the Move Project that provides behavioral interventions for overweight pregnant women to promote healthy weight, eating and physical activity during pregnancy and postpartum.

Through the DHWP's Office of Community Nutrition, diabetes and healthy eating workshops are provided for residents and employees. Nutrition counseling and obesity support groups are held in school-based health centers. Through the generous support of a local foundation, the health department recently completed a project assessing parents' perceptions of childhood obesity to determine potential interventions to combat childhood obesity. They anticipate working with the foundation to implement childhood obesity prevention strategies in the new school year.

The DHWP has established a formal partnership with the Detroit Public Schools to become the school's Public Health and Medical Consultant. This partnership will allow the DHWP to influence children's eating habits, physical activity and policies leading to healthy habits and healthy lifestyles. In addition, the DHWP is leading an initiative titled "Growing Well." This project is comprised of several community organizations and institutions serving children and will address childhood obesity, physical activity, nutrition, immunizations and six other prevention areas.

Through the leadership of the Detroit Department of Health and Wellness Promotion's initiatives, services and partnerships, DHWP leaders hope to realize Mayor Kilpatrick's mission and vision to best serve the residents and visitors to the City of Detroit, creating a healthy, strong and vibrant community as: "Your Partner in Good Health."

For more information, contact: William Ridella, MPH, MBA, General Manager, Family Health Services, Detroit, MI, DHWP, Phone: 313-876-4228 or via E-mail at: Ridellaw@health.ci.detroit.mi.us



January 2003

Federal Judge in New York City threw out a lawsuit against fast food restaurants, saying the "risk is common knowledge."

March 10, 2004

CDC published a study in JAMA indicating 400,000 people die annually due to causes related to excess weight.

September 30, 2004

"Preventing Childhood Obesity: Health in the Balance" issued by the IOM, said daily PE exists nationally at 8% of elementary schools, 6.4% of middle schools and 5.8% of high schools.

October 19, 2004

"The Biggest Loser" TV show premiered; aiming to help 12 overweight contestants transform their bodies and health.

2004

"SuperSize Me" opened; documenting "one man's journey into the world of weight gain, health problems, and fast food."



Colorado Program Targets Inadequate Weight Gain in Pregnancy through Local Strategies

Colorado has one of the highest rates of low birthweight infants in the nation. In 2003, 9.1 percent of all births, over 6,000 babies, were low birthweight births. Low birthweight is a significant health problem, contributing both to infant death and to long-term developmental and neurological disability.

In 2000, the Colorado Department of Public Health and Environment determined inadequate maternal weight gain during pregnancy to be the largest population-attributable risk factor contributing to singleton low weight births. Nearly one in four Colorado women does not gain an adequate amount of weight in pregnancy. These women are 1.6 times as likely to have a low birthweight baby as women who gain an adequate amount of weight. Inadequate maternal weight gain is a serious problem affecting women of all races, incomes, and ages. The good news is that weight gain is a factor that can be influenced.

As a result of these findings, the Women's Health Section launched a social marketing campaign, "A Healthy Baby is Worth the Weight," which seeks to motivate Colorado women to gain sufficient weight during pregnancy. MCH-funded, the campaign is designed to influence both health care providers and consumers about weight gain during pregnancy through education, tools, training, and other resources.

Campaign goals are to reduce the incidence of low birthweight infants in Colorado by ensuring adequate weight gain during pregnancy and to increase the number of health care providers who provide accurate weight gain recommendations to pregnant women.

Campaign materials include a combined body mass index (BMI)/gestational wheel with corresponding weight gain recommendations and a provider counseling pocket card and patient education materials. These assure quick and easy weight gain assessment and counseling.

MCH funding has supported the campaign efforts. MCH funds, in the form of special grants or as part of

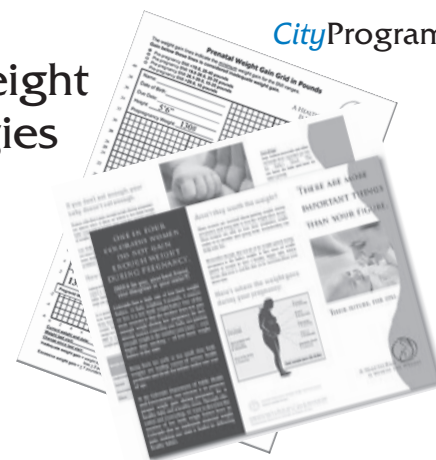
their comprehensive MCH Plan, were provided in 2004 to six large health departments and two health maintenance organizations (Rocky Mountain HMO and Kaiser Permanente) to roll out the campaign.

Each agency identified a campaign coordinator (registered dietitian or public health nurse), who participated in a day-long training and monthly conference calls with the State campaign coordinator. Local coordinator's sought to provide at least 100 health care providers and support staff with training. Physicians were the primary focus of this training; other targets were prenatal care practitioners, nurses, registered dietitians, health educators and other office staff. Provider training consisted of a 15-minute orientation to the campaign and materials within a staff meeting or more intensive grand rounds presentations to medical students. Within this six-month rollout, 945 physicians, nursing professionals and support staff received training on the campaign.

The ultimate goal, change in practice, was measured through an initial and one-to-three-month post-training practice questionnaire to identify current practices around weight gain assessment and counseling. It came as no surprise that most practices were not calculating BMI or using a weight gain grid to visually assess trends in weight gain. Therefore, completion of just these two parameters was an excellent starting point in placing more emphasis on providing appropriate weight gain recommendations for pregnant women.

Within the initial rollout, 34 clinics changed practice in some fashion to promote the campaign's goals. For many of these agencies, the change in practice was typically limited to one or two changes including distributing brochures, using the BMI wheel to calculate weight gain recommendations and adding the prenatal weight gain grid to the medical record.

One of the greatest successes and challenges of the pilot was working with providers to change practice. Many struggled with inducing providers to change practice, yet still felt strongly



that educating them on weight gain recommendations and getting them to calculate BMI and give weight gain recommendations by BMI category was a step in the right direction.

Educating providers that inadequate weight gain has consequences was a challenge as many providers focus only on excessive weight gain. However, if providers are not plotting weight gain over time, they cannot know if patients are gaining weight appropriately. That fact helped market the campaign and the weight gain grids.

Evaluation of the campaign involves quantitative and qualitative evaluation components including tracking material dissemination, assessing adequacy of weight gain and provider awareness, and determining the extent to which consumers receive appropriate weight gain recommendations as determined through a revised PRAMS survey. The long-term goal of decreasing the number of low birthweight births in Colorado attributable to inadequate maternal weight gain will ultimately be assessed utilizing birthweight data obtained from the birth certificate.

A media campaign, planned for the fall of 2005, seeks to educate the public and motivate pregnant women to discuss weight gain with their health care provider. Within the media campaign, the project web site—geared to both the general public and to health care professionals—will be promoted.

For more information, please visit the website: www.healthy-baby.org or contact the author, Stephanie Beaudette, MEd, RD, Colorado Department of Public Health and Environment, Prevention Services Division by phone: 303-692-2487 or by E-mail at: Stephanie.Beaudette@state.co.us

2004

American Society of Plastic Surgeons reported 324,891 liposuction procedures were conducted in 2004.

2004

Hardee's introduced the "Monster Thickburger" -- A 1,420-calorie burger with 107 grams of fat.

2004

Coca-Cola CEO admitted obesity is a major issue to the Wall Street Journal, but says customers have the right to choose what they eat.

January 18, 2005

In JAMA, CDC conceded to an error in their previous study, reducing number of annual deaths to 365,000.

April 20, 2005

CDC researcher Katherine Flegal and colleagues published new estimate in JAMA: obesity kills about 112,000 annually, while being moderately overweight is potentially beneficial.

Sources:

Web-based resources: AOA, ASPS, Boston.com, CNN, FOX News, KC Website, Star-Ledger Report, 'SuperSize' Me, USA Today, and the Washington Post



MCH Leaders Talk About Local Strategies for Healthy Weight

(Continued from page three)
 that we did not have three to five years ago. For example, Colorado

has long had a problem with low birth-weight rates. Recently, it was learned that the primary reasons are related to inadequate weight gain in pregnancy and smoking, so we can now target our activities better.

Elkind: The difference is as stark as night and day: from perhaps limited referrals and limited resources for individuals who were already obese, to complete community engagement for prevention and strategy building in the area of healthy weight.

How is your community responding to your health department's efforts to promote healthy weight?

Ayala: The local affiliate of the OSF-Health System has been fully supportive of our newsletter which was designed to promote nutrition and physical activity—providing in-kind color printing for the quarterly publication. The communities receiving this newsletter have been very supportive; however, community-wide efforts are slow in building momentum.

Burford: We really do not yet know. We do know that most of our clients are very busy juggling their lives and that they become confused with the multiple and often conflicting nutrition messages they hear from different sources.

Elkind: The community has absolutely partnered with the agency in this joint community endeavor—including chairing the Coalition and subcommittees, representing the Coalition, developing materials, sharing speaking engagements and trainings, putting on professional and community events and grant writing.

Has your health department developed innovative approaches for promoting healthy weight in your community, and if so, what lessons learned would you like to share?

Ayala: Collaboration with our efforts has been the key to our progress thus far. We have not had outside funding for any of our efforts, and have relied upon the partners in our collaboration. For example, our after-school program relies heavily upon the YMCA, the school, the health department and a local fresh produce market.

Another lesson worth noting is to encourage people/projects to “strike while the iron is hot!” In more practical terms, work very hard to get potentially controversial projects (which could be any project) approved and started prior

to upcoming local elections, assuring continuity of progress through your efforts. That being said, we have evidence to support the converse position is true—the bike path was fully supported by the previous village administration. After a local election this past spring, the bike path project has in fact, been halted.

Burford: The State of Colorado recently changed their birth certificates to reflect BMI information for the mom and to document how much weight her provider told her to gain in pregnancy.

The agency partnered with the state as one of the pilot sites for the “A Healthy Baby is Worth the Weight” campaign (see page nine for further details) to provide easy and useful information to both moms and providers.

The agency is partnering with other organizations on urban planning for healthier communities. One example has been assisting in efforts to create parks and open space, i.e., places that encourage people, especially those in low income areas, to be outdoors and active.

The agency has completed a health care provider needs assessment focused on healthy weights in children, and has developed related information/resource packets for those providers.

Elkind: Our health department has developed some innovative approaches. Highlights of several efforts follow:

First, the Coalition on Children and Weight - San Diego (CCWSD) sponsored a School Food Summit bringing together school administrators, board members, food service managers, school nurses and others from 42 of the 43 public school districts. During this summit, participants shared practical approaches to improve food served on school campuses. This includes foods sold in vending machines, those given as rewards and food served in cafeterias. A similar School Physical Activity Summit is being planned.

Second, the CCWSD worked with the local Childcare Coordinating Agency to develop a self-assessment tool and a

training module which childcare providers could take. Once providers complete the training module, they are known as nutrition-friendly childcare providers. When the central childcare referral agency responds to queries for a nutrition-friendly facility, referrals can be given accordingly.

Third, a presentation was developed for school boards, PTAs, etc. This presentation closes with a written request for commitment from the board to change one or more nutrition and/or physical activity practices.

Finally, an effective partnership was established with the local American Academy of Pediatrics (AAP). Physicians volunteer to be matched with a local school and to provide the school with nutrition as well as other health expertise.

What sources of funding are used to support your health department's efforts to promote a healthy weight?

Ayala: Funding?! To date, we have creatively and efficiently used existing community resources people, products, services and interest.

Burford: Our health department has used a combination of MCH resources, local funds, Medicaid, WIC and local/state grants.

Elkind: Maternal, Child and Family Health Services (MCFHS) has received funding from our Board of Supervisors to both plan and support efforts. Additionally, we use MCFHS staff, funded by the Child Health and Disability Prevention Program, Early and Periodic Screening, Diagnosis and Treatment and Maternal and Child Health. We have also received funding from the California Nutrition Network. One of the HHSA's Regions also received a large California Endowment grant. The Coalition's community partners contribute significantly to efforts and achievements.

For more information, contact Maureen Fitzgerald, MPA, at 402-561-7500 or E-mail at mfitzger@unmc.edu.

Decision 2005: CityMatCH Elects New Board Members

CityMatCH would like to thank all candidates who ran for the 2005 Board of Directors. The response rate to this election was high, with over 70 percent of members responding. The quantity of talented and qualified nominees for each open position made the decisions difficult.

Congratulations to the following CityMatCH members elected to the Board for a three-year-term (2005-2008):



- ♦ Region I: Peter Simon, Providence, RI
- ♦ Region V: Carolyn Slack, Columbus, OH
- ♦ Region IX: Vicki Alexander, Berkeley, CA
- ♦ At-Large: Kenneth Swann, Orlando, FL



CityMatCH/AMCHP Women's Health Partnership Considers Impact of Healthy Weight



CityMatCH and the Association of Maternal and Child Health Programs (AMCHP) have recently formed a Women's Health Partnership (WHP). The intent of the WHP is to identify and promote unique state and local MCH roles and related opportunities to ensure and improve women's health before and between pregnancies. Initial efforts have focused on the importance of healthy weight among women of reproductive age as a means to improve maternal health and birth outcomes.

The Partnership sponsored a Healthy Weight for Women Strategy Meeting in August, 2005 in Denver, CO. AMCHP and CityMatCH joined with a select group of leaders representing local, state and national organizations with MCH concerns.

The primary goals of the Healthy Weight for Women Strategy Meeting were to: 1) review existing research and recommendations; 2) consider opportunities for collaboration; 3) identify, investigate and recommend strategies, tools and approaches; and 4) form a Women's Health Partnership Advisory Committee to assist with planning and implementing of proposed recommendations.

The meeting was successful in reaching the identified goals. Considerable progress was made and continues in the review of research and ideas for collaboration (Goals one and two). Goals three and four yielded a wealth of strategies that public health professionals can implement. Selected highlights are presented below. We also share proposed recommendations for the Women's Health Partnership.

Goal 3 Outcomes: Healthy Weight Strategies

1. Data and Research: Public health professionals can work with Vital Statistics to add the mother's pre-BMI and pregnancy-related weight gain to the birth certificate.

2. Maximizing: Those responsible for women's health programs can build upon existing initiatives through the integration of nutritional and physical

activity components to address healthy weight. For example, with limited additional funds, physical activity programs can be incorporated into local WIC programs.

3. Collaboration: Many disparate factors impact healthy weight, therefore community collaborations should be broad and include nontraditional partners—food industry, urban planners, insurance, HMO's and supermarkets.

4. Cultural Competence: To improve the effectiveness of healthy weight interventions, the impact of cultural factors related to food selection, weight perception, practitioner training, messaging, weight standards and food choices must be understood.

5. Advocacy: Informative materials designed to persuade funders, legislators and/or the general population, should incorporate stories of "real-life" women impacted by overweight and obesity.

6. Food Availability and Distribution: Interventions should include the promotion of farmers' and community markets and ensure that fresh fruits and vegetables are more readily affordable and available. Interventions can also link to governmental efforts such as the alignment of food stamp regulations with dietary guidelines and the establishment of equity in food prices through agricultural subsidies.

7. Communication: A simple and consistent message about healthy weight similar to The National Milk Mustache "got milk?"® Campaign can be developed and broadly disseminated.

8. Finance: Practitioners can utilize Title X waivers to seek reimbursement for obesity counseling and treatment with interconceptional women.

9. Policy: MCH Leaders can encourage policymakers to shift from an individual-based to a population-based perspective and promote interventions such as "The Built Environment," which offers tax incentives for walking paths and other features designed to promote physical activity.

10. Workforce Development: Public health practitioners and educators can model healthy lifestyles (i.e., "walk the talk").

Goal 4

Outcomes: Women's Health Partnership Recommendations

A result of the Healthy Weight for Women Strategy Meeting has been the identification of eight priority recommendations, summarized for our readers below. These recommendations describe potential activities which the Women's Health Partnership could champion in the years ahead. Next steps include honing the recommendations into a work plan when the WHP's National Advisory Group meets in December 2005, during the CDC-sponsored MCH-Epi Conference* in Atlanta, GA.

- 1) Design and implement a needs assessment of local, state and national MCH-related organizational membership;
- 2) Identify promising practices and evaluation efforts to further practice;
- 3) Develop an evaluation framework for healthy weight interventions;
- 4) Implement a Healthy Weight Multi-site Learning Collaborative for state/local integration and evaluation;
- 5) Develop and disseminate relevant policy papers and communications;
- 6) Collect and develop information for training professionals;
- 7) Define and develop a healthy weight "toolkit" of selected practices, strategies and messages for MCH practitioners; and
- 8) Increase consumer advocacy and involvement through enhanced knowledge.

Two documents, "AMCHP/CityMatCH Women's Preventive Health Agenda" and "Promoting Healthy Weight among Women of Childbearing Age" have been developed to help shape and frame current and future discussions. For more information contact Jennifer Skala, MEd by phone at 402-561-7500 or by E-mail at jskala@unmc.edu.

* <http://www.cdc.gov/reproductivehealth/MCHepi/2005/AboutConference.htm>



DaTA Institute News

Six teams are graduating from the **DaTA** Institute and five newly formed teams are kicking off their yearlong training in Fort Worth, TX, September 10-13, 2005 during the **CityMatCH** Urban MCH Leadership Conference.

Each team begins the Institute with a proposed data use project of importance to their community and organization; the Institute then provides customized opportunities for the teams to apply new skills acquired throughout the year. As part of the Graduation Workshop, the 2004-2005 teams showcase their projects by presenting promising practice posters.

The six **DaTA** Institute teams graduating at this year's **CityMatCH** conference include:

- ♦ **Golden, CO—Jefferson County Department of Health and Environment:** Cynthia Farkas, Carolyn Kwerneland, Gayle Miller, Norma Tubman.
- ♦ **Nashville, TN—Metro Public Health Department, Nashville/Davidson County:** Stephanie Blansett, Frances Clark, Judy Dias, Tonya Gunter, Latissa Hall, Susan McDonald, W. Burns Rogers, J. Chris Taylor, Linda Walton, Kimberlee Wyche-Etheridge.
- ♦ **Philadelphia, PA—Philadelphia Department of Public Health:** Marjorie Angert, Rackell Arum, Brian Castrucci, Abike James, Marie James, Paulette Rhodan.
- ♦ **St. Paul, MN—St. Paul-Ramsey County Department of Public Health:** Mary Elizabeth Berglund, Sharon Borg, Leah Bower, Sharon Cross, Deborah Hendricks, Ann Hoxie, Amy Lytton, Susan Mitchell, Deborah Schlick, Rahel Tekle.
- ♦ **St. Petersburg, FL—Pinellas County Health Department:** Karen Cochran, Maridelys Detrés, Claude Dharamraj, Ann Doyle, Carrie Hepburn, Robert Janssen, Rhonda Miller Sheared, Michael Stone, Beth Tobias, Judi Vitucci.
- ♦ **San Jose, CA—Santa Clara County Public Health Department:** Dolores Alvarado, Alma Burrell, Lee Anna Botkin, Joyce Chung, Jose Colome, Jeannette Ferris, Supriya Rao, Anandi Sujeer, Sandra Trafalis.

As these teams graduate and become a part of the network of nearly 65 **DaTA** Institute alumni teams, a new cohort of five teams has come forward to begin the training year. Through a mix of on-site workshops, conference calls and one-on-one technical assistance, these teams will gain skills in the areas of data, policy and program to better translate data relevant to their communities into action.

Congratulations to the five teams listed below:

- ♦ **Eugene, OR—Lane County Public Health Services**
- ♦ **Fort Worth, TX—Tarrant County Public Health**
- ♦ **Orlando, FL—Orange County Health Department**
- ♦ **Philadelphia, PA—Philadelphia Department of Public Health**
- ♦ **San Diego, CA—County of San Diego Department of Health Services**

For more information, please contact: Kathleen Kock, MPH, Project Coordinator, **DaTA** Institute by phone at: 402-561-7500 or E-mail at: kkockt@unmc.edu

CityLights is supported in part by Grant # 1 G97 MC04442-01-00 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.



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