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Roundtable Summary Report

Prevention and Treatment of Overweight and Obesity: Toward a Roadmap for Advocacy and Action

Sponsored by:
American Association of Health Plans ▪ Centers for Disease Control and Prevention ▪ HealthPartners
Kaiser Permanente Care Management Institute ▪ Kaiser Permanente Institute for Health Policy
The Robert Wood Johnson Foundation ▪ Washington Business Group on Health

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I. Introduction

On August 14 and 15, 2003, 47 public and private sector professionals convened for the roundtable discussion entitled "Prevention and Treatment of Overweight and Obesity: Toward a Roadmap for Advocacy and Action." The roundtable was jointly sponsored by the Robert Wood Johnson Foundation, Kaiser Permanente, the Centers for Disease Control and Prevention, the American Association of Health Plans, HealthPartners, and the Washington Business Group on Health[1]. The purpose of this meeting was to identify priorities to address the epidemic of obesity, which now affects more than half of the adult population and 15% of children and adolescents in the United States. The format of the roundtable included presentations, interactive discussion, and brainstorming to develop public policy recommendations. This report provides a synopsis of the roundtable's goals, major discussions, and suggested next steps to ensure that recommendations and key learnings are documented for future reference. The topics that are highlighted in this report are not necessarily presented in the order in which they were discussed.

II. Goals

The goal of the roundtable was to provide a neutral forum for critical discussion between diverse stakeholders focused on three specific objectives:

- To summarize the evidence on effective prevention and treatment of overweight and obesity and how lessons learned from other social change initiatives may be applicable to weight control.
- To discuss the applicability of the Improving Chronic Illness Care (ICIC) Chronic Care Model[2] to the issue of weight management and identify an action plan for how the Chronic Care Model can be expanded to effectively address the issues of overweight and obesity.
- To identify short- and longer-term public policy interventions and/or other actions necessary to improve the prevention and treatment of overweight and obesity.

III. Background

The roundtable was the culmination of a collaborative effort between Kaiser Permanente (KP) and the Centers for Disease Control and Prevention (CDC) to develop a national,

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broad-based approach to the public health crisis of obesity and overweight. The collaboration began in 2002 with a series of working meetings that created a forum to connect practicing clinicians who were actively engaged in programs for overweight and obese patients with their colleagues in the academic and research communities and federal agencies. The goal of these initial meetings was to identify practical, effective, non-surgical approaches for prevention and treatment of overweight and obesity. The focus was to increase the adoption and implementation of evidence-based interventions and to identify clinical research opportunities.

KP and CDC recognized that a broad-based public health approach was necessary to prevent and treat overweight and obesity effectively, including strategies that link medical care delivery systems with community resources and other domains. Such an approach would have to address the concerns and needs of the various key stakeholders.

After the initial working meetings in 2002, KP and CDC determined that a roundtable discussion among a diverse group of expert stakeholders to identify priorities for advocacy and action was an appropriate next step. The meeting scheduled for August 14 and 15, 2003 in Washington, DC would bring together policymakers, health care delivery systems, researchers, and representatives of employers, the food industry, schools, and non-governmental organizations directly affected by the impact of obesity. A roundtable advisory committee was convened, consisting of individuals representing seven co-sponsor organizations: American Association of Health Plans, Centers for Disease Control and Prevention, HealthPartners, Kaiser Permanente Care Management Institute, Kaiser Permanente Institute for Health Policy, The Robert Wood Johnson Foundation, and the Washington Business Group on Health. A total of 47 experts attended the roundtable. Appendix A lists all roundtable participants, observers and staff.

IV. Roundtable Presentations

Four presentations in plenary sessions provided context and insight for subsequent discussions:

- *Trina Histon, Ph.D.,* delivered a presentation entitled, "Determinants of the Epidemic of Overweight and Obesity," in which she discussed the main drivers of obesity in the United States and presented a review of evidence about effective prevention and treatment of overweight and obesity. Dr. Histon is the Project Director of the Weight Management Initiative at the Kaiser Permanente Care Management Institute.
- *James Hill, Ph.D.,* delivered a presentation entitled, "Lessons Learned from Other Social Change Campaigns," in which he presented findings from a systematic review of social change efforts. Dr. Hill is the Director of the Center for Human Nutrition at the University of Colorado Health Sciences Center and the Chair of the steering committee for the Partnership to Promote Healthy Eating and Active Living.
- *Nico Pronk, Ph.D.,* delivered a presentation entitled, "The Chronic Care Model as a Framework for Comprehensive Prevention and Treatment Strategies: Application to Overweight and Obesity," which introduced the Chronic Care Model and described its components, as well as discussed the model's application to overweight and obesity prevention and treatment. Dr. Pronk is the Vice President of the Center for Health Promotion at HealthPartners, Inc.
- *Michael McGinnis, M.D.,* set the stage for sub-group discussions about policy changes needed to effectively address overweight and obesity by reviewing policy pressure points, levers and barriers. Dr. McGinnis is Senior Vice President and Director of the Health Group at The Robert Wood Johnson Foundation.

The following section provides an overview of the presentations.

Trina Histon, Ph.D.—Determinants of the Epidemic of Overweight and Obesity

As with many diseases, the prevalence of overweight and obesity in a population reflects the interaction of host, vector, and environmental factors, as described in the epidemiological triad. When considered in the context of the obesity epidemic, host factors include genetic makeup, physiological adjustments, and personal behaviors. Vector factors include food content, food packaging, and food delivery routes. Environmental factors include the physical, economic, political, and socio-cultural environmental conditions that impact individuals and communities. An understanding of these factors and how they interact can provide insight into how they can be addressed in efforts to reduce overweight and obesity.

Changes in social, cultural, and environmental factors over the past several decades correlate with higher rates of overweight and obesity. Individuals are spending more time in sedentary activities at work, school, and home. They are also eating fewer meals at home and more commercial food products than in previous decades. Moreover, foods high in caloric density are cheaper and more readily available, and portion sizes have increased significantly over the past thirty years. The number of vending machines in schools has increased, and some schools are contracting with fast food companies to provide school lunches. Television advertising for foods has increased—especially advertising targeting children. Additionally, changes in community design discourage walking and other forms of physical activity.

Interventions can address all three components of the epidemiological triad. Research has provided a large knowledge base about effective host-based approaches to preventing and treating overweight and obesity. For example, we know that both low-calorie diets and very low-calorie diets are effective methods of weight loss. The most effective weight loss interventions include physical activity and behavioral modifications in addition to dieting. Moreover, medication can help promote weight loss of 5 to 7 percent when used as an adjunct to weight loss programs. When addressing overweight in children, family-based interventions are more effective than individual interventions for children. Maintaining weight loss, however, is difficult, and most people regain weight after they discontinue participation in weight loss programs. To effectively maintain weight and/or weight loss, research suggests that monitoring weight is a critical component. In addition, ongoing physical activity is key to maintaining weight loss, although physical activity has a more limited effect on weight loss itself. Finally, for severe obesity, bariatric surgery is currently the most effective treatment.

The breadth of knowledge on effective host interventions is not as well developed for vector approaches or environmental approaches. For vector approaches, the research that is available needs to be translated for the general public. For example, conferring endorsements to healthy foods—like the American Heart Association's mark of approval—may help consumers make healthier food choices. In addition, nutritional content labels can inform people about the caloric and nutritional content of foods.

As for environmental approaches, research reveals that urban design can discourage walking to school or within community settings. In addition, availability of grocery stores in neighborhoods with low socioeconomic status has decreased, and the small markets that do exist in those communities offer limited food choices. Furthermore, schools provide less opportunity for physical activity; food availability and affordability has increased—allowing for greater levels of consumption at lower cost; and the media and health advocates communicate mixed messages about recommendations for healthy eating. Overall, the environment is not supportive of developing and sustaining healthy lifestyles.

While the efforts to date have primarily focused on host-based approaches to addressing overweight and obesity, long-term success is not likely without addressing the vector or environmental factors. Instead, a broad framework that addresses all three corners of the epidemiological triad will be necessary to mitigate the impact of overweight and obesity in the U.S. population. This will require an integrated approach that draws on broad support from a diverse set of stakeholders to move forward and achieve successful results.

James Hill, Ph.D.—Lessons Learned from Other Social Change Campaigns

The Partnership to Promote Healthy Eating and Active Living (PPHEAL) conducted a three-part research investigation to support development of a framework to understand the interrelated factors affecting dietary and physical activity behaviors. The final part of the investigation sought to answer the question: What lessons have been learned from attempts to guide social change?

The PPHEAL working group assigned to this task looked at the following social change movements: tobacco control, auto restraint devices (including seatbelts and child car seats), recycling, breastfeeding, and international efforts in nutrition, physical activity, and obesity control. For each movement, literature reviews and key informant interviews were used to investigate various factors. Results show that all of the social movements investigated shared the following ten components:

- **Crisis.** Each movement began with a dramatic revelation of a clear and life-threatening problem. Seminal events and/or key reports created a sense of urgency and built a commitment to collective action.
- **Science Base.** Each movement relied on a scientific evidence base to back up its recommendations. Expertise from a wide range of disciplines supported the dangers or drawbacks associated with the targeted activity.
- **Economics.** Each movement utilized economic tools or information to leverage its position. Examples include: detailed cost-benefit analyses, economic incentives or disincentives, funding to develop solutions, or financial benefits that could accrue with the desired behavior change.
- **Sparkplugs.** Each movement benefited from having charismatic individuals who assumed active leadership roles in promoting the movement's agenda.
- **Coalition Building.** Each movement was supported by active coalitions of individuals or groups, representing diverse backgrounds, coming together to work toward common interests. Each movement also generated innovative grassroots initiatives.
- **Advocacy.** Each movement engaged in strong advocacy, drawing on resources such as the media, grassroots constituents, volunteer organizations, and activist groups to promote the movement's messages.
- **Government Involvement.** Each movement strategically involved the government in changing social norms. Federal, state, and local governments were called upon to educate the public, create public safety laws, collect surveillance data, allocate funding and more.

- **Mass Communication.** Each movement effectively used mass communication to promote their health or social agendas. Positively framed messages were supported by scientific evidence that highlighted the need for social change.
- **Environment and Policy Change.** Each movement relied on environmental and policy changes to initiate and sustain systematic change in attitudes, behaviors, and underlying social structures. Monitoring systems and outcome reports were essential for evaluating impact.
- **Plan of Action.** Each movement was supported by a plan of action which recognized that no single approach was sufficient, but instead multiple pieces had to work synergistically. The plans targeted all levels of government and society, and they were both comprehensive and flexible, while also maintaining a clear focus.

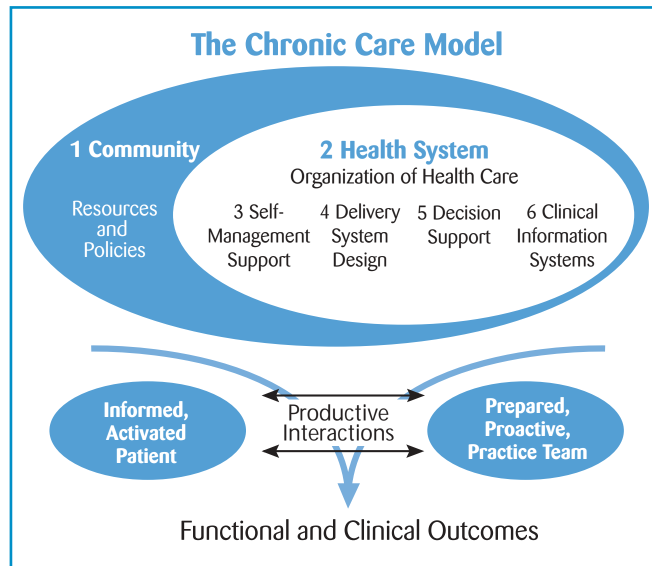
From these study findings, key commonalties from previous social change efforts were identified that can offer insight for obesity prevention and treatment efforts. For example, advocates should remember that change is slow and that previous social change campaigns took decades to achieve significant results. Previous movements took advantage of key opportunities that arose in the political and social environments to further their causes. They used broad-based public-private coalitions to build extensive support for their efforts. Lastly, they all used multiple strategies in a well-developed plan to approach their goals.

While other movements benefited from having clear solutions—such as using seatbelts, recycling, or smoking cessation—a single straightforward solution for reducing overweight and obesity does not exist. Social change initiatives targeting obesity and overweight will need to address multiple related but different goals (for example, preventing weight gain versus treating obesity) that will require different strategies, resources, and support systems. Coming to a consensus on goals and solutions will therefore pose significant challenges.

Nico Pronk, Ph.D.—The Chronic Care Model as a Framework for Comprehensive Prevention and Treatment Strategies: Application to Overweight and Obesity

The Chronic Care Model (CCM) was developed in 1998 by the MacColl Institute for Healthcare Innovation under the leadership of Dr. Edward Wagner. Based on a systematic review of successful strategies for managing chronic illness care, the CCM identifies essential elements of a health care system that produce high-quality chronic care and improve functional and clinical outcomes. Applied in a context that includes informed, activated patients and prepared providers, the CCM targets productive interactions between providers and patients.

Figure 1. Overview of the Chronic Care Model



The CCM focuses on six components of the health system and the extended community in which the health system resides:

- **The Health System: Organization of Health Care.** The CCM requires that chronic care management be a key goal for a health care organization or system. This requires active leadership, support for change, re-alignment of staff incentives, and adherence to evidence-based guidelines.
- **Clinical Information Systems.** The CCM emphasizes timely information on populations and individual patients. To achieve this goal, the health care system should develop tools such as disease registries, performance indicators, reminder systems, and systems to support tailored treatment plans and tailored messaging for disease self-management.
- **Decision Support.** Under the CCM, effective decision support mechanisms and knowledge transfer are critical for managing chronic care. This includes evidence-based practice guidelines or protocols and integration of team-based care over multiple visits.
- **Delivery System Design.** The CCM recognizes the role that delivery system design can play in providing effective care. Practice-teams should be culturally competent with clearly defined roles for care and case management. In addition, the system should incorporate adequate follow-

up protocols to ensure that patients are offered pre-visit, visit, post-visit, and between-visit care.

- **Self-Management Support.** The CCM emphasizes patient-centered management of chronic illness. This requires a collaborative process between the patient and the provider team; tailored education, skills training, and psychosocial support for the patient; and heavy reliance upon an extended care team.
- **Community Resources.** The community provides the backdrop against which the health system delivers chronic illness care. Community resources and policies are needed to support patient treatment plans with non-clinical resources. In addition, the community can provide peer support, long-term care, encouragement for healthy living, and other forms of assistance.

While the CCM emphasizes chronic care management, its applicability to prevention of illness has also been proposed. Prevention efforts can benefit from appropriate consideration of each of the six CCM components. For example, health care system leaders can prioritize resources for prevention interventions and align incentives to promote prevention goals. Likewise, clinical information systems can provide status summaries of preventive services, provider prompts for prevention services, and health promotion registries based on self-reported lifestyle-related risks. Decision support tools can feature guidelines related to prevention and behavior change. Delivery system design can include extended care teams and patient follow-up that support prevention activities. Moreover, prevention relies actively on self-management support and community resources — as patient activation and empowerment are critical to prevention, and maintenance of health behaviors is strongly related to social support mechanisms. Finally, both chronic illness care and prevention strive for productive interaction between individuals and providers, which is one of the primary goals of the CCM.

Given these factors, the CCM appears sufficiently robust to be applied to the prevention and treatment of overweight and obesity. In doing so, however, health systems would need to align with community-based support services, resources, and policies.

Michael McGinnis, M.D.—Introduction to a Public Policy Discussion

Stakeholders involved in advocacy and action to address the obesity problem should be familiar with the pressure points for policy at each level of government. The pressure points for obesity issues include (1) the personal knowledge, resources, and incentives that impact individuals and their choices; (2) schools and youth-serving organizations; (3) worksites and employer programs; (4) community resources; (5) the food industry (includes meal retailers, food retailers, food manufacturers, and food producers); (6) the fitness industry and the inactivity industry (e.g., computers, auto, TV); and (7) the health care system.

Public policy levers at each level of government can help individuals to make the right choices in nutrition and physical activity and can accelerate the rate of improvement in certain areas. There are several potential policy levers to bring to bear on the pressure points mentioned above. Examples include:

- **Bully Pulpit**—includes statement from political champions such as the President, Surgeon General, or the Cabinet Secretary, governors, and mayors.
- **Public Education**—includes educational tools in the form of official policy such as the HHS/USDA Dietary Guidelines and the Food Guide Pyramid.
- **Services Delivery**—includes incentives for a wide range of programs including school meals, WIC, food stamps, and meals served by the Department of Defense and within health care institutions.
- **Insurance Payment**—includes the way in which federal, state and private payment systems provide incentives for delivery of services, and codes that are used to allow for reimbursement.
- **Tax Policy**—includes tax strategies targeting, for example, portion size, calorie/nutrient ratio, and marketing budgets. Such policies are controversial, and we are a long way from feeling confident that they are the right approach—but they are a potential item on the public policy agenda.
- **Regulations**—includes policies affecting FDA/USDA labeling, vending machines, advertising, school physical education, and zoning for physical activity or for concentration of fast food outlets.
- **Capacity Building**—includes policies to support voluntary organizations, local governments and states to give them the means to undertake effective programs.
- **Training**—includes efforts to promote provider competence in nutrition and physical activity.
- **Research**—includes investigation into important issues such as evidence-based interventions, food rating, economic incentives, and the impact of nutrition and physical activity on student performance.
- **Data Collection**—includes measurement and compilation of data for indicators such as eating patterns, and sales and marketing profiles.

Public policy initiatives to encourage healthy weight will encounter a variety of factors in science and society that act

as barriers. The multiplicity of social and environmental factors associated with diet and physical activity requires organizations trying to make a difference to deal with many moving parts. A related barrier is there is not a binary element to the obesity issue as there is in other social change movements (e.g., smoke/not smoke, seatbelts/no seatbelts). The absence of a binary element is the fundamental challenge to message development for obesity initiatives. Another barrier is the lack of scientific consensus necessary to support resolved and sustained policy action. For example, there is lack of consensus on healthy foods, the best interventions, and how to target different at-risk populations. In addition, economic and social forces such as changes in the labor market and the food preparation industry are major drivers of sedentary lifestyle and over-eating. The common national belief in the importance of individual responsibility is also a barrier. There is no question that individual choice is the fundamental action step. However, these decisions are made in a social and environmental context that does not support healthy choices. And finally, although there is an abundance of resources available through alliances, partnerships and media, lack of resources remains a barrier. However, lack of funding is by no means the most important limiting factor to progress.

V. Roundtable Discussions

Participants were given the task of identifying the components of a guiding framework for a comprehensive approach to the treatment and prevention of overweight and obesity and identifying and prioritizing strategies and actions. The following section highlights the main points of discussion that occurred during plenary and small group sessions during the roundtable. The major themes of discussion included: 1) A Guiding Framework, 2) Messages and Communication, 3) The Environment and Community, 4) The Medical Care System, and 5) Research.

A Guiding Framework

Participants discussed models for a guiding framework to provide a common conceptualization of the obesity problem and to align the efforts of a diverse set of stakeholders involved in a comprehensive strategy for prevention and treatment. Clinical models for the treatment of obesity were the initial focus of discussion at the KP/CDC working group meetings in 2002; however, the limitations of these models were soon recognized. The Chronic Care Model (CCM) was offered by the roundtable organizers as a potential framework to move beyond the health care delivery setting to begin addressing the social and environmental factors driving the obesity epidemic. With emphasis on productive interactions between patients and providers, the CCM offers a framework to mobilize the resources of health care systems for better treatment of obesity. In addition, its recognition of broader community resources and policies provides a starting point for bridging health care systems to the community—though the need to expand the community role was acknowledged from the outset of the discussion. Participants were asked to evaluate the CCM to identify if it could make an impact from both a treatment and prevention standpoint and if so, how it would need to be modified.

Several concerns were raised about the applicability of the CCM. A primary concern centered on the model's emphasis on health care systems, rather than on individuals and their communities. The CCM focuses on functional and clinical outcomes with less emphasis on healthy lifestyles and behavioral outcomes. The CCM's emphasis on disease states limits the model to unhealthy individuals who are connected to a care delivery system rather than the population as a whole. Furthermore, uninsured, underinsured, and individuals without a regular source of care do not fit well into the CCM. Several participants indicated that the CCM needs to more clearly illustrate that its "Community" component addresses the underlying social, environmental, economic, and political factors that influence diet and physical activity choices. There was general agreement that the CCM needs to be re-framed through a public health lens—especially for its application to prevention.

At its core, a model that promotes both treatment and prevention of overweight and obesity should place the individual within his or her community—not within the health care system. One participant offered a public health/ecological model for prevention of obesity that reflects this view (see the diagram on next page). Several participants also noted that prevention and treatment efforts within a conceptual framework require different approaches that might rely on separate strategies and resources.

Participants felt that a guiding framework must emphasize community resources critical for helping individuals make healthy choices and manage their weight. Health care systems must also be embedded within the framework, ideally in a manner that allows them to complement the prevention-oriented work of public health systems and community-based organizations. Linkages that enable health systems to support community resources and vice versa must emerge. A conceptual model should also incorporate other players in the larger environment—such as government, media, academia, and industry groups—acknowledging the significant role they play in the pervasive environmental factors driving the prevalence of overweight and obesity. Participants also indicated that an ideal model would have a population-based approach that leverages community resources to reach even those individuals who infrequently access health care systems.

Messages and Communication

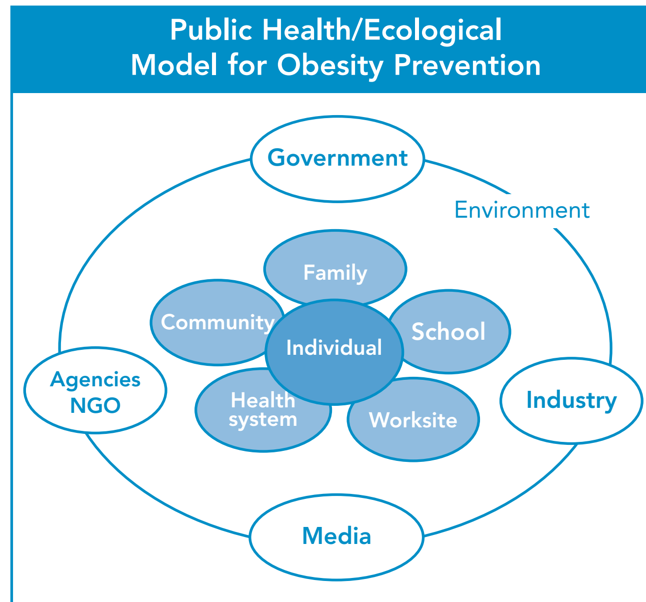


Figure 2. A public health/ecological model for prevention of obesity places the individual at its core.[3]

Roundtable participants engaged in discussion about the language and messages that are used to communicate the obesity problem with the American public. Several participants noted that current communication about the "obesity crisis" does not resonate well with the public. Research shows that patients are uncomfortable with physicians using the terms "obese" or "fat" to discuss their weight problem.[4] Individuals find these labels demeaning and discouraging. Additionally, messages focusing on long-term health risk reduction are less effective in engaging individuals in behavior change than messages that acknowledge the more immediate well-being of an individual.

Individuals are frequently overwhelmed by recommendations calling for significant and immediate lifestyle changes. Small steps towards small victories in nutrition and physical activity give individuals tangible goals and hope for success. Often small changes are more sustainable than drastic lifestyle changes, and individuals who lose 5-10-% of their body weight significantly improve their health status and can lower their risk for developing diabetes by as much as 60%.

A key point of discussion focused on the fact that current messages to the public from the media and other sources about healthy choices in nutrition and physical activity are confusing and ineffective. For example, reporting by the media of contradictory diet and physical activity recommendations makes it appear that the research community is vacillating on the science of weight loss—adding fuel to the confusion and distracting the public from key issues. One participant noted that when a critical mass of experts begins delivering consistent messages about nutrition and physical activity, it would become more difficult for journalists to exploit their disagreements.

Discussion about specialized communication focused on the need for two very different messages for different populations—one for prevention and one for treatment. Each would emphasize different key messages and suggest different strategies. Likewise, separate communication strategies may be needed to motivate individual behavior change and to effect environmental and policy change. Organizations seeking to make a positive impact on the overweight and obesity problem need to find out which messages and language regarding achieving a healthy body weight are most effective with the public. Ultimately, communication needs to be coherent, consistent, culturally competent, and sustained. Roundtable participants agreed that the words and labels used are so critically important that key stakeholders should convene to get consensus on the nature of the obesity crisis and how best to communicate it to the public. Resources will be needed to support the development and communication of these messages.

Environment and Community

The role of the environment and community in the treatment and prevention of overweight and obesity was discussed at length during the roundtable. Participants recognized that motivational interventions delivered in the medical care system can only go so far in solving the obesity problem—environmental and community support are crucial to changing sedentary lifestyle and encouraging healthy food choices. Within the context of an integrated guiding framework, environment encompasses culture, media, advertising, the food industry, community design, and public policy. Community includes families, schools, work sites, and religious and other community organizations.

Participants suggested that community and environment should not be viewed as passive components of prevention and treatment, but rather as active partners in tandem with the medical care system. However, the organizations providing the day-to-day support in the community are disconnected from the medical and scientific knowledge base about effective treatment and prevention strategies. Community "asset maps" were identified as useful tools for health care providers to connect patients to appropriate community resources.

Within models specifically focused on the prevention of overweight and obesity, social support is a critical factor enabling individuals to maintain healthy weight. The health care system can identify at-risk individuals and promote prevention, but the broader community is key to sustaining lifestyle change.

Medical Care System

Despite considerable research and evaluation, there is a great deal of uncertainty about which medical care interventions are effective in the treatment and prevention of overweight and obesity. Participants recognized that the science base is still a work in progress. Nevertheless, the pervasive nature of the obesity problem calls for an immediate and active role in treatment for the medical care system. A key challenge to treating obesity in the medical care system is shifting the paradigm that has characterized disease management in which the patient is a passive recipient of care. A new paradigm must focus on patient self-management interventions. Organizations like Kaiser Permanente and HealthPartners have been actively promoting understanding of how to increase the effectiveness of programs for the management of the severely obese. However, the "medicalization" of the obesity problem is not the most effective strategy. Participants acknowledged that solutions should be based on a public health approach that has a strong foundation outside of the medical care system. Discussion focused on the need for models of collaboration at the local level between medical care systems, public health systems, and community organizations.

Participants discussed the fact that obesity is not currently recognized as a disease covered by insurance, HMOs, Medicare and Medicaid. By recognizing obesity as a disease, reimbursement models will create incentives for providers to deliver treatment and preventive services; however, a clearer understanding of the effectiveness of treatment and prevention within the medical care system must emerge first.

The group came to general consensus that obesity has a significant impact on costs within the medical care system, because diet and activity level, the causal factors associated with obesity, are linked to heart disease, diabetes, hypertension, and arthritis. The cost factor clearly bolsters the case for improved treatment and prevention in the medical care system.

Research

The need for additional research was a theme that arose repeatedly throughout the meeting. Research along multiple dimensions can help to develop effective interventions for the prevention and treatment of overweight and obesity and to make better use of existing resources. While participants acknowledged that several organizations are already pursuing research agendas, they identified a need to synthesize current knowledge and identify the research areas that are not being addressed.

Roundtable participants identified several areas where additional research would support prevention or treatment efforts, including:

- Effective medical approaches to prevention and treatment
- Effective community-based approaches to prevention and treatment
- Effective collaborative approaches between medical and community systems to prevention and treatment
- Cost-effectiveness of prevention and treatment interventions
- Reception of prevention and treatment messages by normal-weight, overweight, and obese individuals

One participant suggested that research on local community initiatives and assessment of available resources would facilitate other local initiatives by identifying potential partner organizations or referral sites. Based on research findings, models that demonstrate effectiveness should be replicated in diverse settings and then evaluated to ensure that the initial success can be reproduced reliably in other contexts.

VI. Suggested Policies and Actions

Participants divided into breakout subgroups to identify and prioritize public policy recommendations and other actions to address overweight and obesity. A subgroup was assigned to each of the following areas of focus:

- Schools and youth-serving organizations
- Work sites and employer programs
- Community support programs, services, and policies
- Community design for healthy eating and active living
- The food industry and food marketing
- Health care systems
- Communications and public advocacy

For each issue area, the recommendation considered as having the highest priority or greatest potential for impact is highlighted below, followed by other suggestions that were identified in small group discussions. These suggestions only scratch the surface of potential actions and policy interventions and are not fully developed due to the limited time for their consideration at the roundtable. They are presented here as examples of policies that could facilitate the development of a roadmap for advocacy and action.

Schools and Youth-Serving Organizations

Priority recommendation: Offer incentives for schools to adopt "healthy school nutrition environment" policies

To encourage schools to provide healthy food choices for students, the federal government should offer incentives to schools to voluntarily adopt "healthy school nutrition environment" policies. In particular, the government should

incorporate higher reimbursement rates into the upcoming reauthorization of the Child Nutrition Programs for schools that meet standards established by an expert panel for providing a healthy school nutrition environment. These standards would require that all foods offered on a school's campus and at school events meet dietary guidelines, thereby limiting students' access to unhealthy foods during school hours.

Additional suggestions include:

- Develop nutrition integrity policies for schools, whereby all foods served in campus environments meet federal nutrition guidelines
- Mandate daily physical activity for all grades K – 12
- Provide quality physical education with resources on par with the academic curriculum
- Incorporate nutrition and physical activity standards in before- and after-school programs
- Establish nutrition and physical activity standards for pre-schools

Work Sites and Employer Programs

Priority recommendation: Develop a HEDIS measure on BMI measurement

Employers can promote healthy weight management practices by contracting with health plans that offer weight management services, tools, and resources. The National Committee for Quality Assurance (NCQA) should develop a measure on the frequency of body mass index (BMI) measurement in clinical encounters to be added to the Health Plan Employer Data and Information Set (HEDIS) to provide employers information about health plan performance. In addition, development of a HEDIS BMI measure would encourage health plans to align incentives with contracted providers to improve their performance on BMI measurement and referral for counseling and weight management programs.

Additional suggestions include:

- Encourage employers to develop comprehensive strategies to engage employees in a healthy lifestyle, which incorporates factors such as health plan contracting practices and employer-sponsored programs that increase access to healthy choices
- Sponsor health risk appraisals for employees, with an appropriate plan of action for those at-risk
- Encourage and facilitate programs like "Weight Watchers at Work"
- Encourage employee enrollment in health plans that offer comprehensive approaches to weight management
- Encourage work site food vendors to provide healthy food choices

Community Support Programs, Services, and Policies

Priority recommendation: Establish food standards for public venues and buildings

Local, state, or federal governments should establish food standards for public venues and buildings to promote healthy eating. These standards would apply to all locations supported by public funds, including government offices and parks. However, consensus on appropriate nutrition standards would be needed first.

Additional suggestions include:

- Conduct special events to educate and involve community members and groups in nutrition and physical activity efforts
- Create alternatives to sedentary behaviors
- Offer community-based exercise, nutrition, and cooking classes, with an emphasis on cultural competence

Community Design for Healthy Eating and Active Living

Priority recommendation: Mandate "health impact" studies for new construction

To promote the development of community environments that support healthy nutrition and activity choices, local governments should mandate "health impact" studies for new construction projects. Local governments would be required to review all development proposals for their potential effects on the physical activity and overall health and well-being of citizens in surrounding communities. This should include multi-sector involvement, with a diverse group of stakeholders participating in the assessments. Results from the assessments should be used to align spending on construction projects with public health goals.

Additional suggestions include:

- Increase access to healthy food, active recreation, and neighborhood resources through incentives, regulations, and public sector involvement
- Encourage strategic revitalization of neighborhoods, with well-funded, well-maintained, and well-supervised activities and venues
- Conduct community needs assessments to help prioritize action and target resources
- Utilize enhancement strategies to build on existing community infrastructure

The Food Industry and Food Marketing

Priority recommendation: Provide funding for research to gain an in-depth understanding of the behavioral factors that influence food consumption patterns

In order to encourage healthy food choices at a societal level, research is needed to better understand the behavioral factors that influence people's food purchasing and consumption patterns. Advertising, marketing, media messages, and a variety of social and cultural factors influence individual behavior. A research agenda should build on the tools, expertise, and existing knowledge within the food industry to better understand what motivates food choices. Incentives will be needed to encourage the food industry to share its proprietary research. Building on a new knowledge base, social marketing interventions involving mass media in collaboration with the food industry can send appropriate messages that create an environment that is more supportive of healthy food choices.

Additional suggestions include:

- Use marketing expertise to 1) promote the concepts of balance, variety, moderation, and physical activity; 2) teach portion size; and 3) eliminate confusion about nutrition requirements and goals
- Encourage restaurants to provide healthy, low calorie choices, appropriate portion sizes, and nutrition information
- Encourage development of shops and restaurants that are more accessible by walking or bicycling
- Increase federal funding for research on nutrition messaging and techniques – e.g. food labels and food pyramid information

Health Care Systems

Priority recommendation: Provide funding for research and demonstrations to determine the effectiveness of prevention and treatment interventions

Public and private funding should be made available to build the knowledge base around overweight and obesity treatment and prevention interventions. Expanded research in areas such as message development, behavior-change mechanisms, coordinated health systems approaches, and successful medical practice demonstrations is needed to achieve improved weight and health outcomes.

Additional suggestions include:

- Provide adequate reimbursement for effective services, including incentives to encourage positive outcomes and good performance
- Establish support structures and tools to enable providers to deliver weight management services, such as information systems, training, and access to community resources

Communications and Public Advocacy

Priority recommendation: Provide funding for a coordinated national media campaign

Broad social and environmental changes must take place to shift the public's attitudes and behaviors around nutrition and physical activity to reduce the rates of overweight and obesity. To effect these changes, major stakeholders — including government, food industry, insurers, the foundation community, etc.—should provide increased funding for a broad-based media campaign designed to increase public awareness and alter environmental conditions to support good nutrition and physical activity.

Additional suggestions include:

- Link media campaigns to the work of coalitions conducting community program
- Link media campaigns to public policy advocacy
- Focus messages on the science base, the need for prevention (particularly among children), and collaboration
- Priority areas for public advocacy include: 1) reduced soda consumption in schools, 2) reduced advertising of unhealthy food to children, 3) increased availability and quality of physical education in schools, and 4) improved community infrastructure

VII. Conclusion and Next Steps

In the concluding session of the roundtable, participants agreed that an integrated approach is necessary to make a positive and sustained impact on the nation's overweight and obesity problem. How that approach is conceptualized within a guiding framework was clearer to participants at the end of the roundtable, but they recognized that additional work is required to flesh out the details and give appropriate emphasis to the various components. Participants identified a window of opportunity, created by the current groundswell of media and public interest, to form a broad-based strategy for coordinated action. Participants offered the following general guidance for immediate action:

- Efforts should focus on both the local and national levels to achieve the broadest impact; however, more immediate results may be seen at local levels.
- Efforts should try to incorporate win-win strategies, where all stakeholders will have the highest likelihood of success.
- "Healthy Eating and Active Living" could serve as a

rallying theme for a broad range of stakeholders, providing a foundation for developing messages that unite the medical, public health, and social service communities.

Participants suggested next steps and follow-up activities listed below:

- Widen the circle of participants for further discussion
- Work on the message for social marketing by developing positively framed, focused messages for communication to the public and enlisting industry marketing expertise to support this effort
- Foster and evaluate local initiatives
- Identify and share examples of community collaboration
- Identify research being conducted or planned
- Get consensus on a research agenda to fill the gaps in knowledge
- Hold a separate dialog focused specifically on prevention—build on evidence review of target behavior and new chapters of CDC's "Guidelines to Community Preventive Services"
- Draft a policy agenda that builds on the existing knowledge base of effective prevention and treatment approaches

VIII. Appendix A: Roundtable Participants

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Endnotes

[1] The Centers for Disease Control and Prevention, Kaiser Permanente and The Robert Wood Johnson Foundation provided financial support for the roundtable discussion.

[2] ICIC, with the support of the Robert Wood Johnson Foundation, developed the Chronic Care Model (CCM). The CCM identifies the essential elements of a system that encourages high-quality chronic disease management. Those elements include: the community, the health system, self-management support, delivery system design, decision support and clinical information systems. ICIC, with the support of the Robert Wood Johnson Foundation, developed the Chronic Care Model (CCM). The CCM identifies the essential elements of a system that encourages high-quality chronic disease management. Those elements include: the community, the health system, self-management support, delivery system design, decision support and clinical information systems.

[3] Public health/ecological model for prevention of obesity suggested by Francine Kaufman, MD, 2003

[4] Wadden, T.A., Didie, E, "What's in a name? Patients' preferred terms for describing obesity", Obes Res, 2003 11:1140-1146