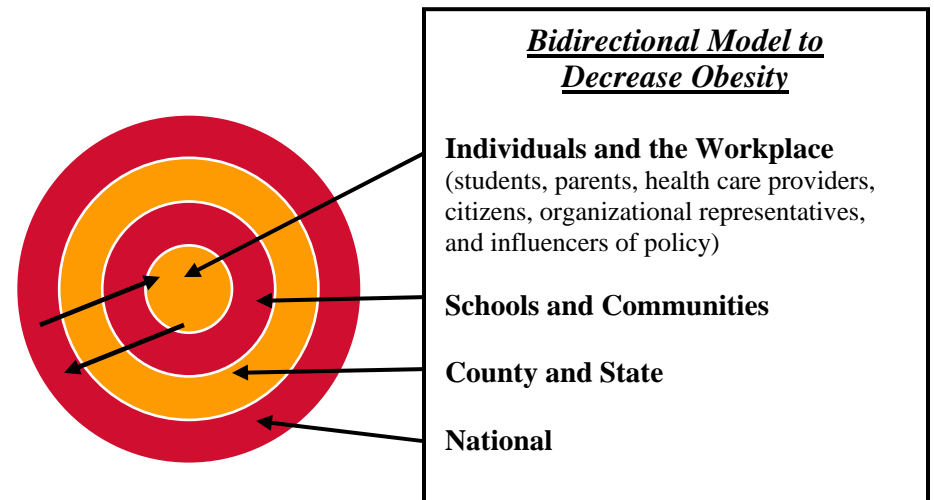


**Action on Obesity (AOO) Manual**  
***Guidelines for Implementation***  
***in the Community***

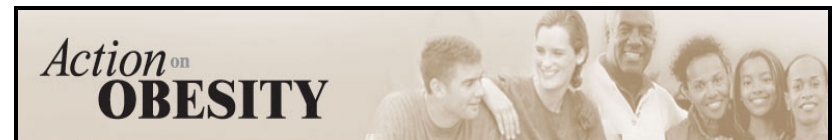
Formulated by the Action on Obesity Taskforce

[www.actiononobesity.org](http://www.actiononobesity.org)



First Edition  
October 11, 2008  
Editor: Joseph W. Roberts

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- 5) Ensure there are dates and deadlines by which time specific action should be completed.
- 6) Through social networking, continue to add new members to your taskforce.
- 7) If possible, hold annual community, county, or state “summits” to highlight what has been done throughout the year, look at existing models, and new calls to action. These can be a few hours in an evening, a full day or two days long, depending on your objectives, content to cover, etc.

Continue to meet, keep the meetings dynamic, try to get some newspaper coverage, radio or television, so the action taken is recognized and others feel compelled to join you in making a difference in the obesity epidemic.



## Section VIII: How to Implement AOO in Your Community

Using the AOO model as a guide, the following steps might be helpful for communities interested in forming an AOO taskforce. The actions below describe the framework used to develop our AOO Taskforce.

- 1) Connect with several different organizations and members of your community, including but not limited to:
  - High-profile medical personnel
  - School superintendent, school wellness coordinators, school nurses, physical education teachers, nutritionists, school meal vendors and workers, and other interested individuals at local academic institutions
  - Public health department nurses and others such as graduates in health and exercise science
  - Local and city government officials such as the mayor and city council members
  - Local food industry members (i.e. food process plant employees, restaurant owners, grocery store managers, etc.)
  - Local business owners, especially members of a community’s key industry (i.e. large employers)
  - Park and recreation department officials
  - Local athletic clubs
  - Local elected officials
  - Anyone with an interest in taking action on obesity
- 2) Plan an initial meeting with these interested persons. At the initial meeting, discuss what is currently taking place and what has already taken place. Talk about what barriers exist in the community. Encourage all in attendance to contribute thoughts and ideas.
- 3) Organize subsequent meetings, preferably on a monthly or bimonthly basis. At these meetings, discuss what is being done, current programs or initiatives, see how to eliminate “separate silos” (page 8), and look for areas of collaboration.
- 4) Identify strategic goals and process goals to help the community move forward taking agreed-upon action on obesity.



## Table of Contents:

- I. The Obesity Epidemic:  
Can You Start AOO in Your Community? ..... Page 5
- II. Background of AOO in Rochester, Minnesota .....Page 8
- III. Interfacing with the Community .....Page 10
- IV. Action on Obesity Summits .....Page 12
  - i. AOO Summit, 2004
  - ii. AOO Summit, 2005
  - iii. AOO Summit, 2006
  - iv. AOO Summit, 2007
- V. Suggestions from the Initial AOO Summit, 2004 .....Page 15
- VI. Barriers to Rapid Change ..... Page 17
- VII. Accomplishments ..... Page 18
- VIII. How to Implement AOO in Your Community ..... Page 22



Sports Medicine, in helping determine the Health and Human Services Physical Activity Guidelines released in October, 2008.

**V. Other**

- An AOO website was created at [www.actiononobesity.org](http://www.actiononobesity.org).
- An AOO Coalition was formed under the leadership of Mr. James Whitehead, American College of Sports Medicine. This linked, via teleconferences, many of the organizations who have regularly attended the AOO Summits.
- Dr. Sharon Tucker is a fellow of the Robert Wood Johnson Executive Nurse Fellows Program (2007-2010), with her fellowship focused on childhood obesity prevention as a national health focus of influence.
- The AOO Clearinghouse will be partially coordinated by the AOO Coalition. All attending organizations and delegates are encouraged to return to their communities and begin an Action on Obesity program in their communities and states.



Schools, Olmsted County Public Health Services, Winona State University, and the University of Minnesota.

- Some activities accomplished by the Public Health Department were supported by a STEPS grant.

### **III. County and State**

#### ***A. Nutrition***

- A Town Hall forum in October of 2004. The objective of the forum was to increase public awareness of the obesity epidemic, engage community members by education and action, identify multidisciplinary resources needed to decrease obesity and to engage individuals.
- Informational materials for children and at-risk population on portion control, nutrition, and physical activity – some of these materials have been translated into Spanish.
- Developed “Kids Gardens” at the local Farmers Market where children can learn about gardening and nutrition.
- Participation in the 2007-08 MN Childhood Obesity Prevention Steering Committee (Mayo Clinic representative).
- Contributor to the MN Obesity Plan: Minnesota Plan to Reduce Obesity and Obesity-Related Chronic Diseases 2008-2013 (Promoting Healthy Eating, Physical Activity, and Healthy Weight).

#### ***B. Physical Activity***

- Informational materials such as “Catching the Exercise Thief.”

### **IV. National**

#### ***A. Nutrition***

- Dr. M. Molly McMahon and Dr. Donald Hensrud, co-chair several nutrition courses throughout the U.S. annually. They try to bring an awareness of optimal nutrition and AOO to their attendees. In San Francisco in 2007 they included a presentation on AOO in their agenda.

#### ***B. Physical Activity***

- Both Dr. Edward Laskowski and Mr. James Whitehead have actively been representing their organizations, the President’s Council on Physical Fitness and Sports and American College of



## **Section I:**

### **The Obesity Epidemic: Can You Start AOO in Your Community?**

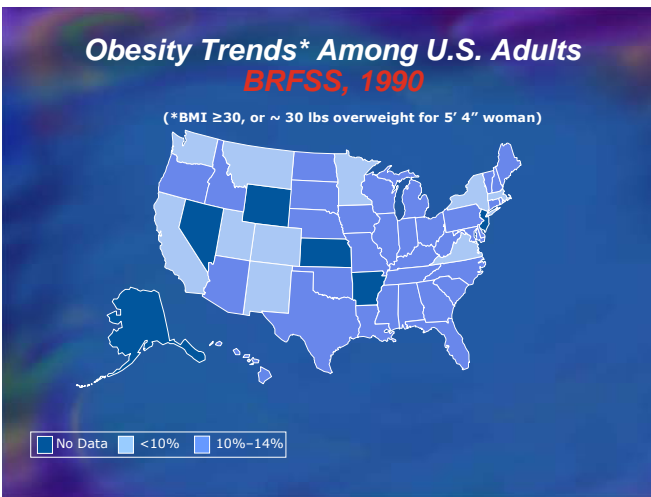
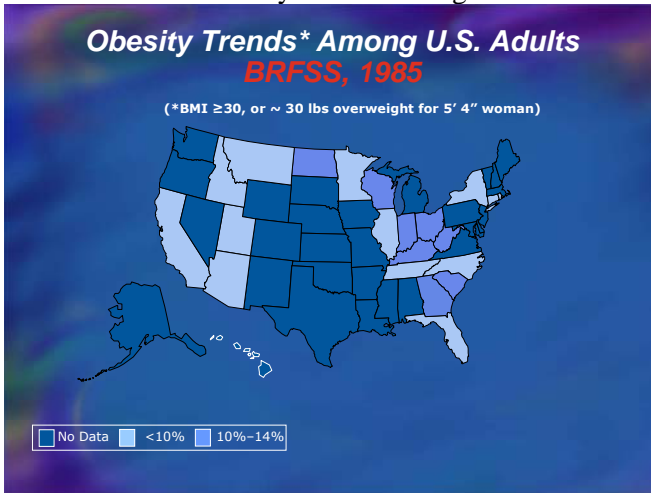
The prevalence of obesity has increased. Over the past two to three decades, there has been an unprecedented increase in the number of overweight and obese people in the United States and around the world. This increase has been observed in both genders, and all ages and ethnic groups. Currently, about 64% of Americans are overweight and about 30% are obese. The prevalence of extreme obesity [Body Mass Index (BMI) over 40] has tripled in just 10 years from 0.8% in 1990 to 2.2% in 2000. Among children and adolescents, the prevalence of obesity increased two-to threefold between 1980 and 2000. In a study reported in March, 2005, it was suggested that as childhood obesity becomes more prevalent, for the first time in U.S. history, the current generation of children may “live less healthful and shorter lives than their parents.”

In 2000, obesity was responsible for an estimated 400,000 deaths, compared to 300,000 in 1990. Obesity is second only to smoking as the leading preventable cause of death in the United States. In addition, obesity is a significant contributor to premature death. Health care costs increase with increasing body mass index numbers, and obese adults, ages 18 to 65, have 36% greater health care costs than those of normal-weight individuals. Direct costs have been estimated at \$54 billion per year with indirect costs as high as \$94 billion to \$117 billion. It is estimated that public obesity is responsible for more health care expenditures than any other health condition, including smoking and problem drinking. It has been estimated the health care costs attributable to obesity are greater than any other health condition. Furthermore, it is affecting babies and children, also at unprecedented rates.

The obesity epidemic is escalating rapidly, is complex in nature and, by its magnitude, is humbling individuals and organizations striving to make a difference. It is only by working together to approach the problem, with “hat in hand,” that we can possibly create an environment for all people that supports physical activity and healthy nutrition.



Below and on the next page are Behavioral Risk Factor Surveillance System (BRFSS) maps depicting the rise of obesity among U.S. citizens. Although the BRFSS maps are available for other years, depicting these images across two decades clearly illustrates the rapid escalation of obesity in the United States. Note that as you review the maps, a new category had to be created to absorb the ever increasing higher percentage of obesity rates. There are three categories in 1985, four in 1995, and five in 2000. How is your state doing?



- Developed walking maps of the Mayo Clinic campus and mile markers put on designated walking routes.
- We requested and received \$27,000 to register Mayo Clinic, Rochester, with the America on the Move program and enrolled almost 4,000 employees in the first year.
- A Mayo Clinic stairwell campaign was created to encourage employees to use the stairs. The program utilized signs encouraging employees to take the stairs, inspirational messages in the stairwells, and music in stairwells when possible.

## II. Schools and Communities

### A. Nutrition

- Promotion, primarily by our public health AOO members, of a popular and healthy Farmer's Garden.
- Developed various publications and media releases in worksite and community in order to raise awareness of obesity-related issues.
- Invited presentations from the Rochester school lunch programs to describe the progress with school lunches meeting wellness criteria.

### B. Physical Activity

- All worked together to have Rochester named by the Governor of Minnesota a "Governor's Fit City."
- Public Health Department worked with the Rochester schools to promote "walk to school days."
- Public Health folks developed a DVD for physical education teachers to teach hip-hop dance in schools.
- Public Health promoted the "walking school buses" in several areas of Rochester; they also worked with the Parent and Teacher Association.
- Conducted workshop exploring the built environment in our community and walkability of the downtown area.
- In conjunction with the AOO Summit, a session was held for community children called "Kids Walk the Talk."
- A collaborative childhood obesity prevention project began in early 2008, funded by the Robert Wood Johnson Executive Nurse Fellows Program, between Mayo Clinic, Rochester Public



## Section VII: Accomplishments

Many action initiatives have been presented by members of the AOO Coalition that emanated from their own organizations. All previous initiatives published in past AOO Summit programs are available on the AOO website at [www.actiononobesity.org](http://www.actiononobesity.org). The following accomplishments were facilitated by members of the AOO Taskforce, which is primarily composed of members from within Mayo Clinic, within the City of Rochester, and within Olmsted County.

### I. Individual and Workplace

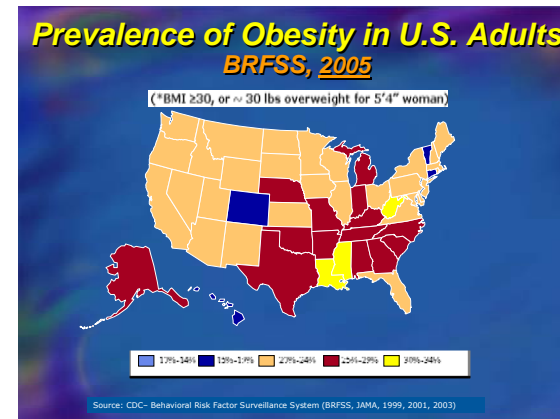
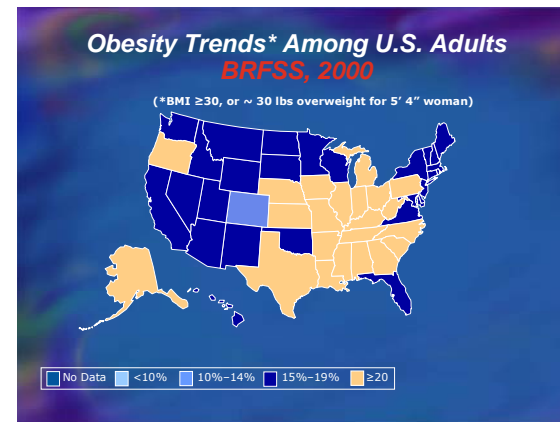
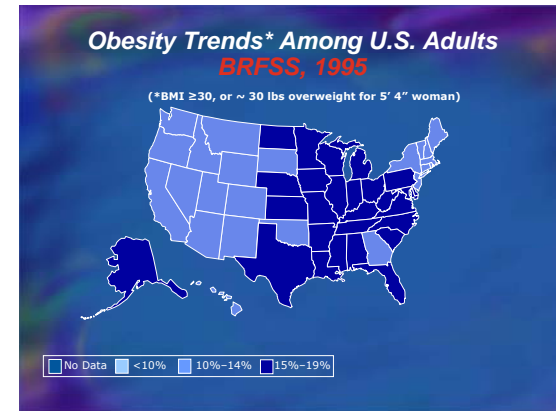
Presented to Mayo Clinic Administration in effort to heighten the awareness of the impact the obesity epidemic has on employees and our patients.

#### A) Nutrition

- Wellness criteria for Mayo Clinic campus foods were developed.
- Accurate portion sizes of foods served by Sodexo Food Service.
- Wellness icons to identify healthy food and vending choices.
- Wellness box lunches were created and labeled.
- Selected nutrient (i.e. calories, fat grams, and mg sodium) information is displayed on cashier register receipts in selected areas.
- Web-based meal ordering system was improved to make meal ordering easier.
- Created the Center Café menu at the Dan Abraham Healthy Living Center (Mayo Clinic employee health center). All items meet wellness criteria and are trans fat free.
- Created “take away” evening meal program at the Center Café which offers healthy meal choices for staff and families.
- Increased options for fruits, vegetables, and whole grains around campus.
- Vending machine item changes within the Mayo campus and in other community organizations with ties to the AOO Taskforce.

#### B) Physical Activity

- Made pedometers available at Mayo Clinic Patient Information desks for patients to track steps taken between appointments.



## Section II: Background of AOO in Rochester, Minnesota

### A) Stimulus for Developing AOO in Rochester, Minnesota

During his keynote at the Association of Applied Sports and Exercise Psychology (AASP) convention in 2003, Dr. Hugh Smith, then CEO of Mayo Clinic, Rochester, challenged convention attendees to take Action on Obesity.

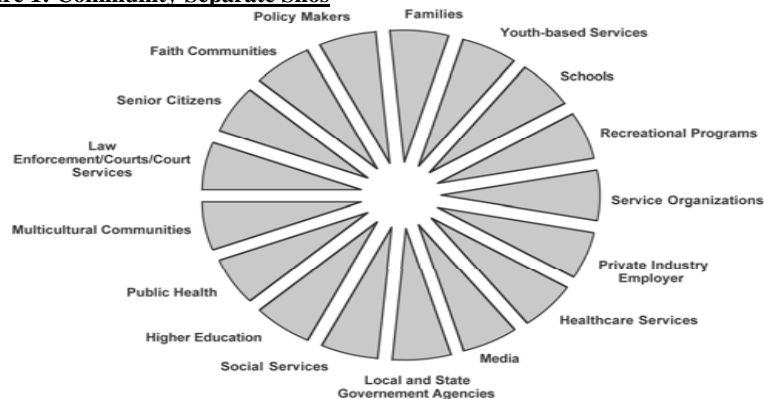
### B) Formation: Stake-Holders Invited to Initial AOO Meeting

On January 8, 2004, an enthusiastic multidisciplinary Action on Obesity Taskforce was formed. At the initial meeting, held at Mayo Clinic, Rochester, attendees committed their own time and energy to work collaboratively to take action on the obesity epidemic. Attendees at the initial meetings included sport and exercise science professionals, cardiologists, endocrinologists, preventive medicine specialists, pathologists, communications experts, nutritionists, public health officials, public school administrators, city administrators, park and recreation representatives, and other concerned community citizens. This taskforce has continued monthly meetings since that initial meeting.

### C) Awareness of Separate Silos

It was soon apparent that there were many different groups and organizations who were already dealing with different programs to address obesity, many of which duplicated efforts. These “separate silos” existed within Mayo Clinic and within our community and Olmsted County (see Figure 1).

**Figure 1: Community Separate Silos**



## Section VI: Barriers to Rapid Change

Some of the barriers identified to making effective and prompt changes in the internal and external environment are listed below:

- I. **Politics** – At times, individuals or organizations have competing interests to effectively and meaningfully take action on obesity.
- II. **Lack of Resources** – Time, funding, financial restrictions, and proper training are all examples of resource barriers.
- III. **Lack of Education** – Many are not aware of how significant the obesity epidemic has become (see BRFSS maps on pages 6 and 7). Many individuals are not aware of the acute significance of health consequences, as well as the financial, economic, and societal consequences of obesity.
- IV. **Built Environment** – Lack of an appropriate city trail system, unappealing walkways and stairwells, and the increasing omnipresence of technology are all examples of barriers in the built environment.
- V. **Safety** – Unsafe walking trails in high-traffic areas and increased crime rates in neighborhoods are examples of safety barriers.
- VI. **Socioeconomic** – Healthy food options are often more expensive than unhealthy food options.
- VII. **Ethnic and Culture** – Language barriers and changing societal norms can also be barriers if not clearly understood and properly engaged.



on cash register receipts might provide a useful technique for nutrient-content education. On-site nutrition and health promotion educational classes could be considered. Increased physical activity at the work site should be actively promoted with a goal of 10,000 steps per day, monitored with the use of pedometers and distance markers within the facility if feasible. Facilities should be upgraded to provide a welcome and safe environment for physical activity. For example, stairwells can be painted, artwork added, and background music installed. If possible, an onsite fitness center with utilization encouraged, particularly for beginners, could be used. Leadership of the organization should help facilitate a cultural shift by providing appropriate infrastructure, policies, and strategies, as well as setting an example through personal physical activity and nutritional practices and participation.

**State and National:**

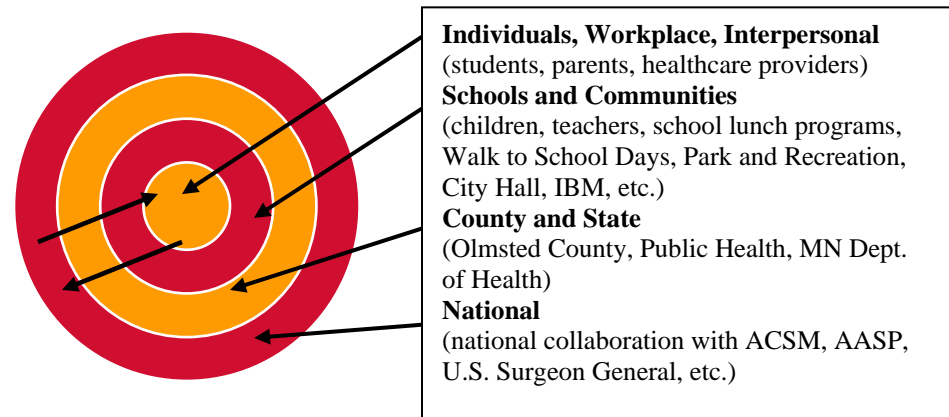
The focus was on five main areas of activity: marketing and communications, policies (including legislation), research, education, and building coalitions. Education and communication messages should be simple, consistent, tailored to the audience, and linked to benefits. A simple and consistent message on balancing energy intake with energy expenditure (calories count) should be delivered. Certain high-risk populations should be targeted, such as children, parents, and those of low socioeconomic status, as well as obese individuals. The benefits of improved nutrition and increased physical activity on body weight should be emphasized, including lower health risks, improved quality of life, and decreased health care costs. Funding and other support for research should be encouraged. Outcome measures for all interventions should be documented. Legislative and policy changes should be explored to promote increased physical activity, reduced energy intake, and ongoing research. The different organizations working on these issues should more effectively coordinate their efforts.

**D) Development and Explanation of the AOO Bidirectional Model**

The AOO Taskforce decided to use a public health approach similar to a model recommended by Dr. Abby King, Stanford (in a text by Dr. Rod Dishman) to promote physical activity. In this public health approach adapted and depicted on Figure 2, Dr. King suggested that activity promotion should be encouraged at the personal, interpersonal, organizational, environmental, institutional and legislative levels of intervention. From that theoretical framework, a bidirectional model was developed to decrease the prevalence of obesity by increasing physical activity and making nutritional changes (see Figure 2).

The Action on Obesity Bidirectional Model serves as a visual depiction for physical activity and nutritional change needed at four levels of intervention. Levels of intervention are 1) Individuals and the Workplace, 2) Schools and communities, 3) County and State, and 4) National. The model is bidirectional, as changes at each level influence behavior at the other levels.

**Figure 2: Bidirectional Model to Decrease Obesity:**



### Section III: Interfacing With the Community

The AOO Taskforce began by inviting various community organizations with a vested interest in the obesity epidemic to attend and share their action programs at monthly AOO Taskforce meetings.

Some of these organizations included:

- Mayo Clinic, Rochester (physicians, nurses, nutritionists, exercise professionals, administrators, etc.)
- Olmsted County Public Health Department
- Rochester Public and Private Schools
- Rochester City Council
- Rochester Parks and Recreation Department
- Local Business Partners (IBM)
- Olmsted Medical Center
- CardioVision 2020 (community grassroots health initiative)
- Minnesota Medical Association Alliance
- Rochester Area Y
- United Way

It was learned that some health promotion activities or programs were already operating within the Rochester community including:

- Families
- Youth-based services
- Schools and higher education
- Recreational programs
- Service organizations
- Private industry employers
- Healthcare services
- Media
- Local and state governmental agencies
- Social services
- Public health
- Multicultural communities
- Law enforcement/courts/court services



### Section V: Suggestions from the Initial AOO Summit, 2004, Breakouts

#### *Individuals and Health Care Providers:*

Individuals and health care providers were encouraged to avoid the terms *diet* and *exercise* because of preconceived negative connotations. Health care systems should be organized to optimize identification and treatment of obesity and coordinate resources. Multidisciplinary and novel treatment approaches were encouraged. Family interventions and psychological health were emphasized.

#### *Schools and Communities:*

Mandatory physical education was encouraged at kindergarten through 12<sup>th</sup>-grade levels. In addition, supervised, safe, spontaneous after-school physical activities through youth and community groups should be promoted. Moreover, spontaneous, noncompetitive recreational physical activity options should be available for the entire community. To change cultural norms, educational efforts should be increased to raise awareness of overweight and obesity, along with strategies for prevention and treatment. City planners, landlords, and others should ensure that there are adequate walking and biking paths, stairs in buildings, playgrounds, and other opportunities for physical activity.

Social marketing strategies should be used to increase awareness of portion size and decrease energy intake. Vending machines should have healthy choices, and calories should be labeled on restaurant menus. Within schools and community eating areas, a specified proportion of foods should be required to meet designated healthy criteria. Consumer-led nutrition and physical activity policy initiatives should be developed.

#### *Work Site:*

Employees should be engaged to develop goals and strategies. Topics of focus should include education, incentives, promotion of enjoyable activities, events, supportive “competitions,” feedback, and recognition. Healthy, low-calorie food options and appropriate portion sizes should be available in employee cafeterias. Printing calories and nutrient analyses



play and graded their activity based on fun, level of exertion, activity accessibility, age appropriateness, and interest sustainability.

**D) 4<sup>th</sup> AOO Summit, March 8 and 9, 2007**

The overall objective for the 4<sup>th</sup> AOO Summit was to focus on childhood obesity related policy approaches to action in this domain. Following this summit, it was hoped that Minnesota would be ready to adopt statewide BMI surveillance of school children so the prevalence of obesity in high-risk populations could be identified and subsequent improvements measured. Keynote presentations included Dr. David Katz from the Yale University School of Medicine, the Minnesota Department of Health, Dr. John Jakicic from the University of Pittsburgh, and Dr. Martha Kubik from the University of Minnesota. Other presenters included pediatric nurse practitioners, student wellness administrators, the Minnesota Senate Minority Leader, and other government officials. It was learned at the summit that there is currently compelling science and data on childhood obesity, however, the effort, time, and budget for measuring BMI in schoolchildren is a barrier. School nurses, we were advised by their association president, while not opposed to measuring BMI, felt they could only obtain that information if there was a referral process in place for children who were found to be obese.

**E) 5<sup>th</sup> AOO Summit, October 16 and 17, 2008**

The 5<sup>th</sup> AOO Summit will be held on October 16 and 17, 2008 and will be an action focus on individuals, populations at risk, health policy, and establishing an Action on Obesity Clearinghouse. This summit's primary objective will be to integrate the knowledge and awareness of individuals, students, parents, healthcare providers, citizens, organizational representatives, and other influencers of policy into effective, sustainable action on obesity. The post-summit objective is to encourage summit participants to take action in their own communities, programs, and states to address the obesity epidemic. Content for a continually evolving obesity clearinghouse will be discussed, and a first edition of a similarly evolving AOO Manual has been developed as a launching point.

- Senior citizens
- Faith communities

Clearly, a major challenge for the task force was to learn to work collaboratively and promote the growth of all programs and efforts to decrease obesity. By sharing information each month, partnerships were formed such that an event or program planned by one organization was assisted by members of another.

The local level of collaboration has been greatly facilitated by the ongoing annual summits described in the next section. While hosting a summit may not be feasible for small communities, an evening session, open to the citizens of a town might be an excellent way to share the action a committee or community has taken. A specific session, while having an educational component, also simultaneously provides a deadline, by which time the group will want to share action taken within their community (i.e. have walking trail maps ready, display progress made in labeling restaurant foods by community restaurants, label "air miles" on produce in the supermarkets or small markets, etc.).



## Section IV: The Action on Obesity Summits

The AOO Taskforce soon determined that holding annual, national Action on Obesity Summits would be an optimal method to bring together like-minded individuals and organizations to discuss the obesity epidemic and share “action” being taken. The rationale for summits and working with other organizations were six-fold:

- 1) Provide the opportunity to learn relevant material from each other.
- 2) Triage beliefs/strategies into those needing change via policies, education, legislative action, insurance incentives, insurance penalties, etc.
- 3) Organizations working together can pledge their support to combating the obesity epidemic, lobby for wise and meaningful change (large numbers of professionals unified by an important initiative).
- 4) Mayo Clinic and Olmsted County Public Health were committed to working with other Rochester organizations to facilitate change in the obesity epidemic in their own community.
- 5) Bring in delegations from national organizations to share additional pieces of the solution that can be integrated into a viable program.
- 6) To share what has worked in combating the obesity epidemic at the various levels of the bidirectional model, as well as acknowledging barriers.

### A) 1<sup>st</sup> AOO Summit, May 21, 2004

The 1<sup>st</sup> AOO Summit convened at Mayo Clinic in Rochester Minnesota to discuss and explore novel methods to address the problem of obesity in the United States. The overall goal of this one-day summit was to identify creative and effective strategies to increase physical activity and improve nutrition in the United States population to curb the increasing prevalence of obesity. The overall objective of the 1<sup>st</sup> AOO Summit was to collect ideas for an optimal “cradle to grave” model for implementation in our communities to decrease the prevalence of obesity.



From this initial summit emanated two papers: “White Paper: An Update on Action on Obesity,” written in July, 2004, that had been requested and was subsequently presented to the Mayo Clinic Administrative Committee, and a peer-reviewed paper, “Action on Obesity: Report of a Mayo Clinic National Summit,” written and published in the April 2005 edition of *Mayo Clinic Proceedings*. These publications detailed worksite and community action plans.

Within Mayo Clinic, it was realized that dozens of departments had programs focused on objectives similar to or duplicating efforts embraced by the AOO Taskforce. Thus, the Mayo Clinic Health Promotion Committee, chaired by Dr. Donald Hensrud, was developed to help coordinate the health promotion activities of different departments, centers, and programs.

### B) 2<sup>nd</sup> AOO Summit, June 9 and 10, 2005

The overall objective for the 2<sup>nd</sup> AOO Summit was to collect ideas for an optimal longitudinal model for implementation in our communities to decrease the prevalence of obesity. This summit included 30 ten-minute action items focusing on childhood obesity, high-risk populations, worksite wellness programs, and physical activity. Keynote speakers included Dr. Susan Blumenthal, former U.S. Assistant Surgeon General and Rear Admiral; Dr. Robin Mockenhaupt from the Robert Wood Johnson Foundation; and Dr. James Hill from the Colorado Clinical Nutrition Research Unit and America on the Move.

### C) 3<sup>rd</sup> AOO Summit, June 8 and 9, 2006

The overall objective for the 3<sup>rd</sup> AOO Summit was to focus on curbing childhood obesity using a multilevel approach. Some of the organizations represented by delegates who presented at this summit include Hormel Foods Corporation, Twin Cities Public Television, The Weight Watchers Group, Inc., the Center for Ecoliteracy, the Sesame Workshop, General Mills Inc., and the Grocery Manufacturers of America. A highlight of the summit was a cooking competition for area schoolchildren, as well as a “Kids Walk the Talk” segment where summit attendees watched Rochester Area Y children at various levels of

