



Task Force on Early Childhood Obesity Prevention
Friday, September 30th, 2011
Blue Cross Blue Shield of North Carolina Blue University
10:00am-3:00pm
Meeting Summary

Attendees:

Task Force & Steering Committee Members: Kathy Higgins (co-chair), Olson Huff (co-chair), Alice Ammerman, Mark Archambault, Abena Asante, Nell Barnes, Tamara Barnes, Lindsey Bennett, Ron Bradford, Alex Daniels, Diana Dolinsky, Anthony Emekalam, Jeff Engel, Stephanie Fanjul, Moses Goldman, Greg Griggs, Gibbie Harris, Brenda Jones, Terry Kinney, Jonathan Kotch, Miriam Labbok, Sarah Langer, Alice Lenihan, Beth Lovette, Jennifer MacDougall, Mary Etta Moorachian, Robin Moore, Jim Morrison, Alec Parker, Jenni Owen, Rich Rairigh, Richard Reich, James Rhodes, Melissa Roupe, Meka Sales, Steve Shore, Florence Siman, Willona Stallings, Barbara Thompson, Diane Ward, Henrietta Zalkind, Helene Zehnder

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Jennifer Hastings, Emily McClure, Pam Silberman, Rachel Williams, Berkeley Yorkery

Other Interested Persons: Najmul Chowdhury, Walter Pettiford, Andrea Phillips, Michelle Wells

Welcome and Introductions

Kathy Higgins, President, Blue Cross and Blue Shield of North Carolina Foundation

Olson Huff, MD, Chair, Board of Directors, North Carolina Partnership for Children

Dr. Huff and Ms. Higgins introduced themselves and welcomed everyone to the meeting. They asked everyone else to introduce themselves and share something about the children in their lives.

Overview of the Task Force Process and Expectations

Pam Silberman, JD, DrPH, President and CEO, North Carolina Institute of Medicine

Dr. Silberman gave the task force an overview of the NCIOM, the task force process, and the charge to the task force. The Task Force on Early Childhood Obesity Prevention was convened at the request of the Blue Cross and Blue Shield of North Carolina Foundation (BCBSNCF) to create a broad-based, long-term blueprint that will provide a roadmap for North Carolina's public and private investments around early childhood obesity prevention. The task force is a collaborative effort by the BCBSNCF, NCIOM, and North Carolina Partnership for Children, Inc. Dr. Silberman's presentation can be found here: [Overview of the Task Force Process](#).

Selected questions and comments:

- Q: Do individuals that represent other members of the task force get the opportunity to vote?
 - No. Representatives for official members of the task force do not get the opportunity to vote, unless those representatives are official members of the task force.

Charge to the Task Force and Task Force Organization

Kimberly Alexander-Bratcher, MPH, Project Director, North Carolina Institute of Medicine

In the context of the task force organization, Ms. Alexander-Bratcher presented the charge for the task force: (1) examine evidence-based and promising practices from prior North Carolina related task forces, as well as from the White House and national Institute of Medicine Committee on Childhood Obesity Prevention; and (2) develop a strategic plan to prevent or reduce early childhood obesity in North Carolina that can serve as a blueprint for foundations, government, health professional associations, and other community groups interested in improving the health of young children, ages 0-5.

The task force is organized around the socio-ecological model. In the center of our model, is our core group that is requested to attend all topic group meetings. The three topic groups consist of the related concentric circles of our model. The three topic groups are clinical, community and environment, and public policies. The objective of the topic groups is to bring expertise in specific areas. As the task force topic areas change, the core group will cross-fertilize across topic meetings and create consistency. The task force will meet for 18 months and the report aims to release in 2013.

Ms. Alexander-Bratcher's presentation can be found here: [Task Force Next Steps](#)

Selected questions and comments:

- C: Children in this generation are not expected to live as long as their parents. The prevention health care costs associated with this early childhood obesity present an economic burden on society and huge costs to the health of these children.
 - As we look into strategic solutions for this problem, consider the following: what is the cost we want to reduce?

Early Childhood Obesity Prevention: What do we know about the Etiology and Potential Solution to the Problem

Diana Dolinsky, MD, Pediatrician and Snyderman Foundation Fellow in Childhood Obesity, Prevention, and Personalized Medicine, Duke University Medical Center

Dr. Dolinsky explained the need for early prevention of childhood obesity. She addressed both the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) standards for normal growth of a young child, which are based on birth data, variable rates of breastfeeding, and body mass index. The standards serve as a tool to assess whether or not a child is in a healthy state of growth. For children who measure overweight as defined by weight for length, several risk factors should be considered. Dr. Dolinsky examined categories of risk factors via several current studies including the following: prenatal, perinatal, early infant growth, breastfeeding, supplemental feeding, sleep, screen time, physical activity, and childcare setting. By addressing these nine potential risk factors for early prevention, providers can more effectively counsel mothers during pregnancy about weight gain and smoking, and encourage breastfeeding, minimal screen time, adequate sleep, and greater investigation of childcare practices.

Dr. Dolinsky's presentation can be found here: [Early Childhood Obesity Prevention: Risk Factors for Early Childhood Obesity](#)

Selected questions and comments:

- Q: Could the baby sleeping less be due to the baby being fed more? Was this factor taken into consideration in this study?
 - The origin for the baby sleeping less could be due to being fed more. The study considered screen time, socio-economic standards, and exercise, but not total energy intake.
- Q: Do early infant growth patterns continue for the rest of the child's life?
 - Studies suggest that early infant growth patterns can put children at an increased risk for adult obesity, especially in early infant growth pattern continues into adolescence and adulthood. Once these behaviors for overeating have been established and the child is obese, it is difficult to reverse these outcomes and change these behaviors.
 - When considering the impact of breastfeeding on an infant's growth, providers and caregivers should become familiar with the WHO growth chart, which is being adopted by CDC. Even though this chart is based on upper-class population with breastfeeding support, the chart shows the implications of breastfeeding. This chart should be used as a tool, but not as a final evaluation of the child's future well being.
 - Also, exclusivity of breastfeeding seems to make a difference in the child's growth. There seems to be a difference in gene expression in guts of breastfed vs. non-breastfed children.

- Q: Is there an association with which of the growth curves providers and caregivers use and obesity?
 - In North Carolina, the Division of Public Health has implemented the WHO growth curve chart for the first 2 years of a child's life. The chart does not make a difference for an individual child in hands of a good pediatrician, but it does make a difference on the population. We stop using this tool at 3 years because if we use WHO chart after 3 years then most children would be classified as overweight.
- Q: Which risk factors have a greater effect and how does an obese parent teach their child healthy eating habits?
 - There is not one risk factor that is greater than another. For many children it is a combination of risk factors. Overweight parents often have overweight children due to the passing on of similar habits. Some studies target parents instead of children, which have found some interesting results.
- C: There seems to be a lack of guidelines on nutrition involving supplemental feeding and solid foods. Could this be something that the task force further investigates?
 - It is a tangible thing that can be done without a lot/any cost.
- Q: Is stress in this age group affecting weight?
 - No studies seem to look specifically at the child's stress since this is hard to measure, but parent education and family stress is associated with growth and health. If a family is stressed and eating unhealthy, then often, the child is less healthy. Even though some clinicians have discussions with parents about their stress level, these conversations are difficult. Might be able to recommend to the broader practice that this is something to train providers to talk to a parent about more proactively.
- C: When analyzing growth charts, providers have to take any red flag with consideration. These charts are a guide, not necessary a rule. Also, providers cannot look at just one factor, but they must look at overall child's health too.

Description of Childhood Obesity in North Carolina

Najmul Chowdhury, MBBS, MPH, Public Health Epidemiologist, Nutrition Services Branch, Women's and Children's Health, Division of Public Health, North Carolina Department of Health and Human Services

Through a statistical analysis, Mr. Chowdhury's presentation examined the childhood obesity problem in the US versus North Carolina. From 1983 to 2010, the prevalence of overweight children in North Carolina under 5 years age increased from 13.8% to 30.1% and the obesity rate

increased from 6.8% to 15.5%. An overview of the Pediatric Nutrition Surveillance System (PedNSS) data showed that 32% of low-income children in North Carolina are overweight or obese. The variety of graphs showed prevalence rates for obesity and overweight based on age, income, breastfed time-frame, program participation, and racial and ethnic distributions. The county-level prevalence maps and related bar graphs revealed the disparities and trends across the state over time. When considering the causes of obesity, such as poor nutrition and sedentary behaviors of the children and families, policy makers can move to addressing potential solutions for childhood obesity.

Mr. Chowdhury's presentation can be found here: [Description of Early Childhood Obesity Problem in North Carolina](#)

Selected questions and comments:

- Q: Can you explain the disconnect between Hispanic families' high rates of breastfeeding and high rate of obesity?
 - This issue is a common question, which is often referred to as the Hispanic paradox. We cannot correlate the fact that the Hispanic population has higher prevalence of obesity and their higher prevalence of breastfeeding. While they do tend to breastfeed, they do not exclusively breastfeed for 6 months after the birth of the child. Several studies have shown that using both formula and breast milk is correlated with obesity while exclusive breastfeeding is correlated with healthy weight.
- C: The population in these data is an at-risk population, which means that the statistics are worse than they probably actually are in the general population. The PRAMS survey is better for a more general look at the population.
 - 12 states are currently not participating in PRAMS.
 - Race to the Top Early Learning Challenge Grant also presents another opportunity to evaluate more longitudinal data. The state of North Carolina has applied for this grant. If NC gets the grant, then NC could facilitate this data.
- C: A limitation with this analysis is that there is a lack of data explaining the reasoning for obesity. There are many variables that could determine an infant's sleep. Some of the variables are associations, but unable to make definite determinations.

Overview of National Reports and Recommendations

Alice Ammerman, DrPH, RD, Director, Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill

Dr. Ammerman's presentation provided an overview of the national Institute of Medicine's Early Childhood Prevention Policies. She explained that the objective of the report was to address the obesity epidemic among children ages 0-5 and provide recommendations for agencies. Although parents play the primary role in shaping children's development, the report targets policies that influence programs, institutions, settings, and environments that surround families and shape children's and parents' activities and behavior. Through a multi-prong approach, the committee developed goals, recommendations, and potential actions for implementation based on observational studies, evidence when available, and feasibility in different settings for adaptation.

The report's recommendations were targeted to the following: assessing, monitoring and tracking growth, increasing physical activity, promoting consumption of nutritious foods, creating a feeding environment, ensuring access to affordable healthy foods for all children, limiting screen time, limiting exposure to food and beverage marketing, using social marketing for helpful information, and promotion of age-appropriate sleep durations for young children.

Dr. Ammerman's presentation can be found here: [Early Childhood Obesity Prevention Policies: Institute of Medicine](#)

Selected questions and comments:

- Q: What is the benefit of tummy time versus laying on back and kicking your legs, etc.?
 - The concept of "tummy time" is misleading. This time is meant to be time in an non-restraining, natural position.
- C: The Child and Adult Care Food Program (CACFP) provide federal reimbursement for meals served in child care centers. This program is modeled after the school lunch program.
- Q: What is psychological feeding?
 - Psychological feeding means modeling healthy eating behaviors instead of emotional eating behaviors in the feeding environment. The report, however, did not targeting recommendations towards parents.
- Q: What is the task force hoping will be different from this report?
 - We want to think about the barriers for us implementing these recommendations in North Carolina, which recommendations make the most sense to adopt here, and how we should implement them.
 - Our report will be more of an action plan for the state.

Dianne Ward, EdD, Associate Director, Clinical Nutrition Research Center, University of North Carolina at Chapel Hill

Dr. Ward examined the national health and safety performance standards for preventing obesity in early care and education programs. She categorized the nutrition, physical activity, and screen time standards into the following levels: general, requirements for infants, and requirements for toddlers and preschoolers. The standards have potential uses with families, caregivers/teachers, health care professionals, regulators, early childhood systems, policy-makers, and among academic faculty. Through public-private partnerships, programs such as “Let’s Move!” have decreased the number of silos that do exist for early childhood. The online programs are easy to use and accessible to the public.

NAPSACC’s evidence-based quizzes and online assessments provide helpful feedback back on existing national recommendations, research literature, and expert panels. The checklist quiz covers best practices for food, beverages, physical activity, screen time, and infant feeding in child care settings. Currently, these intervention tools that were developed in North Carolina are being used across the country in many other states.

Dr. Ward’s presentation can be found here: [National Recommendations for Healthy Weight Development at Child Care Settings](#)

Selected questions and comments:

- Q: What is NAPSACC?
 - NAPSACC stands for Nutrition and Physical Self-Assessment for Child Care, a program which was developed and tested in North Carolina. This self-assessment tool evaluates all relevant aspects of child-care environment, with the help of NAPSACC consultants. After receiving the results from the assessment, the child-care locations can select areas to work on for the next 6 months. The program provides continuing education workshops and technical support on implementing changes. All this information is available for free on the NAPSACC website.
 - Creating standards in policy is where NAPSACC can do the most good. Once standards are integrated into policy, they become the social norm.
- C: There is some concern about discouraging entertainment screen time in child-care setting.
 - Child-care settings have a rigorous standard of 30 minutes a week. This limited screen time shows that experts felt it was important enough to limit.
 - Screen time includes computers as well as television screen time.
- Q: Given the high number of recommendations around time for physical activity, does the population understand what is considered the right amount of physical activity?

- I think they used a lot of NAP SACC's recommendations. Children need 180 minutes of activity a day and they should get 120 minutes of that physically active time at child care.
- C: There was concern about the amount of overweight and obese adults providing care in child-care settings. Do they have the energy to get the children to be active?
 - This involvement has a lot to do with workforce as well as the children.
 - Help child-care providers realize the significance of 120 minutes on the playground and how they can incorporate activity into their day in other ways.

Next Steps

Pam Silberman, JD, DrPH, President and CEO, North Carolina Institute of Medicine

Selected questions and comments:

- Q: How can we (the NCIOM) be helpful to you in this process?
 - Make sure that all members receive all previous recommendations, not just ones for their specific topic group.
 - Allow other topic groups to listen in on current topic meetings. Send out notices to everyone, not just specific topic groups.
 - Community group is responsible for public awareness.
 - Remember to be mindful of other departments and divisions in government and their goals when creating policy recommendations.
- C: There seems to be a lot of policies about early childhood obesity, but but not necessarily connections. Are we going to address this issue?
 - There are many programs like putting prevention to work, CACFP, Eat Smart Move More, Shape NC, etc. These programs exist as silos of activity and currently there is no way to track their success or not duplicate efforts.
 - We will try to look at some initiatives already going on in NC. During our task force meetings, there will be some opportunities to identify gaps and where we need to make improvements.
 - All conversations will take place in scope of a broader group; through these discussions we will find intersections.

Dr. Silberman adjourned the meeting.