CHARTING THE COURSE
FOR A HEALTHY FUTURE

A plan to improve child health and eradicate childhood obesity in Dallas County

OCTOBER 2012

Committee for the Improvement of Child Health and the Eradication of Childhood Obesity in Dallas County
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Obesity is one of the most challenging health crises the United States has ever faced. Two-thirds of adults and nearly one-third of children and teens are currently obese or overweight, putting them at increased risk for more than 20 major diseases, including type 2 diabetes, heart disease and some forms of cancer. It’s not just our health that is suffering: obesity-related medical costs and a less productive workforce hamper America’s ability to compete in the global economy. Twelve states now have obesity rates above 30 percent; Texas is one of these states (Robert Wood Johnson Foundation, 2011).

More than 60 leaders in the Dallas–Fort Worth area joined together in Fall 2011 to collectively consider how to improve the health of our children and reduce their risk for, and the occurrence of obesity. These leaders believe that by fully engaging local expertise and resources, our community can make childhood obesity an issue of the past. As a result, they developed a plan for coordinating community efforts in order to significantly improve our children’s health; the aggressive goal is to eradicate childhood obesity in Dallas County by 2020.

*Charting the Course for a Healthy Future: A plan to improve child health and eradicate childhood obesity in Dallas County* begins the conversation with the Dallas-area community about how it can take up the initial call to action. Casting light upon the local issues and considering the key factors and challenges that must be addressed provides a good starting place for eventually ensuring that all children in Dallas County have the opportunity to grow up happy, healthy and strong.
Childhood obesity impacts children of all ages

Infants
Current statistics indicate that more than 1 in 10 children under the age of 2 meets criteria to be considered obese. The Centers for Disease Control and Prevention estimates that breastfeeding reduces the risk of childhood overweight by 15 to 30 percent (2007). The World Health Organization and the American Academy of Pediatrics emphasize the value of breastfeeding for mothers as well as children. Both recommend exclusive breastfeeding for the first six months of life.

While more than 75 percent of mothers in Texas reported breastfeeding, only 44 percent report having continued the practice for 6 months, and just 11 percent report breastfeeding exclusively for 6 months.

Toddlers
Among preschoolers, 2 to 5 years old, more than 20 percent are considered overweight and more than 10 percent meet the criteria to be considered obese. In the past 10 years, the percentage of obese preschool children has increased by more than 40 percent (Ogden 2006).

School-age children
Childhood obesity rates in Texas are higher than those reported for the nation. The American Obesity Society lists Dallas as one of the "Top 10 Overweight Cities" in the United States. According to statistics from the U.S. Health and Human Resources Department, 36 percent of Dallas children and teens are overweight or obese. More than 20 percent of 10- to 17-year-old children in Texas are considered obese (Centers for Disease Control and Prevention 2009, Robert Wood Johnson Foundation 2011).

High school youth
Out of every four Dallas-area high school students, one is overweight or obese. And the behaviors reported by these youth in the Texas 2011 Youth Risk Behavior Survey do not indicate that there is momentum to reduce this alarming statistic:

- Just 44 percent report being active for 60 minutes each day.
- Only 17 percent eat fruits and vegetables five or more times a day.
- Almost 40 percent drink at least one sugar sweetened beverage each day.
- Additionally, 40 percent report watching three or more hours of TV on an average school day (Texas Department of State Health Services 2011).
Childhood obesity impacts some children to a greater extent

While childhood weight issues impact all communities, there seems to be disproportionate impact on minority children. White children and adolescents ages 2-19 have a 29 percent rate of obesity and being overweight, whereas their Hispanic and African-American counterparts have rates of 38 percent and 36 percent, respectively. The prevalence of childhood obesity has risen among all racial and ethnic subgroups over the years, but the growth has been more pronounced for communities of color. Childhood obesity rates among non-Hispanic whites it grew by 50 percent between 1986 and 1998, but among African Americans and Hispanics the rates increased by about 120 percent.

Researchers have found that the epidemic in these communities is a multifactorial issue that will not be effectively addressed by a single or simple intervention. Some of the intervening factors that affect obesity rates in Hispanic and black communities include eating patterns and accessibility to healthy food options, lower levels of physical activity, the quality of the built environment, social or cultural attitudes around body weight, and reduced access to primary care and nutritional counseling. These factors may be driven by income, culture, and other dynamics that result in a disproportionate rate of obesity among black and Hispanic youth (Whelan 2010).

Childhood obesity impacts homes, schools, community, and work places

Research indicates that overweight and obese children may:

- Incur more health care expenses.
- Miss more school. As a result, schools miss out on attendance revenue and parents and guardians are more frequently absent from work, impacting paychecks and workplace productivity.
- Do worse on standardized tests than their schoolmates with healthier weights.
- Experience more discipline problems than their schoolmates with healthier weights.
- Be more likely to be teased and bullied by peers and ultimately drop out of school before graduating.

Obese children have greater than a two-thirds chance of remaining obese at age 35 and suffering lifelong health and productivity consequences. Obesity in adulthood contributes to an increased likelihood of diabetes, cardiovascular disease, and some forms of cancer. According to the state comptroller's office, obesity already costs Texas businesses more than $3 billion per year. If the problem goes unaddressed, by 2025 that cost will climb to nearly $16 billion. Based on the current number of obese children, the number of obese adults is expected to triple the state’s adult obesity rate by 2040 (Children’s Medical Center 2011).
When children are obese and inactive, they are much more likely to develop early onset of one or more of 20 chronic diseases. These health problems have a significant impact on a child’s physical and emotional well-being and their ability to learn and lead productive lives.

Poverty and weight related issues frequently present together
In a national sample of almost 7,000 children, childhood food insecurity was associated with overweight (Casey 2006). Poor diet is just one of the reasons that our children are becoming heavier. High-calorie foods with minimal nutritional value can often be a staple for families that are food insecure or on the cusp of being food insecure and are trying to make their food dollars stretch.

While research indicates that families know high-calorie food with minimal nutritional value (ramen noodles, macaroni and cheese, other pre-packaged boxed meals) are not the “healthiest” choice, it is often the best or only choice they may have if their children are going to have any meals at all.

Relationship between hunger and obesity cannot be overlooked
According to current data, Texas has the second highest rate of adult hunger in the country, and the highest rate of child hunger. (United States Department of Agriculture 2011). Over the last three years, approximately 28 percent of Texas households, including more than one in three children, experienced hunger. Research indicates that families and children who are hungry are at greater risk for obesity because they often have more limited access to healthy food choices.

An alarming 192,502 of the 654,263 children in Dallas County live in hunger and poverty. Dallas Cowboys Stadium could be filled twice and still not accommodate all of Dallas County’s children affected by hunger (Children’s Medical Center 2011). In Dallas County, 64 percent — more than 300,000 children — enrolled in public school live in households that are at or below 185 percent of the poverty level, making them eligible for free and/or reduced-price meals. In Dallas ISD, student eligibility for the free and reduced-price meal program soars to more than 84 percent (Texas Education Agency 2011).
Food insecure children are more likely to be overweight or obese

- In two national samplings of almost 13,500 children, childhood food insecurity was associated with children being overweight or obese (Casey 2006, Townsend 2009).

- A three-city study of 1,011 adolescents in Boston, San Antonio, and Chicago found that the combination of maternal stress and adolescent food insecurity significantly increased an adolescent’s probability of being overweight or obese (Lohman 2009).

- One study using a national sample of 8,693 infants and toddlers found an indirect association between food insecurity and overweight rates that operated through parenting practices and infant feeding practices (Bronte-Tinkew 2007).

- Among 2- to 5-year-old girls — but not boys — in Massachusetts participating in WIC, those from food insecure households with hunger had 47 percent higher odds of being obese compared with those from food secure households (Metallinos-Katsaras 2009).

Sources


http://www.tea.state.tx.us/index2.aspx?id=2812&menu_id=2147483656


Dallas County leaders take action
In December 2011, having completed two years of foundational work related to childhood obesity in Dallas County and eager to move forward to the next level, Dallas Regional Chamber of Commerce Health Care Initiative co-chairs Eduardo Sanchez, MD, vice president and chief medical officer of Blue Cross Blue Shield of Texas; and George Manning, Texas region partner-in-charge at Jones Day, called upon Susan Hoff, senior vice president of community impact, United Way of Metropolitan Dallas.

Together, they agreed that the Dallas Regional Chamber Health Care Initiative would become a steering committee committed to developing, funding, implementing and evaluating a comprehensive, regional strategic plan to improve children’s health, decrease chronic diseases, and reduce childhood obesity. This steering committee, now called the Committee for the Improvement of Child Health and the Eradication of Childhood Obesity in Dallas County, galvanizes the process and provides the United Way of Metropolitan Dallas with the organizational leadership necessary to develop the plan. Organizations with member representatives include Blue Cross Blue Shield of Texas, Children’s Medical Center, The Cooper Institute, Dallas Area Coalition to Prevent Childhood Obesity, Dallas County Medical Society, Dallas ISD, Dallas Regional Chamber, DFW Hospital Council (DFWHC), Genesis Physicians Group, Jones Day, Oncor, Parkland Health and Hospital System, PricewaterhouseCoopers LLP, and United Way of Metropolitan Dallas (Appendix B).

Stakeholders address needs and establish a plan
In November 2011, a diverse group of stakeholders came together for the Children’s Health Summit, co-hosted by United Way of Metropolitan Dallas, the Dallas Regional Chamber, and the Cooper Institute. This community-wide conversation provided a deeper understanding of regional work and efforts currently underway and highlighted areas in which work would need to be done to improve children’s health and reduce childhood obesity. The work of this summit was chronicled in the Health Summit Report.

Working from the information garnered at the Children’s Health Summit, five stakeholder subcommittees (Appendix C) participated in a facilitated process to develop strategies and tactics to improve children’s health and reduce childhood obesity in Dallas County. In this process, they identified data gaps and research opportunities, and documented tools for evaluation and measures for success.

The subcommittee members were challenged to develop strategies to improve child health and reduce childhood obesity based on a paradigm of prevention. As the paradigm has been successful in bringing change in tobacco use and seatbelt laws within a generation, the Spectrum of Prevention tools — based on the work of Larry Cohen at the Prevention Institute — were used to guide the process and test the strategies (Appendix D). The Spectrum of Prevention is a broad framework of seven strategies designed to support the consideration of complex, multifactorial health issues that require the
collaborative engagement of multiple groups, organizations, industries, and stakeholders. This model is designed to result in real, sustained change.

Texas has a statutory mandate under which all school districts are required to implement a Coordinated School Health program in grades K-8. Coordinated School Health is a systemic approach for promoting health and advancing student academic performance. By promoting, practicing, and coordinating school health education and services for the benefit and well-being of students, it aims to establish healthy behaviors designed to last for students’ lifetimes. Subcommittee members were challenged to consider implementations that could be made through the Coordinated School Health framework to capitalize on the educational mandate and increase ease of plan adoption (Appendix E).

At the federal level, Healthy People 2020 reaffirmed the overarching goals from Healthy People 2010 and added:

- Promoting quality of life, healthy development, and healthy behaviors across life stages.
- Creating social and physical environments that promote good health and the attainment of longer lives free of preventable disease.

The subcommittee gave consideration to the goals of Healthy People 2020 and paid additional attention to the newly added goals (Appendix F).

The subcommittees embraced the Centers for Disease Control and Prevention Framework for Program Evaluation as the tool to ensure a systematic way to consider, improve, value, and understand the health activity delivered through the plan (Appendix G).

*Charting the Course for a Healthy Future: A plan to improve child health and eradicate childhood obesity in Dallas County* is a comprehensive, coordinated, regionally strategic plan to improve children’s health, decrease chronic health conditions, and reduce — and eventually eradicate — childhood obesity in the Dallas County.

“The consequences of today’s high rates of obesity have two broad dimensions. The first is the direct and sometimes devastating health and social consequences to individuals—the potential for illness or disability, social ostracism, discrimination, depression, and poor quality of life. The second dimension encompasses the indirect effects of obesity on a society, reflected in population fitness, health care costs, and other aspects of the economy.”

— Institute of Medicine, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*, 2012
Strategy 1: Assessment
Understand the magnitude of the health and weight challenges children in Dallas County face and the programs and services available to support them and their families as they address these challenges.

Strategy 2: Stakeholder Engagement
Engage stakeholders to improve children’s health by reducing and eventually eradicating childhood obesity in Dallas County by establishing a common agenda with shared metrics and mutually reinforcing activities.

Strategy 3: Focus on Schools
Support and assist Dallas County independent school districts to comprehensively integrate Coordinated School Health and implement a Texas Educational Agency–adopted Coordinated School Health curriculum. Engage child care and out-of-school-time programs to implement extension and complementary programs, as well as elements of the adopted curriculum.

Strategy 4: Activity Access
Expand throughout the community opportunities for daily moderate-to-vigorous physical activity in early childhood programs, schools, and out-of-school-time programs, including structured and unstructured, and indoor and outdoor options.

Strategy 5: Good Food Access
Provide access to healthy foods and quality, affordable, fresh produce in Dallas County schools, neighborhoods and communities.

Strategy 6: Influence Decision Makers
Teach and empower leaders, stakeholders and health care professionals to advocate for and implement evidence-based strategies to eradicate childhood obesity in community-based programs.
**Strategy 1: Assessment**

Understand the magnitude of the health and weight challenges children in Dallas County face and the programs and services available to support them and their families as they address these challenges.

**Tactic 1:1**

Annually quantify the number, location, and demographic profile of children presently and projected to be overweight or obese.

**Measure 1:1**
- Year 1 = Identify and map Year 1 baseline data.
- Year 2 = Map and contrast Year 1 and Year 2 data sets.

**Tactic 1:2**

Identify and rank the areas in Dallas County with significant incidence of at risk, overweight, and obese children.

**Measure 1:2**
- Year 1 = Identify and map Year 1 baseline data and ranking areas
- Year 2 =
  - Map and contrast Year 1 and Year 2 data sets to demonstrate impact within neighborhood school communities.
  - Map and contrast ranking from Year 1 and Year 2 based on delivery of services, interventions, and educational outreach.
  - Create a Year 3 plan for action based on the comprehensive findings of Years 1 and 2.
Tactic 1:3
Annually identify and catalog the programs and services in Dallas that (a) are available to families with children at risk of becoming or already overweight or obese, (b) are consistent with the intent of the strategies of the plan and (c) improve a child’s risk status.

Measure 1:3
✓ Year 1 = Establish baseline data marks.
✓ Year 2 =
  o Assess progress on continuum relative to YMCA of USA Community Healthy Living Index assessment markers.
  o Develop a neighborhood school–based resource guide to identify programs and services available, which can be used to inform parents and other stakeholders, and guide program investment.
  o Create a report that identifies gaps in programs and services needed but not available in a community or not to scale, to inform stakeholders and guide program development.
Tactic 2:1
Develop a mixed-media, comprehensive communication plan to deliver a simple, countywide public message that articulates the magnitude of the need in Dallas County.

Measure 2:1
✓ Year 1 = Develop messaging campaign with benchmarks that would include changes in behaviors relative to the goals of the campaign.
✓ Year 2 =
  o Implement campaigns in targeted communities based on rankings developed in Tactic 1:2.
  o Evaluate outcomes, including changes in behaviors measured and mapped.

Tactic 2:2
Increase and diversify district and neighborhood School Health Advisory Committee membership to include stakeholders with an interest in ensuring that Dallas County children have healthy school environments with strong ties to and support from the community.

Measure 2:2
✓ Year 1 =
  o Establish baseline data, including the number and profile of the committee membership.
  o Identify and engage local, community, and state legislative champions.
✓ Year 2 =
  o Improve on Year 1 baseline data marks.
  o Report back on accomplishments and impact of School Health Advisory Committees.

Tactic 2:3
Collaborate and coordinate to deliver complimentary programs and services that promote child health through the maintenance of a healthy weight, reduce the number of overweight children and eventually eradicate childhood obesity in Dallas County.

Measure 2:3
✓ Year 1 = Establish baseline data marks.
✓ Year 2 = Evaluate maturation of Community Healthy Living Index markers, attainment of plan benchmarks, reduction of poor child-health risk factors, and increases in number of children with healthy weight.
Tactic 2:4
During all well-child visits, medical providers assess Body Mass Index, communicate concerns, suggest strategies to address a child’s BMI, and, when indicated, make referrals to appropriate, evidence-based intervention programs for children at risk of becoming, or already overweight or obese.

Measure 2:4
✓ Year 1 = Establish baseline data marks.
✓ Year 2 = Improve on Year 1 baseline data marks.

Tactic 2.5
Educate and encourage the practice of breastfeeding infants for the first six months of life.

Measure 2.5
✓ Year 1 = Establish baseline data marks.
✓ Year 2 = Improve on Year 1 baseline data marks.
Strategy 3: Focus on Schools

Support and assist Dallas County independent school districts to comprehensively integrate Coordinated School Health and implement a Texas Educational Agency–adopted Coordinated School Health curriculum. Engage child care and out-of-school-time programs to implement extension and complementary programs, as well as elements of the adopted curriculum.

Tactic 3:1
Collaborate with school districts, charter and private schools and districts, and child care and out-of-school-time programs to acquire the resources necessary to implement regionally a Texas Education Association–adopted Coordinated School Health curriculum and the extension and complementary components that provide a continuum of implementation and a consistent message throughout the child’s day.

Measure 3:1
✓ Year 1 = Catalog curriculum and contact for each district.
✓ Year 2 = Assess the degree to which the curriculum has been implemented and the level of support provided by leadership to ensure effective implementation of that curriculum.

Tactic 3:2
Ensure that adequate training opportunities are available to — and attended by — parents, administrators, educators, stakeholders, and volunteers so they are empowered to implement all components of the Texas Education Association–adopted Coordinated School Health curriculum in the classroom, school environment, home environment, and early childhood and out-of-school-time programs.

Measure 3:2
✓ Year 1 =
  o Establish baseline data marks.
  o Deliver each quarter showcase pieces that highlight successes.
  o Produce an annual report to be presented at the summit.
✓ Year 2 =
  o Improve on Year 1 baseline data marks.
  o Produce and present at the summit an annual report with highlights of progress made from Year 1 to Year 2.
Strategy 4: Activity Access

Expand throughout the community opportunities for daily moderate-to-vigorous physical activity in early childhood programs, schools, and out-of-school-time programs, including structured and unstructured, and indoor and outdoor options.

Tactic 4:1
Facilitate the establishment of joint-use agreements between schools, community centers, churches, parks and recreation centers, and other partners to support multipurpose, collaborative uses of existing facilities to enhance physical activity.

**Measure 4:1**
- ✓ Year 1 = Establish baseline data marks.
- ✓ Year 2 = Improve on Year 1 baseline data marks.

Tactic 4:2
District School Health Advisory Committees develop and implement wellness policies that embrace child health best practices.

**Measure 4:2**
- ✓ Year 1 =
  - o Establish baseline data marks, including the identification of Dallas County independent school districts’ wellness policies.
  - o Assess wellness policies for strengths and gaps in advocating for best practices associated with reducing factors that may increase the risk for childhood obesity.
- ✓ Year 2 = Improve on Year 1 baseline data marks.
Strategy 5: Good Food Access
Provide access to healthy foods and quality, affordable, fresh produce in Dallas County schools, neighborhoods and communities.

Tactic 5:1
Support the delivery of the USDA School Breakfast and School Lunch program at schools in Dallas County.

Measure 5:1
✓ Year 1 = Establish baseline data marks.
✓ Year 2 = Improve on Year 1 baseline data marks.

Tactic 5:2
Support US Department of Agriculture, Texas Department of Agriculture, and other government-funded initiatives to provide healthy food for children.

Measure 5:2
✓ Year 1 = Establish baseline data marks.
✓ Year 2 = Improve on Year 1 baseline data marks.

Tactic 5:3
Facilitate the expansion of joint-use agreements that expand use of existing facilities to establish gardens, farm stands, community-supported agriculture programs, North Texas Food Bank fruit and vegetable delivery spots, and Healthy Corner Store and complementary merchandising initiatives.

Measure 5:3
✓ Year 1 = Establish baseline data marks.
✓ Year 2 = Improve on Year 1 baseline data marks.
Tactic 6:1
Support local, state, and national efforts that encourage children to maintain a healthy lifestyle and weight.

Measure 6:1
- Year 1 = Establish baseline data marks.
- Year 2 = Improve on Year 1 baseline data marks.

Tactic 6:2
Support local policies that increase access through zoning, community-based initiatives, and legislative prioritization.

Measure 6:2
- Year 1 = Identify effective policies; policies that require modification, updating and/or repealing; and policies that need to be implemented or passed.
- Year 2 = Assess success in supporting effective policy, achieving modification to targeted policies, and updating and/or repealing of targeted policies. Catalog the number of policies advocated for that were passed and/or implemented.

Tactic 6:3
Collaborate with other state and national agencies and organizations to collectively support commonly embraced legislative agenda items.

Measure 6:3
- Year 1 = Identify and advocate for three to five legislative priorities.
- Year 2 = Assess outcomes of Texas’ 83rd legislative session.
Fall 2012 – Spring 2013: Phase 1
Get expertise and diverse opinions in developing a comprehensive community plan:

- Formal agreement to engage stakeholders in efforts. Include role, responsibilities, deliverables expected, and outcomes to be gained by engaging with the organization.
- Host a “Blue Ribbon Commission” meeting to secure commitment and support from high-level decision makers in Dallas County.
- Identify a well-known and respected champion for children’s health in the Dallas community to help deliver the plan’s messages.
- Engage and collaborate with existing coalitions that have a similar and/or complementary focus on impacting children’s health and fitness.

Spring-Summer 2013: Phase 2
Expand strategic partnerships and focus on the development of a feasible timeline and fundraising plan to implement various aspects of the children’s health plan:

- Children’s Medical Center would assign a “loaned executive” to support staff leadership in the development of relationships, implementation plans, and oversight and management of deliverables.
- Development of fundraising plan to establish the infrastructure needed to achieve the desired outcomes of the children’s health plan.

Fall 2013: Phase 3
Continue to engage community participants and begin collecting solid community data:

- Deliver quarterly (or timely) alerts to subcommittee members to inform and educate on community successes, new data, and identified best practices associated with child health and the maintenance of healthy weights.
- Engage undergraduate, master’s level and doctoral student interns from local university programs to begin community assessment process. Consideration for public policy; health and nutrition; dietetic; education; business management, marketing, and consumer behavior; behavioral economics; agriculture and agricultural education; and ExxonMobil and AmeriCorps/VISTA students.
- Explore the feasibility of implementing a collaborative, community-wide educational event or conference to bring together other community events to maximize scale and resources.
- With secured funding, hire full-time staff to focus on the establishment of the “backbone” organization to implement plan.

Sustaining the Momentum
At its core, *Collective Impact* is the collaboration of members from different institutions working together to promote a common agenda to help solve an adaptive social problem. For example, in order to improve student achievement in public schools with the Collective Impact model, it would be necessary for community leaders, parents, school district representatives, university presidents, directors of education-focused nonprofits, and others to come together to form a collective plan in order to help make a bigger impact in addressing the issue.

Collective Impact is a strategy for solving adaptive social problems and there are five main conditions necessary for success:

- **Common agenda**: Participants must have a shared vision for change or a common agenda that includes a mutual understanding of the problem as well as a shared approach to solving it.

- **Shared measurement system**: In order to bring consistency, clarity, and legitimacy to the endeavor, it is necessary to form a shared measurement system for data collection.

- **Mutually reinforcing activities**: Collective Impact requires that each participant undertakes a specific set of activities that support and synchronize with the actions of others.

- **Continuous communication**: Participants need to be in constant communication to use Collective Impact effectively, and it may take months to build the trust required to efficiently work together.

- **Backbone support organization**: A backbone organization is needed that can plan, manage, facilitate, organize, coordinate, communicate, provide technology and communications support, collect and report data, handle administrative and logistical issues, and provide adaptive leadership, such as framing the issue in a way that presents opportunities and difficulties.

The Dallas Regional Chamber Health Care Committee and United Way of Metropolitan Dallas developed a steering committee to ensure continued engagement of key organizations, community leaders, and stakeholders in the region that are committed to improving children’s health and decreasing the number of cases of childhood obesity in the Dallas area. The steering committee’s purpose is to establish define a set of key principles, goals, and measures used to create a regional strategic plan designed to improve children’s health and, in time, decrease chronic diseases. The steering committee will apply the Healthy People 2020 implementation framework and, through this effort, the steering committee will become the convener and catalyzing unifier of all organizations involved in the childhood health and childhood obesity space in the Dallas region.

The mission statement of the committee is to “convene and catalyze partnerships between all organizations that are developing best practices and behavioral changes that improve children’s health in the DFW region and work towards reducing and eventually eradicating childhood obesity in North Texas.”

Eduardo Sanchez, MD, Co-chairman
Blue Cross and Blue Shield of Texas

George Manning, Co-chairman
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Vanessa Walls
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Appendix C: Project Subcommittee Members

**Advocacy**

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Michaela Bernacchio  Assistant Director, North Texas  Children @ Risk  
Matt Moore  Public Policy Associate  Children’s Medical Center  
Lauren Mish  Chief of Staff  Dallas County Commissioners Court  
Marc Jacobson  Public Policy Associate  Jewish Community Relations Council  
Kelli Thomas-Drake  Community Volunteer  Leadership Dallas Class of 2012  
Jenna Williams  Project Manager  National Initiative for Children’s Healthcare Quality (NICHQ)  
Kimberly Carlisle  General Council  The Paper Plate  
Angela Morris  Legislative Affairs  Parkland Health & Hospital System  
Joel Ballev  Director, Government and Community Affairs  Texas Health Resources  
Stephanie Werner  Director, Public Policy  United Way of Metropolitan Dallas

**Community**

Jeannine Rios  Regional Director  Alliance for a Healthier Generation  
Amy Johnson  VP, Strategic Initiatives  American Heart Association  
Joy Winand  Administrative Director/Co-Chair  Children’s Medical Center and Community Council/DACPCO  
Tammy Chan  Special Projects Manager  City of Grand Prairie  
Ben Leal  Executive Director  Jubilee Park  
Lisa Braken  Manager, National Outreach  KERA Channel 13  
Walter Nguyen  Executive Director  Mosaic Family Services  
Kim Aaron  VP, Policy, Programs and Research  North Texas Food Bank  
Debbie Dennis  Vice President  Oncor/Mayors Fitness Initiative  
Sue Pickens  Director of Strategic Planning & Partnerships  Parkland Health & Hospital System/Vision North Texas  
Victoria Wilson  Special Assistant to President  Paul Quinn College  
Kimberly Clay  Executive Director  Sisterbration  
Rebecca Walls  Executive Director  UNITE  
Jessica Galleshaw  Director, Health Initiatives  United Way of Metropolitan Dallas

**Health Care**

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Lexie McGrane  Dallas County Family & Consumer Science Agent  Texas AgriLife Extension
Danny Henley  Education Consultant  Zero to Five Funders' Collaborative
Caroline O'Brien  Community Volunteer

School Child Care and Out-of-School Time

Kathleen Powell  President, Texas Chapter  Association of School Nurses
Daneshe Bethune  Regional Executive Director  Big Brothers Big Sisters
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The Spectrum of Prevention helps expand prevention efforts beyond education models by promoting a multifaceted range of activities for effective prevention. Originally developed by Larry Cohen while he was director of the Contra Costa Health Services Prevention Program, the spectrum is based on the work of Dr. Marshall Swift in treating developmental disabilities. It has been used nationally in prevention initiatives targeting traffic safety, violence prevention, injury prevention, nutrition, and fitness.

The spectrum identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is about teaching healthy behaviors. The spectrum’s six levels for strategy development (listed below) provide a framework for a more comprehensive understanding of prevention. These levels are complementary and, when used together, produce a synergy that results in greater effectiveness than would be possible by implementing any single activity. At each level, the most important activities related to prevention objectives should be identified. As these activities are identified, they will lead to interrelated actions at other levels of the spectrum.
The healthy development of children and adolescents is influenced by many societal institutions. After the family, the school is the primary institution responsible for the development of young people in the United States.

- Schools have direct contact with more than 95 percent of our nation’s young people aged 5-17 years, for about 6 hours a day, and for up to 13 critical years of their social, psychological, physical, and intellectual development.
- Schools play an important role in improving students’ health and social outcomes, as well as promoting academic success.

School health programs and policies in the United States have resulted, in large part, from a wide variety of federal, state, and local mandates, regulations, initiatives, and funding streams. The result, in many schools, is a “patchwork” of policies and programs with differing standards, requirements, and populations to be served. In addition, the professionals who oversee the different pieces of the patchwork come from multiple disciplines: education, nursing, social work, psychology, nutrition, and school administration, each bringing specialized expertise, training, and approaches.

Coordinating the many parts of school health into a systematic approach can enable schools to:

- Eliminate gaps and reduce redundancies across the many initiatives and funding streams.
- Build partnerships and teamwork among school health and education professionals in the school.
- Build collaboration and enhance communication among public health, school health, and other education and health professionals in the community.
- Focus efforts on helping students engage in protective, health-enhancing behaviors and avoid risk behaviors.

**Coordinated School Health is recommended by the Centers for Disease Control and Prevention as a strategy for improving students’ health and learning in our nation’s schools.**
Healthy People 2020 is the result of a multiyear process that reflects input from a diverse group of individuals and organizations. Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Overarching goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.
A practical, non-prescriptive tool, the evaluation framework summarizes and organizes the steps and standards for effective program evaluation. A strong evaluation approach ensures that the following questions will be addressed as part of the evaluation so that the value of program efforts can be determined and judgments about value can be made on the basis of evidence:

- What will be evaluated (that is, what is "the program" and in what context does it exist)?
- What aspects of the program will be considered when judging program performance?
- What standards (that is, type or level of performance) must be reached for the program to be considered successful?
- What evidence will be used to indicate how the program has performed?
- What conclusions regarding program performance are justified by comparing the available evidence to the selected standards?
- How will the lessons learned from the inquiry be used to improve public health effectiveness?

The Centers for Disease Control and Prevention evaluation framework provides a systematic way to approach and answer these questions using a set of six steps and four standards.

**Effective program evaluation is a systematic way to improve and account for public health actions. Evaluation involves procedures that are useful, feasible, ethical, and accurate.**
## Appendix H: Funding Needs for Year-one Implementation and Evaluation of Impact

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's health collaborative coordinator, full-time staff salary and benefits</td>
<td>$100,000</td>
</tr>
<tr>
<td>Supplies and materials for meetings, outreach, etc.</td>
<td>$20,000</td>
</tr>
<tr>
<td>Mileage and transportation</td>
<td>$15,000</td>
</tr>
<tr>
<td>Professional development costs (conferences, seminars, etc.)</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Specific tactical costs:</strong></td>
<td></td>
</tr>
<tr>
<td>• Tactics 2:1 and 6:1: Implementation of trainings and development of materials</td>
<td>$20,000</td>
</tr>
<tr>
<td>• Tactic 2.1: Development and implementation of community-wide marketing campaign</td>
<td>$100,000</td>
</tr>
<tr>
<td>• Tactic 2.3: Annual health summit; target: 200 participants</td>
<td>$20,000</td>
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<tr>
<td>• Tactic 3:1: Annual conference to promote coordinated school health; target: 500 participants</td>
<td>$50,000</td>
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<tr>
<td>Annual report</td>
<td>$5,000</td>
</tr>
<tr>
<td>Evaluation costs: third-party evaluator or Ph.D. students</td>
<td>$50,000</td>
</tr>
<tr>
<td>Indirect costs and operational support (15%)</td>
<td>$57,750</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$447,750</td>
</tr>
</tbody>
</table>