PHI – State of Obesity, 2019: Better Policies for a Healthier America
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Remote CART Captioning

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>> Welcome to State of Obesity, 2019: Better Policies for a Healthier America.
My name is Kathy Piazza and I'm running this forum with my colleague Tonya Hammond. We thank our partner in this event is Trust for America's Health. Audio for this web forum is through your computer speakers or headphones. Click the icon on participant's panel if you need dial-in information. Realtime captioning is provided by Donna for home team captions. Click the icon with three dots at bottom of your screen. On right side of your screen, locate link in captioning panel that says show, hide, header. If the captioning disappears, click the media again to bring it back. Share your thoughts and questions about today's presentation by typing them in Q&A box. Click the panel by clicking the three dots on the screen. Q&A panel on right side of your screen, select all panelists. Get your question sent to right place. We want to hear from you via a quick poll. Polling panel will open up on the right side of your screen in just a moment. We would like to know the sector that represents you. Select all that apply. Once finished. Click submit button. This is take a moment to tally the results. Wanted to remind everyone if multimedia disappears, click the circle with three dots at bottom of your screen to bring it back. Be sure to get your questions in Q&A panel so that we can answer those throughout the program.

While the poll is continuing to tabulate the as a results, my pleasure to introduce to you John Auerbach, the moderator of the event. President and CEO for Trust for America's Health whether where oversees then to make disease prevention a national priority. Over a course of 30-year career, held positions at federal, state and local levels. John, welcome back.
>> Thank you, Kathy. Welcome to our many registered participants in this web forum. We are glad you will be joining us for discussion of important issue. Let me thank the Robert Hood Funding Organization whose funding makes this possible to occur. They have been a consistent leader in addressing child and adult obesity. I'm John Auerbach the president and CEO of Trust for America's Health. Following the release of our recent obesity report, we held a briefing on Capitol Hill on November of 2019 on the topic of obesity. We were pleased that there was standing room only as staff from numerous offices listened to our panel of experts. We decided to invite the same panelists to national Web forum. We find a high level of interest as 2,000 people quickly pre-registered for the webinar.

In some ways, this is no surprise as our panelists had a lot of insight into what was

necessary to finally reverse the dangerous trajectory of obesity epidemic. Let me introduce our panelist. Each one has remarkable history of addressing these issues. I will keep my introductions brief. I would encourage you to look at more complete biographies by consulting your web browser. Dr. Ruth Petersen director of CDC division of physical activity and obesity. Martha Halko is for the Cuyahoga County Board of Health that represents Cleveland, Ohio and surrounding area. And Devita Davison who is executive director of FoodLab Detroit. We will have time for discussion and questions from you. Feel free to send your questions at any time, we will queue them up. I will provide a recap of our 16th annual edition of state of obesity report funded by Robert Johnson foundation. A copy available at tfah.org. My hope for this web forum is that you will all leave knowing the latest data and trends for obesity in the country and steps needed to relieve the epidemic.

This slide shows that adult obesity rates are still climbing. More than half of adults in every state either overweight or have obesity. In 2012, no state had an obesity rate over 35%. By 2018, nine states did. And in the year 2000, West Virginia was the most obese state in the country with adulterate adult rate of 23%. Colorado was least obese and had a 23%. Worse percentage for obesity is best in the state. Disturbing trend.

The 2019 state of obesity report has a special section that focused on racial and ethnic disparities in obesity and includes policies. This is looking at range of issues that contribute to elevated rates and solutions that are a rising from the communities most effected themselves.

The data show that obesity levels are highest young African-American and Alaska native populations. Primary factors are social and economic condition that is result in few affordable and accessible options for healthy foods and physical activity as well as the disproportion of healthy food to these populations.

This section highlight that is poverty and institutional racism are major factors in inhibiting progress. And the ways that we should support the residents of those communities. You will hear about that our panelists.

Like adults, the number of rate of children with obesity is rising. In 2016, 18.5% of children between the ages of 2 and 19 had obesity. That's the highest rate of obesity ever documented since childhood obesity data began to be collected by federal agency.
Since 1976, childhood obesity rates have more than tripled. And focus on childhood particularly at youngest ages is important preventing is easier than reversing it later. So many programs are focused at school and preschool levels.

It's always worth highlighting that concern with obesity is due to devastating negative impact on health. Increases the risk of Type II Diabetes, blood pressure, arthritis and certain types of cancer and musculoskeletal problems as well. Obesity on baby boomers will shorten life expectation and increase costs for Medicare. And creates a national defense risk as one in three adults are ineligible to serve in military with obesity as principle obstacle.

If we're going to reverse the trend, we need to invest in obesity prevention programming. Unfortunately, as obesity has increased, much of preventive funding has decreased. Accounting for inflation CDC has fallen 10% as have state and local health departments. This is quite striking because 40% of the U.S. population has two or more chronic diseases. 90% of the annual healthcare expenditures are for people with chronic and mental health conditions. Because of obesity, Medicare and Medicaid pay about $75 billion in additional medical costs each year. Yet, in 2019, total federal funding for CDC chronic disease prevention activities amounted to $4 per person. Much lower amount than cost of treating the conditions that result.

Fortunately, good news. That concerns policies and practices that work. In recent years, we had notable examples. Women, Infants, and Children program. While children obesity rates have risen, rate for young children ages 2 to 4 enrolled in WIC program has fallen from 16% in 2010 to 14% in 2016. This is likely due to changes of WIC food package in 2009 where fruits, vegetables and whole-grain in infant farm -- formula added. Second success story involves re-sent evaluations -- recent evaluations on taxation on sugar beverages. Taxes on sugary beverages can change consumer behavior quickly. Since enacting a sugar sweetened beverage tax, citizens have purchased fewer drinks and stocked more bottle water and less soda. Other cities and countries have seen similar reductions in consumption when taxes have increased on sugar sweetened beverages. State of obesity 2019 report offers over 30 recommendations in several key areas. Among the recommendations are following. Increase prevention funding, especially at CDC and in it's state physical activity and nutrition or SPAN program. Focus on strategies or for strongest evidence based. Expand them and increase them to scan. Fund comprehensive approaches that cut cross sectors and government agencies. Think about changes systems and not just funding limited programs. Promoting equity is key. Focus attention on those populations that bear a disproportionate problem of obesity and work to change those conditions in those communities.

Last two points are important since obesity is symptomatic and responsive to broader social issues like poverty and institutional racism. Solutions that span multiple categories as represented by this visual can lead to better and more equitable outcomes. We need to do such things as pay attention to those factors. With food, that means everything from farm to table, including governmental subsidies for healthy foods. Support for SNAP program. Local development support that fosters -- communities and school foods and end to marketing of unhealthful products.

With physical activity, means such things as complete streets, major transportation projects, bikers and walkers, safe routes to school and school recess. They need to set the priorities and leading the plan and implementation.

In addition to federal recommendation, reports includes ones directed to states and locals. Including enacting street scape design to increase outdoor physical opportunities. Strengthening school nutrition beyond the 2012 federal government standards including length of mealtime and appropriate time for meals and recess before lunch and considering the pricing of sugary drinks with use of taxes as I mentioned earlier.

This concludes my presentation. Again, you can find more information on the report at our website at tfah.org. With that, it's my pleasure to start our panel presentations. At end of presentations, we will have a question and answer session. You can submit questions and answers at any time during the program as Kathy mentioned.

I want to poll you again before the first panelist. Poll number two is on the screen. Asks, what is most likely to motivate you to increase your physical activity? Read through the options listed there begin to vote. We should have results in matter of seconds.

>> Remember to click the submit button as soon as you are finished. Thank you.

Looks like poll is closed. The results are tallying. You should be able to see them on the right side of your screen.

>> Because we have so many people on this webinar, takes a little bit longer to do the polling. We expect to see that. Now we do. We can see that the number one reason that you have indicated is that improves the quality of life. About 331 of you said that. Next was it helps me feel good about myself.

That is followed by improving my personal appearance. And lowering my risk for heart disease. There is another one also up there that was making me feel physically fit. Thanks. Clearly a lot of different reasons why it makes sense to increase one's physical activity. Now, great pleasure to introduce Dr. Ruth Petersen who is director of CDC physical activity and obesity center CDC. In her current role. Outstanding job in leading nation in work to prevent obesity. We look forward to hearing from you, Dr. Petersen.
>> We're not hearing you yet, Ruth. Looks like the slides did advance. I'm not hearing your audio just yet. Let me un-mute your audio.
>> Can you hear us now?
>> Yes.
>> Thanks. Thank you, John for the introduction. Happy to be a participant on this panel to discuss the CDC part. As John mentioned, there are numerous data sources we have about obesity to show the burden in the TFAH report. I wanted to give you a visual from CDC data that is similar to what John uses from TFAH report that shows the zones of obesity. Adult obesity continues to remain high across the United States. It's important to start to break this down into race and ethnicity particulars on burden. These three maps show you the illustration for non-Hispanic blacks and non-Hispanic whites. They have darkest color on the left with 39.1% showing that they report obesity at highest level. Hispanic 33.3% and non-Hispanics whites at 29.3%. You see the biggest burden in south and belts that we worry about for the highest burden of chronic disease across the country.

At DNPAO, we take seriously this burden. And work strategically to try to reach all Americans across their life span to support this healthy start for infants having child and youth grow up strong and healthy and older adults maintain a healthy lifestyle. We know that risk factors that lead to increasing your risk for obesity as an individual are really from the habits that are established early on from nutrition and physical activity. At bottom, some of things that take seriously that drive towards the reduction of obesity but be diabetes and heart disease and cancer. I will talk about this, how we implement these strategies with our grantees in the future slide. Breast-feeding is important. Early toddler nutrition is important. Physical activity and good nutrition access is all included in our work.

Part of the reason that we take the issues of childhood obesity so that we prioritize it so much is because not only of that future risk you saw with the adult maps, but also the immediate issues that childhood obesity causes in our young children. Side effects around different cancer and heart disease and high blood pressure and impaired glucose tolerance. Other things we don't think about as much. Such as bullying and stigma and lower reported quality of life that children who are struggling with obesity experience. They have a lower self-esteem. Anxiety and depression. They have breathing problems many times and musculoskeletal and joint problems that we see in the data who are struggling with childhood obesity. It's costly and preventable. First of all, we know that adult obesity costs 147 billion in our annual medical care costs and that children with excess weight will age into adulthood and add to those cost that is medical system has to take on.

We know that primary care and specialty care are struggling to meet the need of those families that are struggling with childhood obesity. If you look at what is estimated for 10-year-olds for obesity in 2012, if you look at their total medical costs over lifetime, this would amount from 9.4 billion to 14 billion when you measured in $2,012 every lifetime for every one of those children. It's costly and yet it's preventable. Question is, how do we take that information and move into action.

Other models have shown us that if we do nothing differently, if our society doesn't take any immediate actions, their projections to show that by 2050, the majority of today's children will have obesity by the age of 35. So as John mentioned, prevention is key. We want to not have this model come true. We would like to help treat the 13.7 million children between the ages of 2 to 19 that currently have obesity. I would like to point out the data and the good news in WIC participants for those 2 to 4 of years old, we can see the trend data where obesity has decreased among WIC participants since 2010. Line you see with red triangle is overall rate and others are racial groups that we are to track with our colleagues at WIC. This is good news. We would like to continue overtime to see these improvements not only in WIC participants over time but general populations.

What are we doing at CDC to work on this issue? Here is a map of the areas where we have funding across the country. We have recipients from three funding streams. Teal color that is over our whole stated is state physical activity or nutrition program or SPAN. These are generally state health departments and work with local to implement evidence-based strategies that I will talk about in a moment. Really to improve healthy nutrition. Also increase safe and be accessible feeding access and breast-feeding.

And then the HOP program or high obesity program. They work with their community extension services. Eligible to apply if they have a county in their state that has a 40% higher rate of obesity through the data. Where you see a gold tag here, gold pin on the map is where we have a funded land grant university to work in that state in particular counties where the obesity rate is over 30%. Third is REACH program. We have 31 organizations who are working to address racial and ethnic approaches to obesity and other chronic diseases through, again, culturally tailored interventions that address physical activity, tobacco, nutrition and breast-feeding. More to come on funded programs if there are questions. I will move on what we try to have people work on.

We get the question a lot, what do you do at CDC? What do you do with your grantees and recipients. How can we pull the same direction to address the risk of childhood obesity and reduce the prevalent across the country. These are steps that we promote and technical assistance to non-funded areas and work with many organizations. Five steps are to make healthy choices available everywhere. Breast-feeding easier to start and sustain and strengthen prevention standards and early care and education settings and spread and scale pediatric weight management programs. Combination of work that is something that effects the whole community versus things that affect individuals and most of these things take a long time to convene the right partners and get community engagement around to get buy-in from communities. It's all very complicated. I don't mean to simplify with slide. It's an arrow or target for people who want to get into this area and need to understand the complex levels that are required to address childhood obesity prevention and childhood obesity management. This will have influence on adult obesity. Improvement that can be made in systems or communities will not only help to promote the health of children but back to our life course perspective slide. Will promote the health of their families and other people that live in that community.

We are excited at CDC to focus on a new initiative with many of our partners and grantees called active people, healthy nation. We announced this with Surgeon General. The point is to get 27 million more Americans more physically active by 2027. Can reduce healthcare costs and have more quality of life. Will involve using the networks of other organizations to make sure that we are spreading and scaling across the country.

One of the reasons that I ask the poll question that I asked was to get your individual feedback because we are all people first, on what motivated you to increase your physical activity. So when you think about that not only as a risk factor in adult obesity, but then if you are a parent or caregiver, that leads into the motivation that your child learns from you or caregiver. And it's interesting the answers that we are getting from other groups across the country. Sometimes we don't get physical activity because we want to protect ourselves from diabetes or cancer which is the data we show. The more immediate feeling of what responses showed. I want to feel good about myself. I want to be more physically fit. I want to improve our quality of life. We seen this with woman. Interested in improving sleep. Motivation for improving physical activity is important from individual basis. Very important from a community basis and do that in active people healthy nation to make sure that each community allows the healthy choice to be the easy choice to promote not only physical activity but increased access to increased quality of nutrition.

In my last slide here, I want to circle back to also what John noted about the importance of investing in prevention. Everything I have talked about with grantees and with the five action steps for states and communities as well as what we hope to do in active people healthy nation requires investment in prevention strategies. When you look at budgets that we have for nutrition and obesity prevention and control and you take that amount of money out to amount of population there is in the United States, our investment from our division is 31 cents per person per year. If you want any other illustration of how important increasing the investment is, use this slide to illustrate the current ability we have to fund the work. With the work with do, we are proud of it and a return on investment. Point I want to bring to all of you. I look forward to questions at end and hearing from the rest of our wonderful panelists that I had the honor to hear in November. We have one more polling question to pull up, I think.

>> Great, thank you so much, Dr. Petersen, for that great presentation. We do see in front of you our next poll. That poll is asking you, does your current obesity and/or chronic disease work address broader equity issues like poverty and already or structural racism? Take a moment and vote. We will see what that result looks like. While you are voting and waiting for response, I will answer the question that was raised. A question about the source for economic impact data I referred to in my PowerPoint presentation. If you would like to see the source of that data, it's at the TFAH websites. Footnotes 26 and 27. Economic impact data for obesity footnotes 26 and 27 in the latest report. We are ready to look at answer to the poll. The answers show that most people say, yes, they are addressing the broader incompetent issues like poverty and racism. Just more than 300 respondents say that.

Fairly large number about 130 people say that they are not currently doing that but plan to do so in the future. And smaller number 70 say that they respond to question by saying no. Just as reminder before next presentation, all of audio and slides for this Web forum are going to be available to download and available at Dialogue4Health website that you dialed in to. Probably will not be available for -- usually takes almost a week for that to be available. For those of you what like those slides, check the Dialogue4Health Web site in a few days. May take as long as a week. You can access it that way.

Moving on to next speaker, we are delighted to have Martha Halko who is deputy director of prevention and wellness for Cuyahoga County Board of Health. This county is known for strong work. Ms. Halko will show what she oversees. We are looking forward to your presentation.

>> Good morning. As John said, Cuyahoga County is located in northeast Ohio, second most

populous county in the state with Cleveland as our county seat. We are not unlike many of the communities across the country. We have escalating rates of obesity and other chronic diseases that are disproportionately impacting people of color and of those living in poverty in our communities. We built strong relationships with our community members. And more importantly through engagement and partnership with residents, we have seen, heard and learned from our residents, children, families and neighbors that they are suffering from poor health, that really has resulted from limited opportunities that many have in their communities. And it's impacting their ability to achieve their fullest health potential. They are living unhealthier and shorter lives. Great to see those responded to polls that are focusing their work to create that balance of historical issues center structures that I will focus on today while focusing on addressing obesity in highest need communities that you serve.

For us, this is a strong value base. As a partnership, we believe that everyone deserves to live their healthiest lives. We have taken a collaborative approach to making change in our communities. So our local collaborative as I mentioned took a multi sector approach. Our HIP Cuyahoga, initiated in 2009 to address our most pressing health issues. And to address long-standing inequities we seen persist. We focused on collaborative approach to align our partnerships to build trusting partnerships, to align expertise from across sectors. So share data and resources, leverage resources. To better be able to serve our community residents across the continuum addressing many key issues impacting the health of our residents. We recognize early that to create transformational and lasting change, we needed to establish diverse and trusting partnerships. And we collectively committed to shared value and common agenda and improve health for all. Our agency at Cuyahoga County Board of Health has coordinated the HIP and REACH grants with network of key partners and trusted partners and community members. We are parenting with community members and working with key decision-maker level. We are committed to including community residents or those impacted by -- in all equities of our work. Members of community involved in our steering committee. We have community members informing planning, implementation as well as evaluation of our work which really has allowed us to be far more impactful and develop more sustainable model for our efforts.

HIP Cuyahoga partners, we selected four priorities based on community health assessment and robust community input. Now over several rounds of community health assessments. Those requirements include eliminating instructional racism that is racial bias that is woven into the fabric of society through our institutions, policies and practices. And healthy eating, active living, linking health and chronic disease management. Instructional racism is woven through all of our important work. We work across this continuum of addressing these social factors and community conditions which both John and Ruth references would shape the health of our residents and at root of ethnic disparities that we see and work across the continuum to work across chronic disease management.

For Cuyahoga County, the data tells us how our history has impacted our current opportunities to improve health. Greater Cleveland areas is rich in healthcare systems. We consistently rank in the top ten in the state for clinical care. According to -- and we have accessed that information from county health ranks that many of you utilize. Despite our high ranking for community care, we rank in bottom for residents health outcome. We are 86 in physical environment speaking to influence that -- opportunities to be healthy. Clearly demonstrating for us that health is far more than healthcare.

There are significant differences in opportunities to be healthy in our country. Worth is in

urban core would be for us city of Cleveland and suburbs. Where this says idea stream, we recognized -- impact on racial and inequities we see perpetuated today. We elevate that urgency. Recently, we selected through our coordinated health process with local hospitals, social service and community residents and others, we identified and selected structural racism as a key priority that will serve as overarching priority that we develop our three-year implementation plan and local media ideas, pick that up and wrote an article identifying the selection of that -- eliminating structural racism as a priority.

So, we often use maps as a really helpful visual way to depict how race place an income matter for health and life expectation in Cuyahoga County. For us, these series of maps clearly demonstrate how historical policies and practices have shaped the inequities we see today. We done a lot of work in red lines in our community and part of our accompany community health improvement plan. As in many other urban communities, they were red lined. Carried out by banked and helped by FHA that limited loans to people of color in 1930s leading to racial separation and limiting access to wealth creating opportunities such as homeownership. If we look at poverty and obesity and life expectancy, those same neighborhoods still have the worth outcomes and shortest life expectancy in the county. Cleveland residents and poverty. Cleveland, Africa population are more than three times than likely to live in poverty. In addition, in Cleveland, is median income is 2.1 times of black residents.

Looking at obesity information as well, this includes high school obesity data and adult obesity data concentrated in same area of the county. Life expectation for us differed by over 20 years between urban core and first suburbs in relation to outside communities that are shaded in light green and dark green. These stark differences are in distances that are only 6 to 10 miles apart.

So, partners are fortunate to receive funding over the CDC REACH grant awards to reduce the chronic disease in our country. Our REACH work aims to racial disparity through best practices evidence-based and innovative strat strategies. Focus on African-American populations on east side neighborhoods of our community and working collaboratively with our partners and community residents to improve nutrition through better food access. Increased physical activities foster linkage between healthcare clinics and community resources focused on chronic disease management and other community-based prevention programs. I will share highlights of healthy eating and active living work is and our key accomplishments. We believe where people live should not dictate where they access and eat healthy foods. In city of Cleveland, people live in food desserts. Small stores are only focused stores. We improved access at these neighborhood stores through the good food here retail project. Encourages them to stock, maintain and promote healthier food choices for residents and patrons. Our agency works closely with prevention research center for healthy neighborhoods and community members and residents in which we are striving to have stores move through a healthy food retail certification process and add whole-grains and healthy foods to their inventory.

Through this program and collaborations we established, we improved trust and collaboration and made healthy food easier and more accessible to 177,000 residents. Our community residents who serve as community health workers have played an integral role in this project and expansion of this work in helping to evaluate the effort. Engaging store owners, building relationships. If you look at the image on this slide, that's an actual store owner from one of our corner stores and two beautiful ladies in the images are our community

health workers and community health ambassadors. They serve as wonderful partners in our effort.

Other pieces around physical activity focuses on creating opportunities to access safe places to be physically active in our community. In the greater Cleveland area, data shows that our residents lack physical activity and higher rates. Locally we have seen growing interests for bicycling in communities of color. This is supported by national data. But this national data shows there is growing interest by African-Americans, they make up only 10% of riders and 30% greater risk for accident than white cyclists. We have focused our work guided predominantly by Cleveland and based in strong collaborations in the city of Cleveland building on their complete and green street ordinance that passed in is September of 2011, focused on establishing protected bike facilities, designing and implementing protected bike facilities to increase usage among African-Americans.

Through this work, team has done a great job of leveraging additional funding to progress of safe and low stress bike ways. That's a bike way that shows a buffer separating them from the traffic. There is a lot of work to ensure that as many of the planned bike lanes included in the resurfacing program are buffered as possible. Promotion for bike social clubs.
We have work around expanding bike share program like silver spokes that promote cycling for older adults and bike safety training. Through this work, we hoped to track the number of potential and actual linear miles of bike lanes and buffered bike lanes providing increased access to physical activity.

This near final slide here is our partnership framework for action. Aligns really well with a lot of recommendations that were provided in the state of obesity reports. For HIP Cuyahoga, we are committed to working on the systemic issues like racism and poverty and trust. And impact their health and well being.

This is an important aspect of our work and we're committed to even with limited funding at times to stretch ourselves to address systemic issues while continuing to provide chronic disease presentation effort understanding that systemic structural issues are at roots of our crisis around obesity and chronic disease.

We will continue to work closely with our community residents and partner. Our relationships with our community residents have been integral to our work and building those trusting relationships have been mutually beneficial. And in essence, our goal is to work collaboratively to foster transformational change that improves the opportunity health and well being of our population.

So lastly, our work is far more comprehensive than just healthy eating and active living. We have a robust website. It's www.hipcuyahoga.org.
>> You can see it tied to chronic disease management for additional information. Thank you for the opportunity to participate. I also look forward to the question and answer session. Thank you.
>> Thank you, Martha, for that great presentation. Here is our last poll. Referring to what many of you are familiar with the notion of foot desert playing an important role in obesity. It's reference to the distance to a healthy food option as being a major barrier to better nutrition. It does reference though that increasingly we are focused on systemic issues of racial, cultural and socioeconomic roots. Should we stop assuming that a grocery store in lower-income neighborhoods will solve the health and nutrition problems? While voting, I will introduce final speaker, Devita Davison who is executive director of FoodLab Detroit. She is a trail blazer. She creates healthy vibrant communities that are run by and for the local residents. Showing

how that can be done successfully by her groundbreaking work in Detroit.
Before Devita, let's look at results of poll if you go back one slide. I think we may see those, Kathy.

What we find is that overwhelming people are saying it's time to not assume that it's as simple as opening a grocery store in lower-income neighborhood. Devita, I know you are going to touch on that and a lot of other issues. We are eager to hear from you.
>> Great. Can you hear me, John? Thank you so much for that wonderful introduction. I am thrilled that I am in a community that feel the same way that I do. It is about time that we start to expand the conversation and move beyond a simple fix of subsidizing national and regional grocery store chain to come into low-income neighborhoods and thinking that will solve our obesity crisis because there is a presence of a grocery store in that neighborhood.
In my presentation, I'm going to make that case. Why it's so important that from the beginning, community be involved in the process of eradicating obesity and lack of healthy, fresh food. I'm going to demonstrate ways in which we are doing it in the city of Detroit. My presentation is going to take to my hometown. City of Detroit. We are going to zoom into 142 square miles in Detroit.

Before I begin, I want to acknowledge a friend or mentor, someone who is inspiration to me and most importantly I am thrilled that Bernard Tyson was named to healthcare Hall of Fame. In modern healthcare magazine, Bernard Tyson wrote, question I am asking every healthcare leaders and group and organization with stake in our collective health is this, who better to my address the factors so critical to our health than the experts who truly understand the population, the problems, the diseases and the steps necessary to make progress? But now I believe like I believe like I think many of you believe that we must have a collaborative approach that includes the community in order to improve the health of the people who live in our cities.

And so today, I'm going to talk about the community that I belong to and work in. That is various neighborhoods that make up my city, city of Detroit. City of Detroit has lost many, many of it's residents. Because of our population loss in the last 50 years, we went from population of 2 million people in the 50s to 60s to today, the population is around 700,000. Because of this population lost, they believe that Detroit abandoned city. Our population of 715,000, rank the largest urban center. Yet the city of Detroit undeniably faces on a grand scale the hardships that are created by some things lifted up on this webinar. Because of America suburbanization. Because of deindustrialization and the automobile factory. We are on hard times. As a result of the economic prospect fall, many supermarkets began to close up shop all around the city of Detroit.

In 2007, last regional grocery store. Name of that grocery store, farmer jacks closed the doors. 2007, city of almost 700,000 people did not have regional or one national grocery store chain. As a result of that, that lack of healthy fresh food in grocery stores even though we did have a network of smaller grocery stores, we did not have an abundance of grocery stores. As a result of that, few things happen. I want to share with you statistics. 30,000 people do not have access to full line grocery store that has healthy, fresh vegetables. 48% of households are food insecure. 40% of our households are enrolled in SNAP. And 92% of stores that except SNAP in Detroit are liquor stores, gas stations and drugstores. These are placers in which Detroiters were shopping.

19% of Detroit's children are enrolled in WIC. Women, Infants, and Children. Meaning about 1 in 5 children are through the government assistance program. 48% of all WIC stores

are liquor stores. I want to provide you context so you can understand what we are dealing with in Detroit. I didn't get on the webinar to tell you that story. I want you to see how community came together and rallied to turn the city around. I show you this picture that you are looking at right now of tomboy supermarket. This is what happens when you do not listen to the community. This supermarket, it closed around 2007 and 2008 when so many grocery stores leaving the city of Detroit. Community came together to buy this supermarket and turned it into a cooperative, local ownership. Sold so not so the neighborhood could have a fresh super market. Sold to Will leather goods. Out of Oregon. That turned into high end leather good. This neighborhood is too experiencing vast gentrification. Even though city of Detroit did not have grocery store and all of doors closed in 2007, around 2013, something happened. Whole foods opened in this neighborhood. As a result of that and Starbucks and others, there was rapid gentrification. A neighborhood that once had a supermarket, turned it into a high end leather goods store. When community is not involved and don't take time to involve the community and development, residents in that neighborhood did not change as retail were changing and many residents in couldn't afford to shop in high end leather store. In 2019, Will's Leather Good closes in Cass Corridor. The neighborhood and residents in that community didn't want to shop there. Didn't want it there and they ended up closing shop. I mentioned this to say that we cannot take for granted that if we bring in national or regional or owners that are not outside of the community that they know what the residents want.

So I ask about food deserts because it's important that we understand we move beyond that narrative. Food desert didn't exist until 1990s that the term coined by UK government task force concerned with nutrition and equality. We jumped on the bandwagon and widely held theory those in deserts are forced to shop at convenience stores where they could find healthy fresh groceries. Proposed solution is advocate for grocery stores and supermarkets in these neighborhoods that they thought would reg better eating -- encourage better eating. Our federal and local governments have spent hundreds of millions of dollars encouraging big grocery stores and developers to open up grocery stores and food retail and restaurants in what we call food deserts. Their absence is primary cause of obesity and chronic related diseases. I paused here on this slide to show you this.

I showed you that Tom's was a supermarket. It closed. Tom's is now going to be a high end Italian restaurant called Sauce. In the city of the Detroit, we resist the notion that government can solve our problems especially when they are not listening to us. What we push back on, what is the assumption that, quote, unquote leveraging subsidizing grocery store conglomerates developers to open up food retail that you have identified as food desserts what if that is not accurate. Many of us on the ground believe that that is not accurate. We take a community-based approach and we believe in the power of the people. I'm going to give you slides to demonstrate our work. Food lab Detroit that is non-profit organization where I'm the executive director, our goal is to build wealth within lower income communities by providing strategic advising and training and try to raise funds for local community members to open up healthy, fresh food businesses providing healthy food. We want them to provide good living waged jobs. So they have time and money to provide for those needs. We know this may be difficult to achieve. We have to look beyond food so that we can build a society that everyone has way to access. We reach out to the community. One of our partners that we reach out to is non-profit organization that's called keep growing Detroit. Keep Growing Detroit is non-profit organization that works with farmers and gardeners in the city of Detroit. They work with them who are taking up vacant lands and community

plots that are creating farms and gardens in the city of Detroit, we have now 1589 gardens and farms. As of 2009, we had 1,589 farms. You wow, Detroit has over 1500 gardens and farms. That's incredible. We are 140 square miles and research has shown us we've had professionals that come into the city of Detroit, third of city of Detroit is vacant. Reality to our population decline. Here is thing that is so incredible that I love to share with folks.

In the city of Detroit, we passed out 530,000 packages of seeds. They were able to pass out 204,000 Detroit grown transplants. Part that I love, in the city of the Detroit, around harvest time about 254,791 Detroiters are engaged in farming and gardening. This is how we began to change the conversation around food and improve health and obesity. Not only do we have a robust community of farmers and gardeners, they have to do something with fresh produce. They give them to neighbors. Sure. They have to sale in marketplace. I work with entrepreneurs who want to open up fresh, healthy retail stores and also source their produce from Detroit farmers.

Let me give you an example. This is an old ice cream shop. That was located in my neighborhood. I went there as a child. Blue moon ice cream. It closed around 2006, 2007. Food lab able to work with community development corporation that provided funding. Able to work with our philanthropic partners Kellogg foundation that worked with JPMorgan Chase and provided entrepreneurs of color fund and worked with two African-American entrepreneurs. They took this ice cream shop that closed in 2007 and in 2018, they opened up a healthy food restaurant that's called Detroit vegan soul. What I love about this, the resources that they needed to open up vegan soul. This is what we are talking about. We are talking about healthy fresh retail that is sit-down restaurant owned by people who are from Detroit and making soul food. That's all African-Americans in city of Detroit which is 86% African-American, they are accustomed to eating. They simply took this cuisine that we loved and made it plant-based. This is what I talk about when I talk about engaging community. Another entrepreneur that we supported in food lab community in cork town neighborhoods and two entrepreneurs woman of color, they took this space and turned it into Folk. Look at how they took a vacant space, beautification on the streets. They won an award by not only being a beautiful restaurant in terms of design and offers no tipping. It is based on upon the fact that the workers front of house and back of house in the industry, they deserve a fair and equitable wage. They are workers are paid in equitable fair wage and they receive health insurance. Folk also local resources from our Detroit farmers and gardens. This is a beautiful example of beautiful avocado toast with pea shoots and radishes. Except for the avocados, raised in Detroit. Sit-down restaurants like Folk, those are important too. Various different ways that we can support food entrepreneurship along the food chain that are outside of restaurants and coffee shops and diners. We can take abandoned liquor stores. This is an example of this in the Bright Moore community of Detroit. How can we turn it into not only a diner which it is. We can turn it into production facility. We have farmers now having access to production facility in their neighborhood where they are able to do what's called process their fruits and vegetables. They can wash it and pack it in commercially licensed facility and individuals who may not be able to open up a restaurant yet, can use this facility as shared use kitchen space. This is what Leah is doing. She is a vegan chef. She has a business that we are helping her stop called -- vegan kitchen. Leah operates out of this Bright moor community kitchen. Went from looking like this to now looking like this. With the help of Phillip land tropic partners, community members able to buy this building and turn it into a shared kitchen space. She is currently a caterer. She is prepared all of her food out of that shared food kitchen

space and offering cooking classes to youth. Being involved in the community.

There are other ways too through events by inviting people out to the farm so they can see where their food is grown. It's one thing for restaurants or chefs to locally have their ingredients. That's great. Farm to table. There is another thing to come out to farm and experience a beautiful meal on your own. We turned farm to table on it's head. We turned it into not farm to table, but table to farm. We bring the table to the farm.

This is an ariel shot of this farm. They are preparing flatbeds or right now for children's garden. We had an event where we would bring the tables out. Bring our chefs to the farm and they would prepare a table to farm meal. Meal would be five courses where all of the ingredients grown right there on the farm. These are some of our chefs. Staff members along with entrepreneurs who are part of food lab to prepare a beautiful meal. This right here is a gumbo that was inspired by a restaurant in New Orleans. All greens. So that was a beautiful dish that was served. Here are William that prepared the meal that particular evening. Kind of introducing themselves and introducing the food that is on the plate.

In Detroit, it really is about community. Extent to which supermarket location shapes our food choices may be significantly overstated. Subsidizing their expansion will not remarkably lead to change at all of what people eat. Not that if it's not culturally appropriate. More importantly, not if they can't afford to buy it. What research has found though that biggest beneficiary of new supermarkets coming into the community are supermarkets themselves. They enjoy and increase share of consumer spending. Not necessarily that consumer spending is on healthy food. Many of them still eating the same types of food. In order for us to start thinking about changing not only our food system but how people are engaging and interact winning food and how food ties into obesity and chronic related diseases and health issues from food labs perspective. We are rethinking current practices addressing the vital concerns of nutrition, looking at policy. Government agencies and community organizations they have a lot of time and money to combating food deserts and hoping that this will help disadvantage Americans to eat healthier. Even though these intentions are well intended efforts, they do not have the same desired effect. Added FoodLab, we have to love each other. Love each other so much that we want to build an inclusive society in which people from all backgrounds can live healthy and happy lives. So we look at the total system in order to do that. Thank you so very much. My pleasure to be a part of this webinar.

>> Well, thank you, Devita, for your great presentation and incredibly inspiring and effective work.

We're going to jump right into the questions for our panelists. You've been submitting lots of questions. Thank you all for doing that. Going to start with topics we have not touched on and solicit your feedback from our panelists. The first one asks specifically about adolescences. Mentioning that the -- sometimes there is a gap between focus on children and focus on adults with regard to obesity that may lead adolescence without a specific focus. So the question is, are there models for prevention and management of overweight obesity that are specifically targeted towards adolescents? I will open up for panelists.

Ruth, make I will direct that to you. I know you know the national picture in regard to different approaches.

>> Great, can you hear me.

>> Yes, yes.

>> Perfect, thanks. That's a great question and gets back to our slide where we look at the healthy start for infants and children and youth growing up strong and healthy and managing

for adults. Any program that will help all individuals who live in that community. I think question that you are passing along to us is more about specific weight management that may happen in clinical setting. Evidence actually shows that there are interventions for very young ages and there are -- there is a little bit less to be known about specific interventions that would be required in adolescents. 26 hours of counseling regarding nutrition and physical activity is evidence-based for young people. What we are doing at CDC, working with other organizations and medical systems to really institutionalize some of those interventions so that we are sure that what gets rolled out in clinical settings meets the evidence-based. I agree there are specific needs that add he sents have. When we work with clinical setting and rolling out intervention. We ask them to think through and they think through that anyway, because of training. What particular needs adolescents will have as individuals that are caregivers. It's complex about the layers of different emotions and control factors and contexts that adolescents have. People are definitely working on that. It's a great question. Changing access where the healthy choices, the easy choice and physical activity and nutrition for entire population will improve those outcomes for adolescents.

>> If I can jump in and piggyback on Ruth's amazing comments. I want to make a statement. Maybe some of my panelists can chime in here and inform me of any work that has been done in this area. I thought that was an excellent question. What concerns me most is -- and no surprise, research has shown that junk food ads diss proportionately target black children. 50% of black adolescents see more unhealthy ads than white counterparts.

I don't know if there is anything that is being done to control the amount of advertising that our young adolescents children are being exposed to.

>> Thank you for raising that. A leader in this effort at Drexel University has done research to exactly confirm what you are saying. I think more and more people are paying attention to this issue of marketing and harms that that can cause. Let me make sure I get a couple of more questions in from the participants.

One asked that while the work that you are describing is great work in terms of obesity and prevention, are there things we can do to avoid is weight bias or stigma that people may be experiencing?

>> This is Ruth again. I will jump in. We see this as a huge problem that needs to be addressed in culturally tailored way not only at ground level but within organizational structures. Working with large healthcare systems or healthcare networks and provider trainings, we do work on the inherent advice -- bias they have and not realize they have that. That permeates outside the clinical setting. What we see in our communities when they work on childhood obesity prevention, if comes from grassroots, this is problem particularly from areas that have culture interventions, that can be built in to training of intervention. We do know with pediatric interventions. Willingness to join such intervention is that family and child trust that they will not be judged negatively. It's a great question.

>> Well, we -- I think we could spend the whole rest of the day asking questions. Unfortunately, the webinar has to ends exactly at top of hour. We only have time for one more question. I would like each of you to answer. It's a challenge. We would like you to answer with one minute of a tough question that was asked by one of our listeners. That is, if you could single in on one thing. One thing that could be done that would have the most immediate impact on obesity rates in short term, what would it be? We definitely want to hear it. If it's possible to say it within a minute, that would be a challenge. Great in terms of staying within time limits of webinar. Let's do Ruth, Martha and then Devita.

>> My quick answer is invest in prevention and understand these are hard fixes and costly to change the environments in which people live and make decisions every day.
>> Thank you, Ruth. Martha?
>> Yeah, I think mine is similar. Focusing on community conditions and looking at some of the historical factors that have shaped the limited opportunities that folks have. Unless we change those conditions, we will not change the chronic disease.
>> Devita, you have final word on this.
>> This is such a great question. Speaks to some of the challenges that I personally see in my family. Even challenges that effect me personally as an African-American woman. And larger and broader the challenge effects on my community. There are many people in the city of Detroit in my community in my own family who have medical issues. Who are suffering from illness. Many of those illnesses are chronic related. Many of them self-medicate and don't go to doctor. Folks are not being preventative of going to the doctor before something becomes a very big problem. Only showing up and going to doctor when it's an absolute emergency and scared to death how much it's going to cost them to go to the doctor.

One of the things I would like to see is Medicare for all. I would like to see healthcare in this country affordable to all people. So that people don't have to worry about is my ill greater than what the bill is going to be because they are afraid to go to the doctor.
>> Well, this is just one more reason why this panel is so terrific. And I assume all of the participants appreciate that. It certainly was something recognized on Capitol Hill when three speakers all presented there.

I want to take this time to thank all of you for participating but especially thank our panelists Dr. Ruth Petersen and Martha Halko and Devita Davison for sharing their terrific presentations and thank Trust for America's Health. Kathy, thank you for your work behind the scenes. Many thanks to all of you. I will turn things to Kathy so you can close out the webinar.
>> Thank you so much, John, Martha, Ruth and Devita for your presentation. And many thanks to our sponsor, Trust for America's Health. And thank you to you, our audience. Recording of today's presentation and slides will be available to you by next week at Dialogue4Health.org. You will receive a link from us to a brief survey. That concludes the web forum. Have a great rest of your day, everyone.
Donna CART Captioner: Webinar has concluded. Thank you.