



CASE 10

The Strategies to Overcome and Prevent Obesity Alliance

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A WEIGHTY ISSUE

Imagine a disease that affected two thirds of adults in the United States, with a prevalence that had doubled in the last 25 years and showed no sign of stopping its upward trend. One would expect any disease this widespread would receive national attention both in the media and policy arena. Policy makers would demand insurance coverage for treatment and prevention. The public would actively protect themselves and their families from contracting the disease or seek treatment if they contracted it. Physicians would screen for the disease regularly and have straightforward conversations with those who contracted the disease. The American public health and medical systems would be geared toward treating and preventing further spread of this disease.

Surprisingly, there is a disease that currently affects two thirds of the U.S. population, yet has not received the expected response. In 2009, 66.4% of the adult population in the United States was overweight or obese (body mass index ≥ 25),¹ which is more than twice the prevalence rate from 3 decades before.^{1,2} Adults are not the only ones affected; childhood obesity rates have also tripled in the last 30 years.³ Additionally, if the existing rates of increase continue, 86.3% of U.S. adults will be overweight and 51.1% will be obese by 2030.⁴ These are staggering numbers for any health condition,

¹ The body mass index is defined as an individual's body weight (in kg) divided by the square of his or her height (in meters). A body mass index of 25.0 to 29.9 is considered overweight while a body mass index of 30 or more is considered obese.

but especially one that is related to a multitude of chronic diseases, such as diabetes, hypertension, high cholesterol, stroke, heart disease, certain cancers, and arthritis.⁵ Beyond the individual health risks, overweight and obesity also contribute to increased health costs, both nationally and for individuals. For example, in 2008, medical spending attributable to obesity was estimated to have been \$147 billion, accounting for 9.1% of annual medical spending.⁶

These statistics show obesity plays a major role in the U.S. healthcare system and affects the lives of millions of Americans. However, despite the extreme prevalence of obesity, the disease often does not receive adequate attention in the healthcare community. In 2010, First Lady Michelle Obama launched her *Let's Move* campaign, which aims to reduce childhood obesity within a generation, helping to bring the issue of childhood obesity to the forefront. In contrast, adult obesity continues to garner little interest. Some groups, however, are focusing on this often overlooked area because they believe real change can be made. The Strategies to Overcome and Prevent (STOP) Obesity Alliance is a collaboration of consumer, provider, government, labor, business, health insurance, and quality-of-care organizations united to drive innovative and practical strategies that combat obesity. The alliance's history is unique, demonstrating how partnerships among public relations teams, public health researchers, business and labor leaders, advocates, and the private sector can work together to make important changes.

EARLY STAGES

In 2006, the France-based pharmaceutical company sanofi-aventis issued a request for proposals for public relations firms to help promote and improve coverage for an obesity drug in their pipeline. Chandler Chicco Agency (CCA) responded, pitching the idea of pulling together major health advocacy organizations to form a coalition focused on the issue of cardiometabolic risk. A key element of CCA's proposal was to create an administrative home for the coalition at an academic institution, which would take the lead on generating policy research related to cardiometabolic risk. After securing the contract, the project lead at CCA, Allison May Rosen, identified The George Washington University Department of Health Policy (DHP) as a potential academic home for the coalition. CCA approached DHP professor Christine Ferguson, JD, to become program director, because of her unusual experience working in both federal and state government.

CCA believed a partnership between a healthcare public relations firm and an academic institution, such as The George Washington University, would be ideal for both the creation and maintenance of the coalition it envisioned. CCA and DHP worked collaboratively to develop the idea. CCA brought public relations expertise and knowledge of how to structure and orient the coalition to get the attention of policy makers. CCA was assisted by Mehlman Vogel Castagnetti Inc, a seasoned government affairs firm in Washington, DC. On the other hand, the team at DHP brought academic expertise and an understanding of policy making in the public and private sectors, as well as research and publishing capabilities unavailable to CCA. The strong teamwork and equality between CCA and DHP was exceptional—the groups used one another's skills and resources to create something stronger than either could achieve individually.

Conversations between CCA and DHP initially focused on how to develop the project to address public and private policy makers' needs, recruit member organizations, and achieve the goals outlined for the project. Cognizant of the way policy makers think about public health issues, Ferguson maintained that while *cardiometabolic risk* was the accurate term to describe the condition, the phrase would not resonate with policy makers or the general public. Instead, she suggested obesity was truly at the heart of the equation, and was a significant public health problem that had long been ignored by policy makers. After significant discussion, the group adopted obesity and its comorbidities, such as diabetes and heart disease, as the main focus for the coalition. They chose to name the new group Strategies to Overcome and Prevent (STOP) Obesity Alliance. Surgeon General Dr. Richard

Carmona was recruited as the health and wellness chairman of the alliance to provide high-level public health visibility to the alliance leadership and steering committee members. Ferguson served as the director. The next step was to recruit representatives of influential health-focused organizations to serve as a steering committee to help direct the work.

Recruiting the organizations from a cross-section of disciplines to serve on the steering committee was a months-long process that involved identifying the organizations, setting up initial discussions, and securing official sign-offs for the organizations to join the alliance. These conversations were important to ensure the organizations understood and agreed with the overall goals of the alliance. As seen in Figure 10-1, the resulting steering committee was comprised of medical, patient, government, labor, business, health insurance, and quality-of-care organizations dedicated to changing the way policy makers think about and approach obesity. The steering committee drew members from diverse groups with an interest in obesity, including the American Diabetes Association, the American Heart Association, America's Health Insurance Plans, the American Medical Group Association, the Canyon Ranch Institute, the Centers for Disease Control and Prevention's Division of Nutrition, Physical Activity and Obesity, DMAA: The Care Continuum Alliance, the National Business Group on Health, the National Committee for Quality Assurance, the National Quality Forum, the Service Employees International Union, and Trust for America's Health.

Question 1 The steering committee organizations represented groups from across the policy spectrum. What views did the various steering committee organizations bring to the alliance, and can you identify any possible conflicts between the organizations?

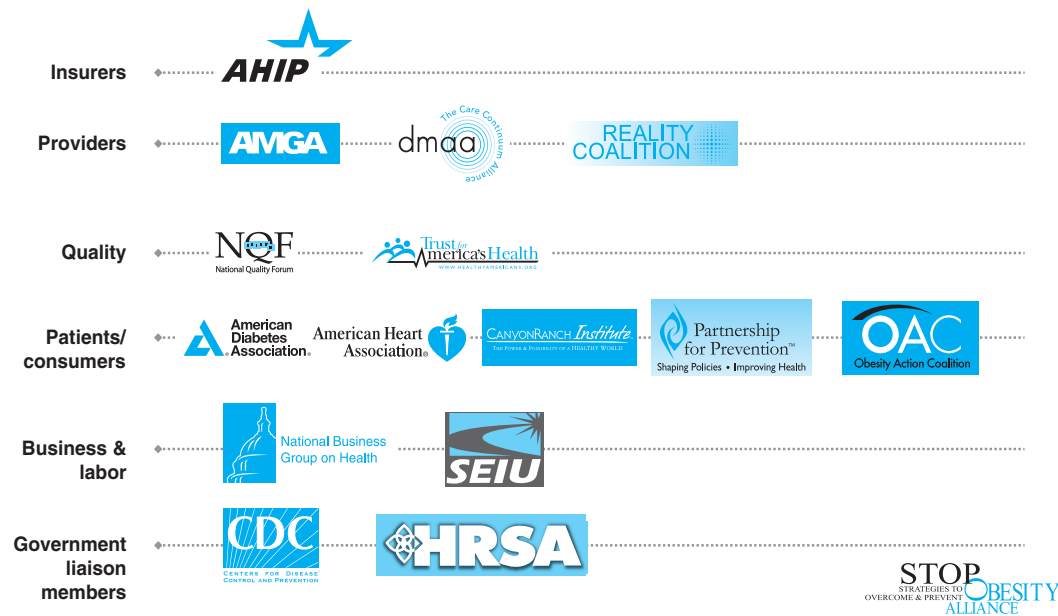
ESTABLISHING THE STOP OBESITY ALLIANCE

The first steering committee meeting was held in July 2007. Representatives from each of the steering committee organizations came to a daylong meeting to discuss the state of obesity efforts and barriers to addressing obesity. Unexpectedly, many of the steering committee representatives shared stories of their personal struggles with weight.

At the meeting, DHP researchers presented data from existing obesity research, focusing on three major barriers they identified. First, patients, physicians and even weight loss researchers often used unrealistic definitions for successful weight loss based more on physical appearance than health. In 1998, the National Heart, Lung and Blood Institute issued guidelines recommending obese individuals attempt to lose 10% of body weight over a 6-month period and then evalu-

FIGURE 10-1 STOP Obesity Alliance steering committee members (as of July 2010).

Aligning key stakeholders: steering committee



Source: Courtesy of STOP Obesity Alliance.

ate whether additional weight loss was needed.⁷ The alliance referred to medical research, which showed many health benefits of weight loss can be achieved after a sustained 5–10% weight loss.^{ii,8} Despite these results, a group of The George Washington University researchers found evidence suggesting many patients would consider this amount of weight loss a failure.^{9,10}

The second major barrier was that although medical interventions for obesity exist, there is a widespread perception that weight loss treatments do not work.¹¹ In addition, some view medical treatments for obesity, especially bariatric sur-

gery, as an easy way out. This attitude prevents people from seeking and receiving appropriate medical interventions. Finally, stigma toward the obese was an overwhelming driver in the way the public and policy makers thought about the problem of obesity.¹² Most saw obesity as rooted in a failure of willpower and personal responsibility. The belief was that because the obese had brought the condition upon themselves, they did not deserve to receive treatment, and especially insurance coverage, for their obesity. In the meeting, steering committee representatives talked about how they saw these barriers reflected in their own areas of expertise and brainstormed ways their organizations, both individually and as part of the alliance, could work to overcome the barriers.

Out of these discussions, the steering committee came to agreement on the following principles to guide the work of the new alliance:

ⁱⁱ In addition to the cited reference, see also Lavie CJ, Milani RV, Artham SM, Patel DA, Ventura HO. The obesity paradox, weight loss, and coronary disease. *Am J Med.* 2009;122(12):1106–1114. <http://www.amjmed.com/article/S0002-9343%2809%2900500-2/abstract>.

1. Redefine success to be based on health rather than physical appearances
2. Encourage innovation and best practices in obesity prevention and treatment
3. Address and reduce stigma as a barrier to treatment
4. Broaden the research agenda on obesity

The alliance issued these principles publicly in 2008 as policy recommendations and have since used the principles to direct the actions of the alliance.

Question 2 While these recommendations were created specifically for obesity policy, they are also applicable to other diseases and health conditions. What other diseases might warrant similar recommendations? Are some of the recommendations more transferable than others? Which ones?

Question 3 What is the role of stigma in other conditions? Think of examples (HIV, mental health, tobacco).

Question 4 Do you think people who feel they have a connection to obesity—either personally or in their families—are more likely to be interested in the issue and accept its complexities?

ACTING AS AN ALLIANCE

The cornerstone idea in the founding of the alliance was the creation of a coalition that would operate through consensus. While the CCA-DHP team managed the daily activities of the alliance, the steering committee met monthly and was integrally involved with all the alliance's work, including helping direct the research agenda, providing expert advice, and supporting alliance initiatives. Beyond this guiding role, steering committee members also reviewed and agreed to all publications issued under the alliance's name. Achieving consensus among steering committee members took time but ensured the work of the alliance represented all members and did not create conflicts for any individual organization. This consensus approach strengthened the message of the alliance from the beginning. Any policy recommendation from the alliance was backed by its diverse membership body, many of whom found themselves on opposite sides of policy debates. While this variety was a significant asset for the alliance, it also forced the alliance to remain neutral on issues where consensus could not be reached.

Question 5 The alliance specifically chose a consensus governance model for its strengths, but there are weaknesses. What are the strengths and weaknesses? What other public health problems could benefit from the alliance's model?

ACTIVITIES AND OBJECTIVES OF THE ALLIANCE

From the beginning, the alliance mainly targeted its work towards policy makers in both the private and public sectors. In order to reach this specific audience, the alliance conducted a range of research and activities about obesity. One of the key functions of the alliance was to bring together policy makers and influential stakeholders to discuss and brainstorm innovative solutions to obesity prevention and treatment. The alliance was not an advocacy organization, but instead used education and research to provide policy makers with tools to create effective approaches toward obesity and its related conditions.

During the first 3 years, the alliance hosted numerous roundtables and discussions on various topics, such as primary care, body image in the media, and the impact of obesity on women, to highlight current research and innovative practices. The diversity of research topics and activities of the alliance represented its broad membership base and message. The alliance continually stressed that all decisions must be based on the existing obesity research and evidence and worked to bring this information to policy makers. In addition, the alliance engaged in its own primary research activities in order to expand the evidence available to decision makers.

Highlights from the Alliance's Research and Activities

To advance its goals, the alliance engaged in a number of key research, communication, and advocacy activities.

- **Obesity GPS (Guide for Program and Policy Solutions):** The alliance created a navigation tool to guide the development and assessment of policies aimed at addressing overweight and obesity. The Obesity GPS offers questions to consider when designing legislative or private sector initiatives focused on health, research, and clinical issues. The tool is intended to help policy makers create programs that reflect the four policy principles of the alliance. The tool was publicly released at an event at the U.S. Capitol in December 2008.
- **Health Decision Makers Survey:** The alliance commissioned a survey on employer and employee attitudes toward obesity. The results were published in the January/February 2009 issue of *Health Affairs*. The article was one of the 20 most viewed articles on the journal's website in 2009, indicating growing interest in obesity.
- **STOP Obesity Alliance E-Newsletter:** The monthly newsletter provided commentary and news on alliance and member activities. In addition to the website, the newsletter was the primary way for people outside of the alliance to receive information about alliance updates. As of mid-2010, the newsletter had over 2,000 subscribers, including mem-

bers of Congress and staff, federal agency representatives, healthcare advocacy groups, physicians, and academics.

- **Has America Reached Its Tipping Point on Obesity?**

Forum: Although alliance member organizations were on opposite sides of many issues within the national health reform debate, in September 2009, the alliance reached consensus on four recommendations that should be included to address obesity within health reform. These four recommendations were: (1) standardized and effective clinical interventions; (2) enhanced use of clinical preventive services; (3) effective, evidence-based community programs and policies; and (4) coordinated research efforts. At the forum to release the recommendations, former Surgeons General Dr. David Satcher and Dr. Richard Carmona spoke about the urgent need to address obesity. The event and simultaneous webcast were attended by over 100 policy makers and health advocates. The release garnered significant media attention, including ranking as the No. 1 most e-mailed story on *Yahoo! News*.

- **Improving Obesity Management in Primary Care Roundtable and Paper:**

Recognizing the significant role primary care physicians could play in addressing obesity, the alliance convened a roundtable of physicians and stakeholders in August 2009 to discuss strategies for improving the prevention and treatment of obesity in primary care. The DHP research team translated the key ideas from the roundtable into a white paper, *Improving Obesity Management in Primary Care*. The paper was released in March 2010 along with preliminary results from a Harris Interactive survey commissioned by the alliance on primary care physician and patient attitudes toward obesity.

- **Weighty Matters:** Working in partnership with the National Eating Disorders Association, the alliance convened an expert media panel in April 2010 on the depiction of weight issues in the media. The panel emphasized the impact of media on body image, the importance of portraying realistic images and weight loss stories, and the need to focus on health rather than appearance. This unprecedented collaboration was attended by nearly 100 attendees and attracted high-level media interest.

- **Task Force on Women:** In 2010, the alliance created a task force on women to call attention to the significant and disproportionate impact obesity has on women's health. Comprised of 18 advocacy and research organizations, the task force identified the following four ways in which women are uniquely affected by obesity: (1) physiological, psychological, cultural, and socioeconomic factors; (2) pervasive racial and ethnic disparities in obesity prevalence and health outcomes; (3) systemic, gender-based biases portrayed in the media and encountered in educational, workplace, social, and healthcare environments; and (4) the role of women as caretakers for their families.

Question 6 These activities showcase the broad range of research topics and event types that the alliance engaged in during the first 3 years. Which do you think was the most effective based on the goals of the alliance? How might these activities differ if the alliance was targeted at the public instead of policy makers?

MEASURING THE IMPACT

Expanding the Alliance: Associate and Government Liaison Members

Since its founding, the alliance grew immensely; each year, more groups expressed interest in partnering with the alliance or becoming involved with its work. As a way to broaden its reach by engaging additional groups while thoughtfully managing growth, the alliance created an associate member category. Associate members are organizations that partner with the alliance, but do not serve on the steering committee. As of mid-2010, there were over 30 associate members. Because of the significant racial and ethnic disparities in obesity prevalence, one focus area for associate membership has been groups with ties to minority communities, including the Black Women's Health Imperative, the National Hispanic Medical Association, and the National Indian Health Board.

Alliance leadership also saw the need for another membership category that reflected the unique position of government agencies. Called government liaison members, these members participate in steering committee meetings but do not comment on or endorse certain alliance activities, such as commenting on obesity-related legislation.

Question 7 Why were these new membership categories needed? What did the associate and government liaison members bring to the alliance?

Forming Strategic Partnerships

In addition, the alliance partnered with or supported many obesity-related initiatives, including:

- Virgin HealthMiles' National Employee Wellness Month, 2009 and 2010
- Obesity policy forum at the Obesity Society annual scientific meetings in 2009 and 2010
- World Health Congress 2009 and 2010 obesity congresses

Media Attention

Beyond growth of the group, the alliance gained national media coverage for its research and sponsored events. For ex-

ample, the release of the alliance's policy paper, *Has America Reached Its Tipping Point?*, based on the steering committee consensus-driven recommendations for health reform legislation, received significant attention, including an op-ed piece by former Surgeons General Satcher and Carmona in *The Atlanta Journal Constitution*. An article on the recommendations and the event also became the most e-mailed news story on *Yahoo! News*. Similarly, the release of primary care survey research by the alliance garnered coverage in national news media, including *The New York Times*, *USA Today*, and *The Washington Post*.

As obesity gained more prominence nationally, federal policy makers included suggestions supporting the alliance's recommendations, shifting the use of some of the work of the alliance. In 2009, the Government Accountability Office recommended the federal government provide guidance to states for the coverage of obesity-related services, such as screening and counseling, for children enrolled in Medicaid, as well as consider similar guidance for coverage of Medicaid-enrolled adults.¹³ Additionally, federal health reform efforts began with little support or mention of obesity, but the Patient Protection and Affordable Care Act passed on March 23, 2010, included many obesity-specific provisions, which supported alliance recommendations.

These successes demonstrated the strength of the alliance's research. Many of the alliance's continued achievements can be attributed to the strong partnership between CCA and DHP. Since the inception of the alliance, CCA and DHP worked as equal partners in the day-to-day maintenance of the group. Both groups participated in all planning, messaging, and research, but brought their own expertise to each decision. Loosely, CCA handled the logistical planning and messaging for the alliance; specifically, it managed press contacts, organized events, and monitored the media presence of the alliance. Conversely, DHP was the research arm of the team. DHP staff monitored research on obesity, both in policy and clinically, and engaged in and analyzed primary research. DHP brought quick and responsive research capabilities to the alliance, but also added an academic legitimacy. Despite these dual roles, all projects involved the efforts of both CCA and DHP staff. This close working relationship between CCA and DHP helped ensure that the work of the alliance was communicated clearly and effectively.

Question 8 Both CCA and DHP played important roles in the creation and maintenance of the alliance. Why were both roles necessary and how might the alliance have differed without one or the other?

EPILOGUE

When reflecting on the events that have occurred since the founding of the alliance, the leadership of the alliance identified the beginning of three fundamental shifts in the way policy makers and the public think about obesity. First, the conversation about obesity has shifted from portraying obesity as mainly an appearance issue to acknowledging its serious health consequences. Beyond the impact on health, the increasing recognition of the impact of chronic diseases on the U.S. health system has also raised the profile of obesity. Second, policy makers and the public began to realize that fighting obesity is not just about personal responsibility—it's about creating a society where good personal choices are possible. These trends were reflected in alliance decision-maker surveys, in which many employers and primary care physicians agreed that they have a role to play in addressing obesity. Third, many started to recognize that beating obesity goes beyond simply losing weight; in fact, sustaining the weight loss may be the hardest part. This recognition is especially relevant when promoting the creation of healthy communities that support individual success for weight loss.

As obesity begins to gain more traction as a prominent health issue, the alliance hopes to help bridge the gap between the public health and health services communities. Rather than viewing obesity as a problem requiring a single approach or having a silver bullet solution, the alliance believes policy makers should focus on creating environments that support healthy choices that are easy to make, while also providing access to medical treatment for obesity.

In the future, the alliance hopes to expand its influence into state health policy by identifying barriers policy makers face when trying to address obesity at the state level. Many important public health decisions are made at the state level, so making sure policy makers understand the complexities of obesity is essential. Additionally, with the passage of the Patient Protection and Affordable Care Act, there is increased emphasis on the prevention and treatment of obesity and other chronic diseases. Alliance leadership hopes that as the federal government implements the health reform law, it will use the research findings and recommendations of the alliance to further create communities and solutions that support healthy choices for obesity prevention and treatment.

About the Authors

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Casey Langwith, BA, is a research assistant in the Department of Health Policy within The George Washington University's School of Public Health and Health Services. Casey primarily works on the STOP Obesity Alliance, drafting research papers and conducting project management. Most recently, she has focused on developing materials, including memoranda and summary tables, highlighting the public health and prevention provisions in the Patient Protection and Affordable Care Act. Casey also works on obesity management in primary care, the economic costs of obesity, and state-level obesity initiatives, including coverage issues. Casey graduated magna cum laude with a bachelor of arts degree in sociology and history from Rice University in 2009.

Christine Ferguson, JD, is a professor in The George Washington University School of Public Health and Health Care Services in the Department of Health Policy. She has served at the highest levels of federal and state government. Her areas of research include Medicaid, state health policy and financing, federal health reform implementation, and obesity. Prior to joining the School of Public Health and Health Services in 2006, she served as commissioner of the Department of Public Health in Massachusetts; the director of the Rhode Island Department of Human Services, and counsel and deputy chief of staff to then-U.S. Senator John H. Chafee. Her accomplishments as an influential health policy maker have been recognized by Faulkner & Gray¹⁴ and by *National Law Journal*, which named her one of the nation's 100 most influential lawyers. Ms. Ferguson was also named one of the

top 25 most influential working mothers by *Working Mothers* magazine. She is a sought-after speaker and commentator and has appeared on *Good Morning America*, NPR Marketplace, in *USA Today*, *The Wall Street Journal*, *The Washington Post*, *The New York Times*, and various other regional news outlets and trade publications.

GinaMarie Mangiaracina, BA, has worked in healthcare public relations for more than 10 years. She joined the Chandler Chicco Agency in 2006 and is currently the team lead for the Strategies to Overcome and Prevent (STOP) Obesity Alliance. Past work at CCA has included playing leadership roles in public relations and public affairs efforts for the not-for-profit hospital alliance, VHA Inc., and the VHA Foundation.

Allison May Rosen, BS, serves on the Global Leadership Council for the Chandler Chicco Companies from its Washington, DC, office, where she provides strategic communications counsel, coalition management, and editorial services and media training for clients trying to build support for an issue, influence public opinion, or launch a brand or service. Her planning, issue framing, messaging, and advocacy development skills have been put to work for clients including the Strategies to Overcome and Prevent (STOP) Obesity Alliance; the Robert Wood Johnson Foundation Commission to Build a Healthier America; VHA, the national not-for-profit hospital alliance; and other major consumer brands and disease-specific campaigns. Previously, Allison was press secretary for the U.S. Overseas Private Investment Corporation, worked for Texas Governor Ann Richards in Washington, DC, and was an aide on Capitol Hill. Allison served as lecturer for The George Washington University Department of Health Policy chair's seminar and regularly speaks to industry associations on communications and the media. She received her BS from the S.I. Newhouse School of Public Communications at Syracuse University.

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