Health Planning Project: Childhood Obesity in Richmond, VA

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Obesity is such a persistent problem throughout the United States that the public is familiar with it. Online blog sites, such as RichmondHealth.com (2014) report that obesity rates have increased in six states while no state's rate decreased. Meanwhile, news sites attribute the problem to a high amount of fast food available to the public (Avellino, 2012). Our group of Virginia-resident, registered nurses recognizes that our home is deeply affected by the prevalence of overweight and obesity. We turn our attention to our state capitol, Richmond, as Gallup surveys had ranked the city as the third most obese major United States community in 2012-2013 (Riffkin, 2014). County Health Rankings (2015) also offers yearly health factor statistics about our capitol city and reports that 29% of the population is obese with a rising trend during the past decade while 22% of the population has been physically inactive. Our community must take action to improve the health of our people.

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This proposal focuses on childhood obesity as a first step. Childhood obesity has been chosen for effect on the individual's future health – in a study of bariatric patients who were obese through adolescence, many were predisposed to activity intolerance, kidney impairment, asthma, diabetes mellitus, sleep apnea, and hypertension (Inge et al., 2013). Meanwhile, poorer metropolitan communities are more prone to obesity due to an environment that makes health maintenance more difficult (Whitaker, Milam, Graham, Cooley-Strickland, Belcher, & Furr-Holden, 2013). We examine our aggregate of poorer children and the perceived needs of the community in order to arrive at community-wide intervention to combat obesity.

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Aggregate: Richmond's Children

Richmond is a community with obesity continually on the rise especially in children, particularly those children that come from poor economic backgrounds. This group chose to focus on childhood obesity as unhealthy eating habits learned and adapted in childhood are more likely to remain part of their lifestyle into adulthood. Over the last thirty years, obesity in children has more than doubled and in 2012, more than one-third of children and adolescents were overweight and/or obese (Centers for Disease Control and Prevention, 2015). If interventions to combat childhood obesity are successfully implemented throughout the community, we will hopefully begin to see a fall in the rate of this disease among children in Richmond.

The estimated population of Richmond is 217,853 and children under the age of eighteen make up 18.1% of that population. Of the children that make up the population in Richmond, roughly 17% are obese. 50.1% of population is Black or African American and 44.5% is White, a statistic that reflects both children and adults. The median household income is $40,496 and 38% of children live below poverty level. Only 34.8% of adults over the age of twenty-five hold a bachelor's degree; much of the population is not well-educated (United States Census Bureau, 2015).

The leading cause of death among children under the age of eighteen, aside from cancer, is major cardiovascular diseases followed by respiratory disease (VA Dept of Health, 2015) – all of which can be hugely impacted by childhood obesity. In a sample of obese youth with ages ranging from five to seventeen years, 70% had at least one risk factor for cardiovascular disease. Among other health factors, obese children are at greater risk of being pre-diabetic, having bone and joint problems and developing sleep apnea (CDC, 2015). Unfortunately, only 2% of

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Richmond City's Health District expenditures for the year 2014 was spent on chronic disease (including obesity) prevention (Richmond City Health District, 2014).

Anticipated Characteristics

Richmond, VA is a relatively large metropolitan city. As the fourth most populous city in VA, Richmond shares characteristics similar to other populated urban metropolitan cities across the United States. These characteristics impact the risk for obesity in children and include social and physical factors in neighborhoods. One such characteristic is referred to as "structural disorder" (Whitaker, Milam, Graham, Cooley-Strickland, Belcher, & Furr-Holden, 2013). In a community-based epidemiologic study of Baltimore, MD, environmental assessment utilizing the Neighborhood Inventory for Environmental Typology (NIfETy) showed neighborhood disorder trends toward an association with childhood overweight and obesity status even when controlling for individual factors including race (Whitaker et al., 2013). Neighborhood disorder includes physical disorder (buildings in disrepair, damaged sidewalks, etc.), social hazards (public drunkenness for example), and lack of supervision. The physical environment can be a dissuading factor for physical activity.

While neighborhood-level disadvantage, gender, and socioeconomic status contribute to the level of childhood obesity experienced by the youth of Richmond, VA, the city's obesity statistics fall below other similarly sized cities in neighboring states. Indeed, the National Survey of Children's Health found that for 2011-12, 29.8% of Virginia's 10-17 year olds were obese or overweight. With a national average of 31.3%, Virginia ranks 23rd in the country for prevalence of overweight and obese children (Child and Adolescent Health Measurement

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Initiative, 2012). Virginia's central region, of which Richmond is a part of, has a youth population that is 18% obese or overweight. (Virginia Foundation for Healthy Youth, 2010)

Needs that could be expected for health promotion and prevention of obesity in the children of Richmond revolve around the provision of a safe and orderly environment at the neighborhood level. Reducing levels of crime, drug use, damaged infrastructure, and deficit in supervision stands to reduce the risk for obesity and overweight status in among urban children of lower socioeconomic status. Objective assessment of ecological factors in urban environments highlights these obesogenic qualities and contributes the planning for health promotion to combat childhood obesity (Whitaker et al., 2013).

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Specific Needs

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Safe ecological settings are specific needs that apply to the Richmond, VA children in the fight against overweight and obesity status. It is hard to simply go for a walk in a neighborhood that is not safe or cannot maintain adequate infrastructure. These qualities contribute to the sedentary lifestyle that composes significant risk for children (and adults).

The city's residents attribute the cause to another environmental source. According to residents of Richmond as interviewed by NBC12 in 2012, access to fresh fruits and vegetables is a challenge in many local areas of the city. Additionally, fast food restaurants are available in abundance and serve portions that are oversized. Inactivity coupled with a fast food penchant is a common condition for busy adults of the city. When considering that these same adults set examples for their children, the need for meaningful solutions intensifies.

The specific needs of Richmond's children may be prioritized. A safe environment with access to fresh food and acceptable educational facilities is the priority. Provision of a safe

neighborhood provides an arena for physical activity and encourages businesses such as grocery stores that stock fresh food as well as safe means to arrive there. Alternately, transportation or delivery of fresh food is an option. Other needs are largely behavioral in nature. They require a dedicated effort at education and behavioral modification. Eating nutritious foods and committing to a physically active lifestyle will require adult commitment and support for school programs controlling available foods and encouraging physical activity (Schuster, Elliott, Bogart, Klein, Feng, Wallander, & Tortolero (2014).

Planning: Approaching Obesity Education

The lifestyle for children over the years has become increasingly sedentary and more prone to unhealthy eating leading to the increase risk of not only obesity, but chronic health problems now and into adulthood. The above assessment identifies education deficiency as a major contributing factor to the obesity problem. It can extend to other problems: neither child nor parent may not know how to make healthy food choices, may not know that other choices are available, how to become sufficiently active, or that there are opportunities for physical activity. Education would assist in modifying the health behaviors. Our ultimate goal with intervention is to decrease the overall percentage of overweight teens in the city of Richmond. Specifically, a measurable objective to make this improvement would be to decrease the percentage of obese and overweight children from 18% to 14% in five years. While the 4% difference does not seem like a large change, it would indicate that the rate is not rising nor staying the same, and that interventions were significant enough to induce a downward trend.

First, availability and access to healthy foods to low income and low access neighborhoods is a vital component to making any improvement in diet and health of obesity; the

option must be made available before learners can choose it. Those without access to fresh food are instead surrounded by unhealthy fast food and processed food found at convenient store locations. As the NBC12's (2012) interviews have shown, the public is aware of the fast food that are available, but is less aware of better options. One intervention is to utilize a Community Food Security Program for Richmond. Richmond's Food Policy Task Force Report (2013) defines community food security as making healthy and nutritional food choices available to all, including low-income individuals. Community food security includes environmental planning such as providing more farmer's markets in order to purchase fresh local produce and establishing community gardens on vacant properties owned by the city for neighbors to grow their own food together. Also, to prevent many from relying on convenience stores, public transportation should be made available to those people without their own. Making healthier food readily available will prepare the community for education about how to choose the food.

The main setting and space for the intervention should be Richmond's public schools. Education and healthy eating habits begin in early childhood, therefore making public schools ideal to reach the aggregate. A School Health Advisory Board in each school can include parents, teachers, nurses and administrators as members in order to place healthier food choices in vending machines and bring in local experts to educate about nutrition (Virginia Foundation for Healthy Children, 2012). Also, building a school garden is a fantastic way to teach children science and math by using fruits and vegetable grown to learn measurement and weight. Encouraging schools to include more opportunities for physical activity should be included. This can be done by including additional physical education classes and more before and after school programs, encouraging recess, and even taking a walk outside for class such as science.

Support from organization would help assist community change. Fit4Kids may be an ideal associate for assets and funding outside of the government. It is a successful non-profit organization that was established to improve children's health and reduce the prevalence of childhood obesity in Richmond by offering programs that promote physical activity and healthy eating habits in schools and the community (Fit4Kids, 2015). Fit4kids school-based programs have included Healthy School Food Environment (promoting healthy eating including meals served in the cafeteria, snacks, vending machines, student rewards, classroom parties, fundraisers, and Parent Teacher Association events), Active Recess, and Learning Gardens. All of their programs have reached public schools and influenced teaching techniques to become more physically active. An ally like Fit4Kids can be powerful.

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Alternative Interventions

There are multiple interventions to consider when discussing decreasing childhood obesity. First, an initiative and investment should be providing better nutritional components in school lunches. Children who are often unable to afford school lunch are subjected to free lunch programs within the school. Many times, these programs offer limited nutritional options. If an investment was made towards providing well balanced nutritional intake for children early on, the opportunity to decrease the chance of childhood obesity in Richmond continues to grow. This initiative has been addressed before. The Hunger-Free Kids Act of 2010 focused on revising school nutrition and providing well-balanced meals. This program appeared to have an increase in food wastes and increased costs associated with the types of foods bought (Woo Baidal & Taveras, 2014). The role of the school nurses during these changes should have been critical – the nurse could teach about healthy choices. If education in regards to well-balanced

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nutritional diets was the priority, then more children could understand its importance. Therefore, making an option available will not be enough to stimulate change. Another intervention, such as public advertisement could supplement the changes made in school.

A second intervention that could stand alone or supplement the previous intervention is a public advertising campaign. It may be more effective in reaching the general public. National and local campaigns that are dedicated to enhancing awareness about obesity and the issues associated with it can have a major impact on choices children make. There have been healthy eating campaigns all over the world and in the United States. Chicago's 5-4-3-2-1 Go! advertisement campaign, which promotes information through public service announcements and public demonstrations, has been successful at delivering information to poorer areas (Evans, Christoffel, Necheles, Becker, & Snider, 2011). Such campaigns have been able to influence the public's positive behavioral changes because of the wide range of individuals they reach. Although many children in lower-income neighborhoods may not always have access to television, the power of mass media is ultimately word of mouth. Local campaigns also have a role towards positive behavior choices. An initiative in Richmond that is currently underway is the Martin Food Markets' hour-long childhood obesity forums. These forums are done in the grocery store where most of the choices are made by parents to choose certain foods. They include a focus on the best types of food, how to save money when choosing certain meals, present examples of good foods vs better foods, and the best foods to eat. Along with these informational campaigns, government officials are trying to create a food-policy task force in Richmond. Their focus would be to assess the quality of the school lunches and to find better funding for quality meal programs. These programs also provide iPod touch programs where

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students are loving to be a part of tracking their fitness plans, utilizing heart and calorie monitors (Smith, 2012).

Evaluation Strategies

The interventions require evaluation of strategies through measurable outcomes to determine their effectiveness. As stated previously, this improvement would be through decreasing the rate of obese children in Richmond's area from 18% to 14%. This will require chart indicators which log nutrition and exercise history as seen in Rankin's, Chlebowy's, Vorderstrasse's, and Blood-Siegfried's (2015) study, "Quality Improvement: Implementation of Childhood Obesity Identification and Prevention Strategies in Primary Care: A Quality Improvement Project". Measurement methods should include objective and subjective, such as an adherence measurement. The adherence measurement would be a self-reported method completed by child and/or parents (Steele, Steele, & Hunter, 2009).

In the above study, clinics reviewed all well child patient encounters and collected data on child being overweight and community referral and follow-up as needed (Rankin et al., 2015). The school nurse clinic could be an easy point of data collection annually to monitor patient's weight and Body Mass Index (BMI) and community referrals of obese children (Rankin et al, 2015). Steele, Steele and Hunter (2009) recommend utilizing age and gender appropriate BMI tables provided by the National Health and Nutrition Examination Surveys to determine the ideal BMI of the child. Evaluation of motivational counseling techniques from the nurse can be evaluated by interviewing the children for common subjective themes (Rankin et al, 2015).

The time frame should begin immediately for planning. Monitoring and collecting data should occur at that beginning of the year of each school year in all the public schools. If children younger than preschool age are to be added to the study, they would be monitored by

pediatricians and well-baby visits. Progress will be tracked yearly, with goals hopefully achieved by 2020 in time for national Healthy People 2020 goals.

Recommendations and Implications

Depending on the success of the implemented interventions, further recommendations should involve parents, schools, healthcare providers, neighborhoods, businesses, and early childhood educators (VFHY, 2012). In particular, the school nurse and any established school advisory boards are in a position to monitor and record outcomes from established interventions to increase the quality of school lunches and daily physical activities. They have the ability to involve the entire family in healthful changes and provide a supportive environment, including involving psychosocial and cultural dynamics, to set children and their families up for success (Lazarou & Kouta, 2010). Preparing school nurses for the obesity interventions might involve more training on how to teach healthy habits to children or how to manage nutrition. Moving outside of the school, local businesses and community centers can become involved in efforts to provide support and funding to improve environmental conditions.

The community health nurse functions as the contact point and coordinator between the different elements of the community (Lazarou & Kouta, 2010). The community health nurse serves as an advocate, an educator, and some may even be in the position to conduct home health visits that can involve the entire family and their environment (VFHY, 2012). Ideally, a partnership between the community health nurse and the school nurse could be established to advocate for increased physical activity, supporting neighborhood efforts to improve the environment such as walking and bike paths, engage families in prevention activities, encouraging parenting styles that support physical activity and reduce sedentary behaviors, and

encouraging and educating parents to set healthy role models (Lazarou & Kouta, 2010). In Virginia, there exist many training opportunities for the community health nurse to take advantage of when fighting the challenge of childhood obesity.

Summary of Proposal

This proposal was derived from the assessment that our capitol, Richmond, has an obesity problem. Children in Richmond's region had an obesity and overweight rate of 18%. It was also found that only 35% Richmond's adults were well-educated and that 38% of the children lived in poverty. Further research suggested that the environment made it difficult to maintain weight, that the population had difficulty making good food choices and that the children may need more education on weight maintenance. Of these problems, this proposal focuses on public education on healthier food intake and activities. There are a number of interventions in consideration: establishing a food security program, improving choices for a free school lunch program, involving school nurses in health education and food menu, and a general advertisement campaign. The expanding role of the school nurse in conjunction with an advertisement campaign seems most promising as they would teach healthy behaviors to children. Much of the intervention setting will take place in schools, which is part many metropolitan children's' lives, and resources may be obtained through the government and by allying with non-profit organizations, such as Fit4Kids. Finally, evaluations may take place in the school nurse's office or pediatrician offices by tracking students' weights and BMI. The results can precipitate in five years and in time for the deadline of Healthy People 2020 goals. Hopefully the obesity trends will stop rising and begin to fall.

The Next Step

School environment, as a part of a child's everyday life, is expected to have an impact on obesity. However, improving food choices and health education may not completely solve our community's weight problem. As mentioned, there are still other avenues to explore. After improving our schools, the next step may be to reach out to parents and involve them in the paradigm shift to improve children's weight. Evidence suggests that lower body mass index correlates with parents and children who share ideas with each other and increased physical activity of the parent (Hanson, Novilla, Barnes, Eggett, Schiffman & Sugiyama, 2009). Educating and encouraging the parents about physical activity has the potential to influence childhood obesity. Another potential arena that our proposal has not fully explored is the physical environment. The impoverished sectors of the city are more likely to be dangerous – such an environment would make outdoor physical activity dangerous. According to Health Rankings (2015), Richmond reportedly has 87% access to exercise opportunities, but it seems that the residents are not using them. So, the need for a safer environment is a possible cause that would need to be analyzed in the future. One approach will likely not be enough to defeat obesity in Richmond, Virginia.

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Criteria	Comments	Points
Introduction [10 points] 1. Identify yourself and your interest in making the proposal **Assessment** [20 points] 1. Specify level of aggregate selected for study. o Identify and provide a general orientation to the aggregate. o Include why this aggregate was selected and the method used for gaining entry. 2. Describe specific characteristics of the aggregate including o Socio-demographic characteristics o Health status o Suprasystem influences 3. Provide relevant information gained from literature review, especially in terms of		

characteristics, problems or needs that one would anticipate finding with this type of aggregate. o Include comparison of health status of chosen aggregate with other similar aggregates, the community, the state, and/or the nation. 4. Identify health problems and/or needs of specific aggregate based on comparative analysis and interpretation of data collection and literature review. o Include (when possible) input from clients regarding their perceptions of needs. o Give priorities to health problems and/or needs and indicate how these priorities are determined.		
Planning [20 points] 1. Select one health problem and/or need for intervention and identify ultimate goal of intervention.		

○ Identify specific, measurable objectives as (mutually agreed on by student and aggregate, when possible) 2. Identify environmental planning considerations (space, resources) 3. Describe alternative interventions necessary to accomplish objectives. ○ Include consideration of interventions at each systems level where appropriate. ○ Select and validate intervention (s) with highest probability of success. (Note: Interventions may include using existing resources and/or developing resources.)		
Evaluation [20 points] 1. Develop a plan for evaluation of the project including: ○ Strategies (tools if appropriate) ○ Timeframe(immediate, ongoing) 2. Make recommendations for further action based on evaluation and how to communicate these to appropriate individuals.		

○ Discuss implications for community health nursing		
Conclusion [10 points] 1. Provide a summary of your proposal 2. Include your recommendation for "the next step"		
Organization [20 points] 1. Includes ODU SON title page 2. Adheres to APA format (including in text citations and reference page) 3. Uses correct spelling, grammar, syntax 4. Includes Honor Code (1 point) **5.** Includes Grade Rubric (1 point)		
Total 100 points	This was a great paper. Well organized, thought out. A few APA but nothing I suspect you have an APA guru in the group.	100

	Nice job.	

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Signature: Jenna van Hoose, Ashley Sunday, Gretchen Teel, Andrea Titus, Eliezer Urbano, Genesis Webb, Abigail Zuehlke

Date: 7/19/15