Background

There is a growing body of evidence that the foundation of a person’s lifelong health—including his or her predisposition to obesity and other chronic diseases—is largely set in utero and during a child’s early years. Pregnancy in particular is a critical period when the mother’s health and habits, including rate of weight gain, diet quality and level of activity, affect the prenatal environment and the developing fetus’ health and potential growth trajectory. It is also the time when young children develop an understanding of hunger and satiety, establish food preference, build motor skills and capacities, and establish sleep, activity, and snacking patterns. This window from pregnancy through age 5 provides a unique time to influence the current and future health of children, and of their mother.

In the summer and fall of 2015, the American Academy of Pediatrics (AAP) Institute for Healthy Childhood Weight, with support from the Robert Wood Johnson Foundation (RWJF), convened three roundtable meetings to examine policy opportunities with the greatest potential to prevent childhood obesity, especially among the populations most at-risk for obesity, during this window between pregnancy and a child’s fifth birthday (P-5).

Unique Approach

The roundtable series, part of efforts by both AAP and RWJF to ensure all children can grow up at a healthy weight, was unique among obesity policy forums for multiple reasons. The roundtable series was rooted in:

- The developmental approach reflecting the unique opportunities that exist during P-5.
- The needs of the mother-infant dyad, young children and families rather than sector or setting.
- A multi-disciplinary approach that brought together a wide range of experts and practitioners from research, advocacy, clinical medicine, service delivery, and other fields.
- The belief that, in order to have the greatest impact on the populations most at-risk for obesity, public policy must be designed with these populations as the primary focus.

To ensure rich discussions and coverage of important themes, each roundtable meeting focused on a specific developmental period, and potential spheres of influence.

**Roundtable 1: Pregnancy and infancy** (June 22 – 23, 2015)
Focus: prenatal, perinatal, postpartum until the child’s first birthday

**Roundtable 2: Early childhood** (November 9 – 10, 2015)
Focus: children ages 1-5, with a focus on the spheres of influence outside the home

**Roundtable 3: Building a culture of health at home** (December 16 – 17, 2015)
Focus: supporting families in gaining the knowledge and skills needed to create a culture of health at home also included healthcare and workplace environments as well as other settings where parents (and future parents) intersect

Appendix 1 lists the participants at each roundtable meeting.

This report summarizes the results from these meetings and provides a potential focus for those concerned with healthy children and healthy weight. The policy opportunities in this document do not reflect the policy agenda of AAP or RWJF at this time, but they will inform both organizations’ work in this area.
The Meeting Process

Each of the roundtable meetings followed a similar flow and process:

**Context-setting.** Participants heard from experts in the field on the main forces affecting obesity rates for the area of focus for that roundtable, and how taking a developmental approach provides a unique lens and thus may lead to innovative policy strategies. Characteristics of policy were also discussed and participants used this information as a tool to guide discussion and the development of policy opportunities.

**Review of the evidence.** Meeting staff presented summaries of evidence-based protective and risk factors for obesity at the relevant developmental stage (Box 1, page 3). Roundtable participants reviewed, discussed and expanded on this body of evidence, which formed the foundation of subsequent policy discussion.

**Assessment of the existing policy landscape and selection of those policies most relevant for elevation and consideration in P-5 approaches.** Before each meeting, participants received summaries of existing policy strategies—from sources such as the federal Department of Health and Human Services, the Institute of Medicine, AAP, American College of Obstetricians and Gynecologists and the Centers for Disease Control and Prevention—arrayed by the evidence-based protective or risk factor(s) the policy addressed. After discussion at the meeting, participants then identified the existing policy strategies they would like to elevate for ongoing consideration in any future policy agenda.

**New policy development.** After reviewing the current policy environment, roundtable participants determined the areas where new policies were needed. Working in small groups through several iterations, participants fleshed out new specific policy recommendations:

- Clarifying the policy and its rationale.
- Identifying the evidence-based protective or risk factors to be addressed.
- Explaining the relevance to populations most at-risk for obesity.
- Highlighting further research or data needed and potential issues for implementation.

Meeting staff urged participants to approach this work creatively: to aim to design the best policy opportunities without feeling constrained by current political realities.

**Policy Targets**

The process for the roundtables was designed to anchor recommendations in the needs of children and families and emphasize the developmental approach. This process included acknowledgment of the socio-ecological context in which families live and the numerous factors that need to be better addressed in order to foster a positive environment for public policy to reach its full potential. Coupled with this information, each of the roundtables leveraged existing obesity prevention evidence as well as expert opinion to explore policy strategies to facilitate those factors that promote healthy weight (protective) and mitigate those factors that contribute to obesity (risk factors). Box 1 lists the protective and risk factors presented to participants and that subsequently served to guide development of new policy.
### Box 1: Protective and risk factors: specific to the P – 5 space
(See Appendix 2 for Primary Sources)

<table>
<thead>
<tr>
<th>Protective Factors</th>
<th>Pregnancy</th>
<th>Infancy</th>
<th>Early Childhood</th>
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<tbody>
<tr>
<td>Healthy weight prior to pregnancy (maternal and paternal)</td>
<td>Full term healthy weight baby</td>
<td>Breastfeeding continuation</td>
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<tr>
<td>Appropriate maternal weight gain during pregnancy</td>
<td>Breastfeeding exclusively for 6 months</td>
<td>Introduced to a wide variety of flavors, textures and foods</td>
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<tr>
<td>Regular exercise during pregnancy</td>
<td>Appropriate bottle feeding (proper formula preparation, no bottle propping, nipple size, etc.)</td>
<td>Self-feeding</td>
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<tr>
<td>Healthy diet (quality and quantity)</td>
<td>Appropriate complementary food introduction (1. Timing 2. Variety of food and textures)</td>
<td>Fruit and vegetable consumption</td>
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<tr>
<td>Prenatal care</td>
<td>Self-feeding</td>
<td>High fiber and nutrient rich diet</td>
<td></td>
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<tr>
<td>Breastfeeding/lactation classes</td>
<td>Healthy snacking (appropriate timing, amount and quality)</td>
<td>Regular water consumption</td>
<td></td>
</tr>
<tr>
<td>Full term healthy weight baby</td>
<td>Parental/caregiver understanding of hunger and satiety cues</td>
<td>Eating breakfast</td>
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<tr>
<td>Breastfeeding initiation</td>
<td>Meal, activity and snacking routines are established</td>
<td>Regular family meals</td>
<td></td>
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<tr>
<td>Returning to a healthy weight after pregnancy (sets the stage for healthy future pregnancies)</td>
<td>Healthy sleep routines are established</td>
<td>Parental/caregiver understanding of hunger and satiety cues</td>
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<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Pregnancy</th>
<th>Infancy</th>
<th>Early Childhood</th>
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<tbody>
<tr>
<td>Gestational diabetes</td>
<td>Rate of weight gain after birth</td>
<td>Continuous snacking</td>
<td></td>
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<tr>
<td>Maternal undernutrition during pregnancy</td>
<td>Too much time spent in devices that restrain movement (strollers, bouncy seats, etc.)</td>
<td>Consumption of sugary and/or calorie dense (energy dense, low nutrient) foods</td>
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<tr>
<td>Smoking during pregnancy</td>
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<td>Meals eaten outside of the home</td>
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<tr>
<th>Emerging Areas</th>
<th>Pregnancy</th>
<th>Infancy</th>
<th>Early Childhood</th>
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<tbody>
<tr>
<td>Microbiome</td>
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<tr>
<td>Maternal depression</td>
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<tr>
<td>Epigenetics</td>
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- Continuous snacking
- Consumption of sugary and/or calorie dense (energy dense, low nutrient) foods
- Meals eaten outside of the home
- Consumption of sugary beverages
- Exposure to TV marketing
- Television in the bedroom
- More than 2 hours of screen time per day
- Too much time spent in devices that restrain movement (strollers, bouncy seats, etc.)
- Non-regulated family-based early child care and education
- Parent(s) with overweight or obesity
To be Most Effective, Policy Needs to Better Address These Socio-environmental Factors

The roundtable series’ focus on populations most at-risk for obesity drove discussion about the root causes of disparities in obesity rates among children. In addition to exploring those evidence-based protective and risk factors, roundtable participants emphasized environmental and systematic issues of relevance. While all three roundtables addressed social determinants of health, participants in roundtable 2 tackled them most directly, highlighting that the prevention of childhood obesity cannot be fully addressed without attention to contextual factors such as built environment, safety, access, equity, socio-economic status, working and living conditions, exposure to adverse childhood events, and poorly aligned systems and infrastructure. Box 2, below highlights the factors that routinely emerged from these conversations as most critical. Significant points included:

**Poverty**
Potential policies need to be continuously viewed through a poverty-inflected lens; the most critical concern is that policies do not widen existing gaps among income levels. The relationship of these two ideas becomes clear in any evaluation of tax policy as a way to incentivize healthy eating: sales taxes are regressive, and the revenues from such taxes often go to general funds, not health-related initiatives. Multi-generational considerations matter in poor families, as does managing the balance between low-wage work and maintaining eligibility for support programs.

**Institutional Racism**
Institutional racism is a way of embedding a sense of both racial domination and racial inferiority into society, and each new generation must cope with the burdens this imposes on finances, housing, health access, and other issues. Minority children have different expectations for their future because of this burden. Those working on health policy need to address institutional racism directly – it is a different issue than inequity and is not being widely discussed as such.

**Box 2:**
**To be most effective, policy needs to better address:**
- Poverty
- Institutional racism
- Cultural competency
- Systems integration
- The family’s voice and empowerment
Cultural Competency
Cultural competency refers to the lens through which people view and understand the world, and is not bound by race or ethnicity. It affects policy-making as (1) policy makers apply their own cultural outlooks, and (2) different cultural outlooks drive different definitions of desired outcomes, especially in relation to health and wellness. Those working to improve health outcomes among populations most at-risk for obesity need to build a sense of community across cultures and approach cultural differences looking for the strengths they provide rather than highlighting deficits.

Systems Integration
The current early childhood policy and services landscape is disjointed, so programs use fragmented funding streams and eligibility systems that place an undue burden on families who utilize these provisions. Options for improvement include instituting a core set of standards across programs; aligned monitoring and data sharing; cross-training; and unified outcome measures. Alignment needs to occur vertically (across federal, state and local programs) and horizontally (across sectors).

The Family’s Voice and Empowerment
The most important factor in engaging parents and other family members is to meet them where they are. Education and advocacy programs need to do better at this. Specific issues include the power of food as a link to home for immigrant families, the difficulty of engaging people around the concepts of marketing and obesity, the delicate balance parents face when advocating for their children with child care providers, transparency about how a child care setting uses food, and the lack of clear and consistent information for parents in supporting optimal child and family development.
Ensuring payment for important maternal and child health as well as obesity services
Roundtable participants emphasized that changing outcomes requires changing processes; many of the needed process changes take time or involve using new staff in new ways. Provider organizations, especially those serving populations most at-risk for obesity, can’t operate differently unless the associated costs are reimbursed. Paying for services, such as evidence-based childhood obesity prevention programs for all children, also sends a strong message that this activity matters.

Equipping providers with the guidance, resources and training to address healthy active living for those in their care
The people who care for pregnant women, infants and young children need good, clear, consistent and actionable information in order to engage parents, family members and caregivers in discussions about healthy active living and healthy child development; including healthy eating and physical activity in pregnancy, infancy and childhood; and the support systems and resources available for children and families.

Empowering families with knowledge and skills to foster healthy active living
Children develop in the family and the community, and approaches to obesity prevention that stop at the doctor’s office, hospital or clinic door will fail. In order to establish and maintain a knowledge base and skills, families need ongoing support, information, and opportunities to learn from trained professionals and each other.
Ensuring that the healthy choice is the easy choice for all families and young children
Habits in childhood set up lifetime patterns of eating, and research shows food choices are often made unconsciously, out of habit, and are highly dependent on cost. Making healthy foods more accessible and affordable is as important as making unhealthy foods less accessible. The home, the community, health care facilities, the workplace and childcare settings all are venues ripe for action in this regard.

Changing workplaces to better support families with young children
The role of the workplace in preventing childhood obesity is deep-rooted, as being able to earn a living wage mitigates the impact of poverty described above. Beyond this, paid parental leave supports parents in facilitating many of those critical protective factors such as breastfeeding, complementary food introduction and sleep routines and mitigates a host of risk factors including maternal depression.

Eliminating undue burden on families with young children
This theme arose among the new policies proposed by roundtable participants, and links directly to the need for systems integration described previously. Programs exist to support the healthy development of children and to strengthen families in efforts at healthy living, but the programs are fragmented, work in isolation and present barriers to participation for the families most in need of their support.

Supporting access to safe and developmentally appropriate physical activity
Preventing obesity involves a focus both on healthy eating and on physical activity. In reviewing existing policies, roundtable participants highlighted the importance of the availability of safe, developmentally appropriate places for children to be physically active, and of the encouragement of physical activity.

Table 1, page 10, shows the policies (both reaffirmed and strengthened) that fall into each of these categories.

Box 3: Key themes in policies

- Ensuring payment for important maternal and child health as well as obesity services
- Equipping providers with the guidance, resources and training to address healthy active living for those in their care
- Empowering families with knowledge and skills to foster healthy active living
- Ensuring that the healthy choice is the easy choice for all families and young children
- Changing workplaces to better support families with young children
- Eliminating undue burden on families with young children
- Supporting access to safe and developmentally appropriate physical activity
A Sense of Priorities

At the end of each meeting, roundtable participants had the chance, informally, to indicate which of the policy opportunities they felt would have the greatest impact. While admittedly unscientific, the results reflected a sense of the meeting.

In **roundtable 1**, participants emphasized the importance of:

- Instituting reimbursement for weight management services during pregnancy.
- Developing and implementing a formal guideline to counsel about breastfeeding, screen for food insecurity, and refer to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Supplemental Nutrition Assistance Program (SNAP) and the Food Distribution Program on Indian Reservations (FDPIR) during pregnancy and infancy periods.

Participants in **roundtable 2** strongly stressed the importance of developing and pursuing a research agenda on institutional racism. Specific policy opportunities garnering the strongest endorsement were:

- Universal child care and pre-school.
- Taxes on sugar-sweetened beverages if revenue is dedicated to prevention and health care for children 1-5, targeting low and moderate income families.
- Reimbursement by public (Medicaid/Medicare) and private (employers) payers for evidence-based childhood obesity prevention programs and services for all children (or evidence-based physical activity programs) that are developmentally appropriate and family-based.

For participants in **roundtable 3**, the policy opportunities drawing most focus were:

- Establishing universal community-based home visiting as an “opt-out” program for families with children ages 0-5.
- Requiring employers to provide paid parental (broadly-defined) leave for non-exempt workers for at least 8 weeks.
- Taxing and stigmatizing sugary drinks; reducing access to sugary drinks and incentivizing drinking water through tax cuts and funding.
- Expanding the scope of Medicaid, in particular to cover the preventive care services recommended by the U. S. Preventive Services Task Force.
Conclusion

The early obesity prevention policy roundtable series brought together eighty experts, practitioners and advocates over the course of six months to propose the best policy levers to prevent obesity in young children, with a focus on the populations most at-risk for obesity. Although the experts came from different fields and their discussions targeted different stages of child development, a clear consensus emerged that such policies need to focus on:

- Insuring sustainable funding for obesity prevention and treatment services for pregnant women and young children.
- Giving families and care providers opportunities to build knowledge and strengthen skills around healthy active living during the P-5 time frame.
- Changing the environment, so healthy food is easy to get and unhealthy food is not; and so being physically active is a natural part of daily life for children.
- Making the workplace friendlier to new parents.
- Integrating and streamlining the services available to children and their families, so they become easier to use and more accessible.

Roundtable participants also cautioned that any policy initiatives cannot reach their full potential unless they approach their topics in ways that reflect the impacts of poverty and institutional racism, the need for cultural competency, a need for systems integration, and the need to empower parents and families through these policy initiatives.

“Obesity,” one roundtable participant said, “is the canary in the mine of what’s not working well for our children.” The recommendations emerging from the roundtable series reflect this view of obesity as symptom of larger societal issues. While the immediate focus of the policy opportunities relates to maintaining a healthy weight, each category—when more broadly scoped—relates to healthy living and healthy child development overall: prevention of illness, knowledge about healthy living, a healthier environment and workplace, and an integrated approach to health and social services. Set within the context of improving equity, the policy opportunities identified through the roundtable series offer promising approaches for impacting a child’s life course and offer concrete actions for improving the health of our society.

“Obesity, is the canary in the mine of what’s not working well for our children.”
<table>
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<tr>
<th>TABLE 1: PROPOSED POLICIES, BY THEME</th>
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### Ensuring payment for important maternal and child health as well as obesity services

**Strengthened Policy Opportunities**
- Ensure reimbursement by public (Medicare and Medicaid) and private payers for evidence-based weight management services during pregnancy. (RT1)
- Ensure reimbursement by public (Medicare and Medicaid) and private payers for evidence-based childhood obesity prevention programs and services for all children. (RT2)
- Ensure reimbursement by public (Medicare and Medicaid) and private payers for evidence-based physical activity programs that are developmentally appropriate and family-based. (RT2)
- Expand Medicaid to cover preventive care and other risk factor-oriented counseling. (RT3)
- Pilot test payment and incentives for use of provider teams. (RT3)
- To maximize public gain, community-based organizations should leverage the ACA requirement that non-profit hospitals have community benefit plans. (RT3)

**Reaffirmed Existing Recommendations**
- Leverage the ACA requirement for access to prenatal care, breastfeeding support, and access to care for women of childbearing age more generally. (RT1)
- Require public (Medicare and Medicaid) and private payers to pay for weight for length and BMI screening. (RT3)
- Health care providers should measure weight and length or height in a standardized way. (RT3)

### Equipping providers with the guidance, resources and training to address healthy active living for those in their care

**Strengthened Policy Opportunities**
- Create a consistent set of guidance to be implemented across sectors, where families of infants intersect, related to breastfeeding support, food insecurity screening and referral to federal nutrition assistance programs. (RT1)
- Update weight management and physical activity counseling guidelines for pregnant women incorporating the latest evidence and a strength-based approach for information delivery. (RT1)
- Incentivize healthcare providers to deliver and document physical activity counseling of pregnant women. (RT1)
- Require all licensed child care providers to adhere to the nutrition guidelines set forth by Child and Adult Care Food Program. (RT2)
- Expand the pediatric scope of practice to include the social determinants of health and critical maternal health issues including infant feeding. (RT3)
- Expand use of community health workers as extensions to pediatric care to support new mothers in feeding practices for young children. (RT3)
- Implement a broad reaching public awareness campaign to address the weight bias and stigma in our culture. (RT3)

**Reaffirmed Existing Recommendations**
- Require health and education professionals, who interact with families and children, to be trained and educated in healthy weight related competencies and in cross-disciplinary approaches to delivering counseling around healthy active living. (RT2)
**Empowering families with knowledge and skills to foster healthy active living**

| Strengthened Policy Opportunities | • Require public (Medicare and Medicaid) and private payers to pay for group pre- and post-natal care that is accessible to all mothers. (RT1)  
| • Medical associations should promote exploration and utilization of group care by gestational age (prenatal) and developmental stage (postnatal). (RT1)  
| • Fund and support family-based child care networks to improve quality of care and peer support. (RT2)  
| • As part of The Special Supplemental Nutrition Program for Women, Infants, and Children incorporate skill building and support around topics such as food preparation, nutrition, budgeting and other life skills and provide broader education around child development. (RT3)  
| • To support parents and caregivers in building skills around parenting and healthy active living behaviors, establish universal access to community-based home visiting program for families with children ages 0–5. (RT3)  

| Reaffirmed Existing Recommendations | • Require menu labeling in all venues including restaurants and cafeterias. (RT1)  
| • Starting in pregnancy provide anticipatory guidance around the benefits of breastfeeding for both mother and child. (RT1)  
| • Require public (Medicare and Medicaid) and private payers to pay for healthcare providers to screen for obesity risk factors and provide healthy active living related anticipatory guidance at every well child visit. (RT3)  
| • Pilot test new approaches to counseling and supporting families in healthy active living that leverage technology (apps, fitness trackers, text messaging etc.). (RT3)  

**Ensuring that the healthy choice is the easy choice for all families and young children**

| Strengthened Policy Opportunities | • Restrict marketing of infant formula in all health care institutions. (RT1)  
| • Restrict promotion, including product placement and marketing, of sugar–sweetened beverages in all places where young children and their families intersect. (RT1)  
| • Tax sugar–sweetened beverages only if revenue can be dedicated to prevention/care and health programs for children ages 0–5. (RT2)  
| • Incentivize employers to provide an assortment of healthy food and beverage options in the workplace. (RT3)  
| • Continue support for campaigns that promote the benefits of water and elimination of sugar–sweetened beverages. (RT3)  
| • Eliminate sales tax on bottled water. (RT3)  
| • Mandate warning labels on sugar sweetened beverages. (RT3)  
| • Restrict the placement of high density, low nutrient foods from checkout counters. (RT3)  
| • Permit breastfeeding in public places and rescind laws that discourage breastfeeding in public places. (RT3)  
| • Encourage the creation of lactation rooms in public places. (RT3)  

| Reaffirmed Existing Recommendations | • Incentivize baby-friendly hospital designation. (RT1)  
| • Ensure in–store marketing promotes healthful eating by increasing availability, affordability, prominence, and promotion of healthful foods and/or restricting or de–marketing unhealthy foods. (RT2)  
| • Require access to safe, clean drinking water. (RT2)  
| • Restrict the availability of less healthy foods in public service venues. (RT2)  
| • Tax high density, low nutrient foods only if revenue can be dedicated to prevention/care and health programs for children ages 0–5. (RT2)  
| • Ensure geographic availability of supermarkets via incentives, zoning requirements or small business programs. (RT2)  
| • Restrict availability of sugar–sweetened beverages (cafeeteria, vending machines, etc.). (RT2)  
| • Government agencies should promote access to affordable healthy foods for infants and young children from birth to age 5 in all neighborhoods, including those in low-income areas, by maximizing participation in federal nutrition assistance programs and increasing access to healthy foods at the community level. (RT2)  
| • To ensure that child care facilities provide a variety of healthy foods and age–appropriate portion sizes in an environment that encourages children and staff to consume a healthy diet, child care regulatory agencies should require that all meals, snacks, and beverages served by early childhood programs be consistent with the Child and Adult Care Food Program meal patterns and safe drinking water be available and accessible to the children. (RT2)  
| • Require access to safe, clean, free drinking water in the workplace (and ensure employees have time to drink this water). (RT3)  
| • Replace low-nutrient, high-density foods in workplace vending machines with healthy options. (RT3)
<table>
<thead>
<tr>
<th><strong>Changing workplaces to better support families with young children</strong></th>
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<tbody>
<tr>
<td><strong>Strengthened Policy Opportunities</strong></td>
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<tr>
<td>• Expand the Family Medical Leave Act to incorporate a paid component within the larger 12 weeks of leave. (RT1)</td>
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<tr>
<td>• Expand the Family Medical Leave Act to apply to all companies regardless of size. (RT1)</td>
</tr>
<tr>
<td>• Require employers to provide paid parental (broadly defined) leave for non-exempt workers for at least 8 weeks. (RT3)</td>
</tr>
<tr>
<td><strong>Reaffirmed Existing Recommendations</strong></td>
</tr>
<tr>
<td>• Implement smoke-free policies on all worksite campuses. (RT1 and RT3)</td>
</tr>
<tr>
<td>• Require employers to provide a safe, clean and quiet place for mothers to pump. (RT1)</td>
</tr>
<tr>
<td>• Employers should subsidize employee membership in multi-generational organizations for physical activity (e.g., YMCA). (RT3)</td>
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<th><strong>Eliminating undue burden on families with young children</strong></th>
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<td><strong>Strengthened Policy Opportunities</strong></td>
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<tr>
<td>• In order to maximize participation in federal nutrition assistance programs, agencies should work in a coordinated fashion to consolidate and streamline enrollment and renewal processes. (RT2)</td>
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<tr>
<td>• In order to maximize participation in federal nutrition assistance programs, require and fund local program outreach and promotion and retention efforts to vulnerable populations. (RT2)</td>
</tr>
<tr>
<td>• Build a systematic approach to data integration that is family-driven and oriented and works across all providers serving children ages 0-5. (RT3)</td>
</tr>
<tr>
<td>• Establish high quality universal child care and pre-school for all children ages 0-5. (RT2)</td>
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<th><strong>Supporting access to safe and developmentally appropriate physical activity</strong></th>
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<tr>
<td><strong>Reaffirmed Existing Recommendations</strong></td>
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<tr>
<td>• Increase the availability of safe, attractive and developmentally appropriate places for physical activity. (RT2)</td>
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<tr>
<td>• Child care regulatory agencies should require child care providers and early childhood educators to provide infants, toddlers, and preschool children with opportunities to be physically active throughout the day. (RT2)</td>
</tr>
<tr>
<td>• Adults working with children should limit screen time, including television, cell phone, or digital media, to less than two hours per day for children aged two-five. (RT2)</td>
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List of Appendices

Appendix 1.
Roundtable Participants

Appendix 2.
Primary Sources for Protective and Risk Factors
## Appendix 1. Roundtable Participants

**Shaping the Health of the Next Generation: Early Obesity Prevention Policy Roundtable Series**

### Roundtable 1: Pregnancy – Infancy

**June 22 – 23, 2015**

**Participant List**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Institutions/Positions</th>
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</thead>
<tbody>
<tr>
<td>Steven Abrams, MD, FAAP</td>
<td>University of Texas, Austin</td>
</tr>
<tr>
<td>Laura Annunziata, MSN, FNP</td>
<td>Zero to Three</td>
</tr>
<tr>
<td>Leann Birch, PhD</td>
<td>University of Georgia</td>
</tr>
<tr>
<td>Sandra Bishop-Josef, PhD</td>
<td>ReadyNation</td>
</tr>
<tr>
<td>Renee Boynton-Jarrett, MD, ScD, FAAP</td>
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<td>Ronette Briefel, DrPH</td>
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<td>Jill Castle, MS, RDN, CDN</td>
<td>Academy of Nutrition and Dietetics</td>
</tr>
<tr>
<td>William Dietz, MD, PhD, FAAP</td>
<td>Redstone Global Center for Prevention and Wellness</td>
</tr>
<tr>
<td>Ditra Edwards</td>
<td>The Praxis Project</td>
</tr>
<tr>
<td>Lacy Fehrenbach, MPH</td>
<td>Association of Maternal &amp; Child Health Programs</td>
</tr>
<tr>
<td>Jennifer Frost, MD</td>
<td>American Academy of Family Physicians</td>
</tr>
<tr>
<td>Dianne Gerken, MSN, E-MBA-HA, FNP</td>
<td>Nurse Family Partnership</td>
</tr>
<tr>
<td>Matthew Gillman, MD, MS</td>
<td>Harvard Medical School</td>
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<tr>
<td>Douglas Greenaway, MDiv</td>
<td>National WIC Association</td>
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<td>Debra Hawks, MPH</td>
<td>American College of Obstetricians and Gynecologists</td>
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<td>Diana Hu, MD, FAAP</td>
<td>Indian Health Service</td>
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<td>Manel Kappagoda, JD, MPH</td>
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<td>Joan Meek, MD, MS, FAAP</td>
<td>U.S. Breastfeeding Committee</td>
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<td>Natalie Muth, MD, RD, MPH, FAAP</td>
<td>Children’s Primary Care Medical Group</td>
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<td>Andrea Sharma, PhD, MPH</td>
<td>Centers for Disease Control and Prevention</td>
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<td>Leslie Sim, MPH</td>
<td>Institute of Medicine</td>
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<td>Karen VanLandeghem, MPH</td>
<td>National Academy for State Health Policy</td>
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<tr>
<td>Kimberly Vesco, MD, MPH, FACOG</td>
<td>Kaiser Permanente Sunnyside Medical Center</td>
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<td>James D. Weill, JD</td>
<td>Food Research and Action Center</td>
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### Project Advisory Committee

- Sandra Hassink, MD, FAAP (Chair)
- Lucy Sullivan, MBA (Member)

### Program Staff – Institute for Healthy Childhood Weight

- Alison Baker, MS
- Mala Bedient, MPH
- Jeanne Lindros, MPH
- Corrie Pierce

### Consultants

- Brad Sperber, MDiv (Meeting Facilitator)
- Katherine Garrett, MBA (Technical Writer)

### Program Staff – Robert Wood Johnson Foundation

- Jamie Bussel, MPH
- Abbey Cofsky, MPH
- Karen Ellis
- Tracy Fox, MPH, RD
- Tina Kauh, MS, PhD
Roundtable 2: Early Childhood
November 9-10, 2015
Participant List

Participants
Katie Adamson Y of the USA
Laura Annunziata, MSN, FNP Zero to Three
Monica Baskin, PhD University of Alabama at Birmingham
Katherine Beckmann, PhD, MPH Administration for Children and Families
Jeanette Betancourt, EdD Sesame Workshop
Eva Daniels, MEd National Association of Family Child Care
Verónica Figoli Denver Public Schools
Myron Floyd, PhD North Carolina State University (Day 1 only)
Lori Freeman, MBA Association of Maternal & Child Health Programs
Natasha Frost, JD Public Health Law Center
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Lauren Galarza
Claire Gibbons, PhD, MPH

Additional Guests
Madeline Curtis, AAP
Tracy Fox, MPH, RD, Food, Nutrition and Policy Consultants
Tamar Magarik Haro, AAP
Linda Shak, MSW, The Packard Foundation
Elizabeth Wenk, MA, Burness Communications
Liane Wong, DrPH, The Packard Foundation

Consultants
Lisa Silverberg, MA (Meeting Facilitator)
Katherine Garrett, MBA (Technical Writer)
Roundtable 3: Creating a Culture of Health at Home
December 16-17, 2015
Participant List

Participants
Sabrina Adler, JD  ChangeLab Solutions
Tris Barber, MA
Beatriz Beckford
Donna Butts
Christina Calamaro, PhD, CRNP
Ginger Carney, MPH, RDN/LDN, IBCLC-RLC, FILCA, FAND
Curtis Chan, MD, MPH
Kirsten Davison, PhD
Lori Freeman, MBA
Alejandra Gonzalez
Douglas Greenaway, MDIV
Mollie Grow, MD, MPH, FAAP
Diana Hu, MD, FAAP
Amy Knoblock-Hahn, PhD, MPH, MS, RD
Edith Mitchell, MD, FACP
Dylan Landers Nelson, MPH
Monique Norfolk, MPH
Eliana Perrin, MD, MPH, FAAP
Jennifer Savage Williams, PhD
Bellinda Schoof, MHA, CPHQ
Camille Smith, MS, EdS
Joshua Sparrow, MD
Karen VanLandeghem, MPH (Day 1 only)

Consultants
Lisa Silverberg, MA (Meeting Facilitator)
Katherine Garrett, MBA (Technical Writer)

Program Staff – Robert Wood Johnson Foundation
Karen Ellis
Claire Gibbons, PhD, MPH
Monica Hobbs Vinlaun, JD

Additional Guests
Tracy Fox, MPH, RD, Food, Nutrition and Policy Consultants
Linda Shak, MSW, The Packard Foundation


