MEETING SUMMARY
National Collaborative on Childhood Obesity Research (NCCOR)
Member Meeting

Tuesday, July 9, 2024
10:30 a.m.–3:30 p.m. ET
Livestream recording
Meeting binder

IN-PERSON PARTICIPANTS (n= 13)
VIRTUAL PARTICIPANTS (n=46)

CDC: H. Blanck, C. Dooyema, J. Fulton, D. Galuska, L. Kettel Khan, J. Matjasko, C. Okoli, L. Zhao	**USDA:** M. Abley, S. Arteaga, C. Cherry, L. Donze, M. Ehmke, S. Fleishhacker, J. Guthrie, D. Johnson-Bailey, L. Kaume, B. Langlois, Y. Lopez D. Nair, P. Pehrsson, A. Torres, B. Wolford
NIH: A. Alfinini, D. Berrigan, A. Brown, M. Brown, L. Donze, L. Esposito, S. George, A. Goldbaum, M. Green Parker, K. Herrick, B. Kowtha, C. Lynch, A. Oh, C. Okoli, V. Osganian, J. Reedy, J. Self, S. Pasiakos, S. Yanovski	**RWJF:**
Coordinating Center (CC): K. Deuman, M. Din, R. Grimsland, K. Hilyard, C. Kim, T. Phillips, L. Rotholz, A. Sharfman, M. Van Orman, A. Lazarus Yaroch	**Other Attendees:** J. Ard, S. Booth, R. Brownson, S. Hassink, N. Pronk, T. Robinson, J. Sallis

Speakers (in order of appearance)

- Jamy Ard, MD, *Wake Forest University, The Obesity Society*
- Sarah L. Booth, PhD, *Jean Mayer USDA Human Nutrition Research Center on Aging, Tufts University, American Society for Nutrition*
- Sandy Hassink, MD, FAAP, *American Academy of Pediatrics, Institute for Healthy Childhood Weight*
- Nicolaas P. Pronk, PhD, MA, FACSM, FAWHP, *HealthPartners Institute, National Academies Roundtable on Obesity Solutions*
- Ross Brownson, PhD, *Washington University in St. Louis*
- Thomas Robinson, MD, MPH, *Stanford University School of Medicine*
- Jim Sallis, PhD, *University of California, San Diego*

Welcome and Highlights of NCCOR's Recent Accomplishments

Karen Hilyard, PhD, *NCCOR Coordinating Center*

K. Hilyard welcomed participants to the National Collaborative on Childhood Obesity Research's (NCCOR) summer member meeting, reviewed the agenda, introduced the meeting presenters, and highlighted the primary purpose of the meeting—to explore current and future obesity-related priorities for external organizations, as well as those that may be relevant to NCCOR. K. Hilyard shared NCCOR's recent accomplishments and activities from February–July 2024, including:

- Hosted the Obesity-Related Policy, Systems, and Environmental Research in the U.S. (OPUS) workshop on June 4–5, 2024. NCCOR hosted part one of a two-part workshop series that featured presentations from leading obesity prevention and public health experts and examined best practices in obesity prevention research with specific attention to community engagement and systems change through an equity lens. The workshop series aims to advance the field by highlighting opportunities for the design and rigorous evaluation of both proximal and distal policy, systems, and environmental (PSE) interventions. With over 600 registrants, the workshop provided a unique opportunity for experts and attendees to explore the next steps to advance multi-level interventions to prevent obesity. The second workshop will be held in October 2024.
- Sponsored, exhibited, and presented at the International Society of Behavioral Nutrition and Physical Activity (ISBNPA) conference on May 20–23, 2024 in Omaha, NE. The NCCOR team hosted an exhibit booth at ISBNPA, where researchers, students, and experts in the field convened to exchange best practices and emerging research in nutrition and physical activity. At the conference, Laura Balis, PhD, from the *Center for Nutrition & Health Impact*, presented on behalf of the "Identification and Categorization of Evidence Gaps in Physical Activity Research" workgroup. In her talk, "Opportunities for Physical Activity Research, Policy, and Practice: A Conceptual Framework," she briefly introduced NCCOR and described the workgroup's recent research identifying critical opportunities to promote physical activity, especially in communities experiencing health disparities.
- Hosted a Connect & Explore webinar, Sleep's Role in Child Health: Expanding NCCOR's Catalogue of Surveillance Systems (CSS), on March 13, 2024. The webinar highlighted the recent additions of sleep variables to the Catalogue of Surveillance Systems. By integrating new sleep variables into the CSS, NCCOR is filling a critical gap and enabling researchers, health care providers, and public health practitioners to efficiently explore the intricate relationship between sleep and childhood obesity. This expansion streamlines research efforts and public health strategies to address child development. The featured speakers included Marissa Shams-White, PhD, MSTOM, MS, MPH, and Alfonso Alfini, PhD, MS, *National Center on Sleep Disorders Research, National Heart, Lung, and Blood Institute*, who discussed the intersection between sleep and childhood obesity.
- Published the 2023 Annual Report, "Making a Strategic Difference." This year's annual report highlights NCCOR's accomplishments during 2023 and features a 15-year retrospective on NCCOR's contributions to childhood obesity research. Over the past 15 years, NCCOR has created seven innovative research tools, published over 200 resources and research articles, hosted more than 70 webinars and workshops, and fostered a dynamic research community. The 2023 Annual Report highlights this history and features a two-page timeline showcasing a selection of NCCOR's major activities and achievements.
- Published a new tool on the NCCOR website, A Guide to NCCOR's Research Tools. The tool is designed to be an easy-to-use booklet for researchers. The guide provides a preview of each tool, including the tool's purpose, key features, and scenarios on when to use it.

Panel 1: Priorities of Obesity-Related Organizations
Moderated by Karen Hilyard, PhD, *NCCOR Coordinating Center*

The first panel featured a discussion between representatives from The Obesity Society, American Society for Nutrition, the American Academy of Pediatrics, and the National Academies Roundtable on Obesity Solutions. In the conversation, J. Ard, S. Booth, S. Hassink, and N. Pronk discussed their agency's

current priorities in childhood obesity research and recent work that has been done to advance these priorities.

The Obesity Society: Current and Future Priorities Related to Childhood Obesity Research – Jamy Ard, MD, *Wake Forest University, The Obesity Society*

J. Ard presented on current and future priorities for The Obesity Society (TOS) related to childhood obesity research. TOS is the leading professional society focused on obesity science, treatment, and prevention. The current TOS priorities are consensus building and advocacy around standards of care for people with obesity. Future TOS priorities include expanding education and training for clinicians, supporting local and regional-level advocacy, and conducting comparative effectiveness research. In all of its work, TOS will integrate health equity to ensure efforts improve the chance that everyone can have a healthful outcome.

Current TOS priorities:

- The first priority for TOS is on building consensus from a diagnostic and treatment standpoint. TOS is actively collaborating with the following organizations to build consensus: Obesity Action Coalition, Obesity Medicine Association, American Society for Metabolic and Bariatric Surgery, Stop Obesity Alliance, and the Academy of Nutrition and Dietetics. This group of organizations has been working on developing consensus statements to change how we talk about obesity and move away from shaming and blaming people based on their weight. This information will be used to anchor conversions with physicians, policymakers, and the broader society. TOS also collaborates with the International Obesity Collaborative (IOC) to develop consensus statements. Two examples were provided during the presentation: a consensus statement on obesity care versus weight loss and a consensus statement on the five principles of obesity.
- A second priority for TOS is advocacy around two focus areas: the Treat and Reduce Obesity Act (TROA) and addressing medication labeling. The first, TROA, would expand treatment options for individuals covered by Medicare. Currently, there is growing momentum for the advancement of TROA. The second advocacy focus area is to address medication labeling for people with obesity because medications may have different properties or effects for people with obesity. Further, people with obesity may be excluded from clinical trials, especially those with higher BMIs. This is especially impactful for children. TOS is working with industry and FDA to address the issues of inclusion of people with obesity in trials.
- A third priority for TOS is to develop obesity standards of care. TOS is leading a global steering committee with a goal to address the evidence gaps to build sufficient evidence to develop future guidelines. The objectives of the work are to:
    - Build on current clinical practice guidelines to address common clinical questions in obesity management that are not directly covered in those guidelines.
    - Provide direct guidance to the clinician to support clinical decision making at the point of care.
    - Identify specific research questions and study designs that can address evidence gaps for future guidelines.
    - Provide a living document that is regularly updated and expanded to cover the breadth of obesity medicine practice.

Future TOS priorities:

- TOS will work to expand education and training by creating an Obesity Science and Practice Learning Hub with basic didactics and curated content for Instagram and YouTube. The mission

is to provide high-quality educational content in engaging formats from leaders in the field of obesity that enhances the practice of obesity care.
- TOS will focus on local and regional advocacy by generating playbooks that provide best practices for working with local policymakers to expand access and coverage for care. TOS understands that many changes are made more quickly at the local level and will work with patient representatives and organizations to reduce bias in workplaces and health care settings.
- TOS will evolve its approach to research by expanding to include comparative effectiveness research. A major question is, what are the best trial designs to understand heterogeneity of treatment response to tailored treatment strategies?

Across all its work, TOS will integrate health equity to ensure efforts improve the chance that everyone can have a healthful outcome. TOS will advocate for systems change, continue to think systematically, and support research that helps integrate social determinants of health (SDOH) into care.

Current and Future Priorities for Childhood Obesity Research – Sarah L. Booth, PhD, *Jean Mayer USDA Human Nutrition Research Center on Aging, Tufts University, American Society for Nutrition*

S. Booth presented on current and future research priorities for the American Society for Nutrition (ASN) related to childhood obesity research. ASN advances the science, education, and practice of nutrition. ASN members are very engaged in the research of nutrition, primarily focusing on obesity. The current research priorities for ASN include overcoming methodological challenges to research and dietary assessment measures. More research is needed in the future to better understand weight growth trajectories throughout childhood and adolescence, the impact of the food environment on child weight, influencers of child eating behaviors, and how best to address SDOH. In summary, more replication of strong science is needed to build the evidence from which to develop policy.

Current ASN research priorities:
- ASN is working to overcome many challenges in methodology for basic research.
- Another challenge ASN is working to overcome is the accuracy of dietary assessment measures for children. There is great difficulty in capturing accurate dietary intake for children; they either don't remember or must ask caregivers. New and improved technologies to capture and quantify dietary intake are needed and there is tremendous global interest. The NIH's Nutrition for Precision Health study is developing tools and technologies; however, they will need to be validated for use in children. There is also considerable research being done on the optimal introduction and timing of foods for children.

Future ASN research priorities:
- More research is needed to better understand weight growth trajectories throughout childhood and adolescence. We need to better understand what is considered "normal" growth and development. There is concern regarding the use of endpoints such as BMI z-score and BMI, as outcomes. For example, BMI z-scores are based on standard deviation; therefore, children at different levels of obesity can have the same BMI z-score. Instead, we should leverage the expanded growth curve models or look at overweight/obesity prevalence.
- More research is needed to understand how the food environment impacts weight in children. This includes evaluating the effects of marketing to children, considering industry reformulation of food and beverage products, and assessing the social and environmental impacts of screen time and social media.

- Research is needed that integrates developmental theory into basic biopsychosocial research to better understand child obesity risk and prevention within a broader developmental context. Age-related changes in eating among children reflect developmental processes that are rarely considered and/or reflected in approaches to prevention. After close to a half century of research on children's eating behaviors, we still have a relatively rudimentary understanding of developmental trajectories of food preferences, appetite self-regulation, and parenting that reflect cognitive and socioemotional development.
- Research is needed that utilizes health equity frameworks to formulate approaches to prevention on SDOH drivers of energy-balance behaviors and obesity among children. Key research questions include:
    - How can studies of etiology better identify relevant SDOH drivers?
    - How can approaches to prevention better address SDOH that exist (and may differ) across key contexts?
    - What SDOH are critical for making treatment more accessible?

AAP Institute for Healthy Childhood Weight – Sandy Hassink, MD, FAAP, *American Academy of Pediatrics, Institute for Healthy Childhood Weight*

S. Hassink presented on the *American Academy of Pediatrics (AAP) Institute for Healthy Childhood Weight*, its current activities and priorities, and identified research gaps related to childhood obesity research. The AAP Institute for Healthy Childhood Weight is a translational engine for pediatric obesity prevention, assessment, management, and treatment—moving policy and research from theory into practice in American health care, communities, and homes. The current AAP priorities include increasing awareness and dissemination of evidence-based treatment and prevention recommendations, building skills around key aspects of obesity care and capacity building, and building the evidence base and addressing gaps. Future priorities include optimizing growth and development by centering the child in the context of their families and communities and providing personalized, tailored care and informed, shared decision-making.

Current AAP activities and priorities:

- AAP aims to translate clinical guidelines to practice in a timely manner. It can take 17 years to translate guidelines into practice. For that reason, AAP is leaning heavily on implementation science to advance translation. For example, AAP recently launched a clinical practice guideline on obesity treatment. Practicing clinicians are a key component for this translational work. There are a variety of factors that impact translation, including individual-level, guideline-related, and external factors. Individual factors include physician knowledge (awareness, familiarity) and attitudes (efficacy, skills, motivation). Guideline-related factors include the simplicity, plausibility, and clarity of the guidelines, and how applicable they are to clinical flow. External factors that impact translation include organizational capacity (protocols, systems, etc.), collaboration capacity (multi-professional cross-collaboration), and social and clinical norms (consensus). Priorities for AAP include:
    - Increasing awareness and dissemination of evidence-based treatment and prevention recommendations. This can be done through presentations, speaker kits, podcasts, media, marketing articles, commentaries, partnerships, newsletters, HealthyChildren.org, and internet impressions.
    - Skill-building around key aspects of obesity care by developing continuing medical education (CME) modules, live CME, conferences, and clinical decision supports.

    - Capacity building (systems within practice and broader policy systems to support comprehensive obesity care) in areas such as quality improvement, health information technology, payment, advocacy for systems change, and improved quality measures.
    - Building the evidence base and addressing gaps through research project partnerships, advisory committees, and workgroups.
- AAP is also striving to build capacity in primary care and tertiary care. In primary care, AAP is working to provide training in weight bias and stigma; build skills for tailored medicine focused on the whole child; build capacity for motivational interviewing, intensive health and behavior lifestyle treatment (IHBLT), pharmacotherapy, and surgical referrals, as appropriate; support access and spread of IHBLT; demystify growth and growth trajectory/growth chart science; improve knowledge about eating disorders and screening in the context of obesity; and build health communication capacity to help contextualize complexity of obesity and related drivers. In tertiary care, AAP is working to grow and expand the field by providing mentorship opportunities, develop treatment synergy and collaboration between primary care clinicians and their tertiary care colleagues, provide more multi-disciplinary team-based work to allow the primary care provider to have access to resources they need when they need them, and improve access through linkages with primary care.
- In the upcoming year, AAP will focus on the following targeted areas and populations:
    - Help physicians understand BMI as one screening tool and that there are other measures that can be used clinically.
    - Provide opportunities for healing conversations about weight and weight bias/stigma for patients.
    - Work collaboratively with the eating disorder community to help evolve the eating disorder screening protocols for pediatric populations in treatment for obesity, as well as monitoring and assessment of eating disorders.
    - Improve access to treatment and capacity, specifically around IHBLT, pharmacotherapy, and surgery.
    - Develop a better understanding of how to care for Indigenous and rural populations.
    - Continued focus on early obesity prevention (0–2 years, specifically).

Future AAP activities and priorities:

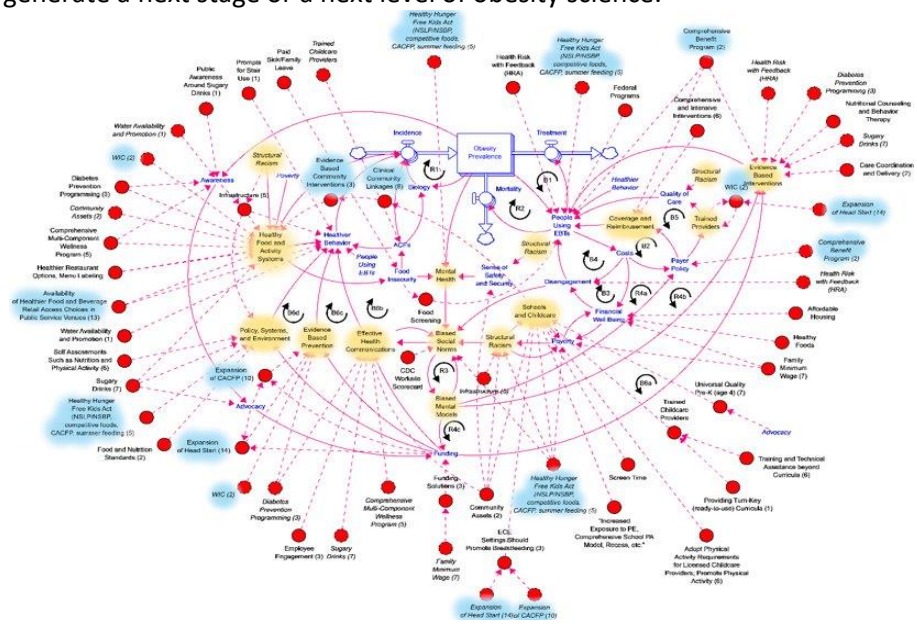
- AAP has identified the following research gaps to be filled:
    - Improved measures that reflect complexities of obesity in the initial evaluation and the outcome measures beyond BMI.
    - Better understanding of the duration of treatment effects and heterogeneity of treatment effects, in both general and special populations.
    - Better understanding of disordered eating and eating disorders in patients undergoing obesity treatment.
- An aspirational focus in the future for AAP is to take an approach that centers the whole child within the context of their family and environment, in addition to their genetics and biology. This requires taking two steps back to understand and promote what supports each child and their lifelong health. The provider must understand how and in what context the child lives, plays, and grows to understand and mobilize the strengths of the child and family. This will require an acknowledgement of the failure to build systems that support health and nourish children and families. AAP is driving toward implementation of personalized and tailored care and informed and shared decision-making for each child and family.

Strategic Planning and Priority Setting for The Roundtable on Obesity Solutions – Nicolaas P. Pronk, PhD, MA, FACSM, FAWHP, *HealthPartners Institute, National Academies Roundtable on Obesity Solutions*

N. Pronk presented a set of strategic planning and priority considerations for obesity solutions based on insights from the Roundtable on Obesity Solutions, current health care challenges, and research. Priority considerations include the need for equity and systems science, consideration of lived experience, prevalence data forecasting, equitable obesity treatment options, development of clinical decision supports, understanding the role of regional cultures, and government action and policies on health. These priorities require an enhanced focus on children and adolescents, community-level change, law and policy, and incidence.

Priority considerations for developing obesity solutions:

- Equity and systems science
    - The Roundtable on Obesity Solutions (ROOS) of the National Academies of Sciences, Engineering, and Medicine (NASEM) embarked on a one year project to create a graphical representation of the complex system around obesity in terms of both its challenges and solutions. Through this process, it was learned that behavior (by people, organizations, economies, countries, etc.) is affected by the context in which it occurs. We cannot understand, predict, or change the behavior of something without looking at the context in which that thing (or person) is operating. The use of systems science can complement what is known today, but it can also complement more traditional approaches and methods. The system science piece increases our understanding and appreciation of complex systems. It can also increase the use of systems mapping as a tool to bring stakeholders together, but also communicate about these complex health issues that exist. It can help generate new questions and approaches to take as well. This is complementary to more traditional randomized control trials. For example, using system science as both an explanatory, as well as an exploratory, method of scientific inquiry. It helped the ROOS set priorities for itself around structural racism, biased social norms, as well as health communications. The broader use of systems science can help generate a next stage or a next level of obesity science.



- Lived experience
    - There is an urgent need to address stigma, bias, and discrimination. The need is particularly urgent in health care where weight stigma remains high. We also need to start including the lived experience perspective in intervention design and research. This can be done by maintaining focus on health outcomes along with indicators such as stigma/bias and social norms.
- Prevalence data forecasting
    - Obesity is anticipated to increase in prevalence in both children and adult populations over the next decade. We need to improve access to highly effective treatment options (i.e., GLP-1 medications). The consequences of rising obesity prevalence include catastrophic impacts on health of the population as a whole and the health of subpopulations (e.g., people from minority groups and people with lower incomes); economic indicators across society; and military readiness and national security. At this point in time, an all-hands-on deck approach is needed to address obesity solutions moving forward.
- Obesity treatment options
    - We need comprehensive treatment options from community programs all the way through to bariatric surgery. This includes digital health programs, commercial weight loss programs, lifestyle coaching and counseling, nutrition counseling by a registered dietitian, worksite health promotion, and well-being programs. We need to use people-first language, in addition to improving access to obesity medical clinics and anti-obesity medications. A comprehensive treatment approach is sorely needed to ensure equitable and affordable access. This includes access to GLP-1 pharmaceuticals that are truly powerful, yet there are major challenges to access in terms of pricing. Questions remain regarding prescribing, as well as a consideration of the breakeven point for these treatment solutions.
- Clinical decisions support (CDS)
    - There is a need to focus on obesity, as well as other health issues at the same time in the context of primary care. For example, many patients have multiple conditions that need to be addressed at the same time. With so many priorities, how can obesity be recognized as a priority consideration? For that, we need systems that help primary care physicians save time and get to the most important issues very quickly. An example is a wizard that presents the clinician and patient with a prioritized short list of care options based on potential clinical benefit to support informed, shared decision-making on topics of high-potential benefit. The wizard is a web-based, electronic health record-linked decision support system that informs patients and health care professionals of important care improvement opportunities. The wizard identifies individuals with substantial care improvement opportunities, prioritizes patient-specific care recommendations based on potential benefit to that patient, displays treatment options and suggestions, provides printed information for both the patient and the clinician, and simplifies ordering of medications, labs, and referrals. The system has been tested and validated; it has been found that the wizard promotes health equity, prioritizes based on benefit, updates recommendations over time, supports appropriate diagnostic coding, and is associated with positive return on investment. The wizard is evidence-based, person-centered, and tailored. It facilitates shared decision-making and increases clinical efficiency. Within the wizard there is a patient view, which is designed for people with low literacy and numeracy and uses symbols to relay risk and what would be of most benefit to your health if action is taken. There is also a clinician view that includes lab

values, treatment considerations, and safety alerts that can be given to patients with higher literacy and numeracy.

- Role of regional cultures
    - There is a need to tailor interventions based on cultural context. Obesity is not homogeneously distributed across the country and there are large variations that exist throughout the United States. That variation is oftentimes related to regional cultures. This heterogeneity influences the way politics show up in the local settings and establishes the linkage to policy development. Policy development, in turn, heavily influences the social, physical, and economic environments that people live in.
- Government action and politics
    - In particular, the pricing strategy that currently exists for GLP-1 medications prevents access and large-scale population level impact. Today, these medications are available for roughly $1,000.00 a month in the United States, compared to France, where it's $71.00 a month. Advancement of policies, like the TROA Act, is important for addressing this. Existing policies today have not demonstrated adequate effectiveness, meaning we need stronger governance to enact meaningful policy changes. Prevention should remain the priority and primary focus, but while that's happening, regulations are needed to eliminate barriers to treatment access and new generations of clinical treatments. Health plans should make sure there is equitable access across all populations, and we should hold those plans accountable for equitable distribution and implementation.

Q&A with Panelists

Q: What fields or sectors do we need to bring to the table to advance childhood obesity work?

S. Hassink: Right now, we need an all-hands-on deck strategy. Every system in the ROOS systems map needs to be involved. It's a complex problem, and I don't think we're going to solve it by staying in our silos.

N. Pronk: A major challenge is starting conversations with all these stakeholders and keeping them at the table long enough to see benefits. These conversations need to focus on solutions, not problems. We need a good view of the field as a whole so we know what stakeholders are missing.

J. Ard: Part of the challenge is related to the translational process and the 17 years it takes to move evidence into practice. As Nico was alluding to, we need to create the anchor that gets people to the table and drives them to understand and see the vested interest. We need to figure out the incentives that will drive people to the table and get them to act.

S. Booth: One of the big challenges for the Dietary Guidelines Advisory Committee has been that there is a lot of research that can't be used for generating public policy. Replication of research is greatly needed. A lot of innovative studies cannot be used because they are too different from other studies. That will lead to more robust data that is acceptable to the research community.

S. Hassink: When reviewing articles for the development of clinical practice guidelines, we saw that the methodology sections were typically inadequate. Due to this, you can't replicate a study based on the published methods. As a field, we could improve how this information is presented and shared so studies can be replicated.

J. Ard: Sometimes research questions and methodologies are way too complex, and this is a hindrance to implementation. We need to be more pragmatic in study designs and strategies. If it can't be scaled, then it may not be a good place to focus on terms of moving the needle on population-level change.

Q: Can you explain TOS' interest in prevention research and what may be some of the barriers to making prevention more of an equal element in our efforts to address obesity?

J. Ard: There is a growing interest in understanding the newest science around treatment targets and to date, prevention efforts have not been successful at scale. There is a lack of political and social will to make broad changes to move from individual to societal and systems-level. Prevention work can be quite challenging. Funding mechanisms don't work as well for prevention either. While there are a number of things that are challenging in the prevention space, this doesn't diminish the importance. We can't treat our way out of the obesity epidemic, because people will continue to be exposed to obesogenic environments.

S. Hassink: As clinicians, we're trying to maintain the entire continuum from prevention through treatment. I think prevention, especially in the earliest days, is about supporting health in all children. Prevention must be looked at holistically, and the clinician's role must be looked at as part of that whole continuum. You must think and look long-term to do prevention work, and we've become short-term thinkers.

N. Pronk: We can't treat our way out of the problem, which is why a prevention focus is key. We may need to think more about adjacent issues. For example, how can obesity be framed in the context of thriving research? We must support long-term thinking, in addition to long-term funding. We need research teams to be funded for 10 years, rather than three years because that is not long enough to answer many questions.

S. Hassink. I agree, we need clear methodology and focus on feasibility and scalability in long-term research questions.

Q: How can clinicians get access to the behavioral interventions they need to implement obesity therapy?

S. Hassink: The CDC has identified five community-based programs that can be scaled and used in different communities for IHBLT. We've made them available to clinicians on our website.

Q: How can we maintain thoughtfulness in meeting patients where they are?

N. Pronk: Health is not important to people until they lose it; however, well-being is important to people. If you ask people what health means to them, they do not typically respond by saying it's important that they go to the doctor. It's much more important that they can spend time with their families and that they can spend time with their grandkids. I think the context of health should be placed in the context of well-being.

S. Hassink: What people value is of importance, and this is what they have energy around. Conversations need to go deeper than BMI and lipid levels. Conversations need to focus on values for their lives. We need to help patients achieve what they value most. Motivational interviewing is one way to get those meaning and value questions answered.

J. Ard: Caregivers will have a different perspective of health for their children compared to their own health. We need to communicate health risks associated with excess body weight for children. In certain communities, people will start to accept their health trajectory, and we need to communicate that there is a different way of achieving health that starts early in life.

Q: How can we engage different sectors that influence obesity (food industry, pharmaceutical industry, health care industry, etc.)?

N. Pronk: Focusing in on one company or sector is not going to be productive. We would be better off including everyone in the conversation and explain that each has a role in an outcome that needs to be improved.

S. Booth: There has been a tendency to demonize individual foods or companies. At the end of the day, they are working based on supply and demand; however, there are some that want to do the right thing.

S. Hassink: If we continue to operate in silos, we won't get anywhere. Somehow the concern for a healthy population needs to become more generalized. We must figure out how to generate these conversations.

Q: Based on history, industry self-regulation in the United States doesn't work. What approach should we take with industry to be most productive moving forward?

N. Pronk: We need to go to our politicians and tell them that we need policies that are conducive to health. How can we increase civic participation and give people agency to express their desires around what they want for health through their opportunity to vote? Voting is directly related to health outcomes.

Q: What is the name of the bias mental model that Dr. Ard shared?

J. Ard: That was an area called out specifically by the ROOS systems map that Nico showed. It was one of the areas of focus that we saw as a driver of a lot of the subunits within that system and it underpinned decision-making, policy making, allocation of resources, all those types of things.

N. Pronk: It was a priority factor that came out of these deliberations of the roundtable over the course of that year. It has a lot to do with the context of culture, the complexity of how people in their regions and across the country think about things. It's a generic way of addressing how people think across the board.

S. Hassink: All of this is connected to how we value each child in our population and in our culture. When it comes to putting resources behind what children really need to build health, I think we're lacking. There is an issue of how we view the child, the importance of health, and those foundational elements of health for each child.

Panel II: NCCOR's External Scientific Panel: Perspectives on Future Directions

Moderated by Karen Hilyard, PhD, *NCCOR Coordinating Center*

Three members of NCCOR's External Scientific Panel (NESP) discussed their perspectives on future directions for childhood obesity research and how NCCOR can contribute to progress in the field: R. Brownson, T. Robinson, and J. Sallis.

Q: In the next five years, what are the most pressing needs to address the childhood obesity epidemic in the United States? What would be your top two topic areas and why?

R. Brownson: My top two are interrelated: return on investment (ROI) and mobilization. For ROI, a major question is, what is the ROI for obesity intervention research and evaluation, and who is the eye of the beholder of that ROI? In the health field, the ROI might be reductions in rates of obesity, higher quality of life, or cost effectiveness of different obesity interventions. However, for a family it might be weight loss or the ability to live in a healthier environment. For a policymaker, it might be reelection or how much it helps their constituents, specifically. Underlying all of that would be the issue of disparities and equity. How does the ROI play out for different populations, especially those that are marginalized? In terms of mobilization, the COVID-19 pandemic showed us that when there is a sense of urgency, we can mobilize and act on a very large-scale quickly. The question is, how do we raise the urgency around issues related to childhood obesity and what is going to help that urgency rise? We need to think about strategies for increasing the sense of urgency.

T. Robinson: There is a lot of excitement right now around pharmacological treatment, and it is receiving a lot of attention. Thinking forward, especially the next five years, I feel there's a need to double down on developing a much stronger evidence base for community interventions and policy interventions. I haven't seen a lot of new creativity or innovation in those areas in recent years. We need to show that there are benefits from community and policy interventions that can be scaled. Secondly, there is a need for behavioral treatment models for children and populations that already have obesity. Even if these pharmacological treatments continue to be as effective as they appear to be, and hopefully as safe as they appear to be, the reach is only going to be a small proportion of the people who really need them. We've seen this happen many times before, for example with statins and antihypertensive medications. There are infrastructures put in place for pharmacologic treatments that ensure they can be disseminated and paid for. Yet, the medications still don't reach the majority of people who need them. Behavioral treatments are still going to be needed because we can't leave behind the people who have inequitable access to the latest medical advances.

J. Sallis: There are two areas that I think need exploration and research that will hopefully lead to new or more focused opportunities for intervention: commercial determinants of health and climate change. First, I see the commercial determinants of health as a compliment to the SDOH. Last year, *The Lancet* released a series on commercial determinants of health, and this is important to nutrition. There's been a lot of study about food marketing, food availability and promotions however, on the physical activity side there's been a lot less of that. We don't have a good understanding yet of how commercial activity, investments, advertising, placement of stores affects childhood obesity and what might be the opportunities to intervene. The corollary of that is understanding what the inequities in commercial behavior might be, such as differences in targeted marketing and retail environments among children of different racial and ethnic groups and different socioeconomic groups. Secondly, we need to prepare for climate change adaptation. There are likely going to be a lot of implications for agriculture and food, but also physical activity. We need to think about how to adapt our environments to hotter climates because there are going to be incentives to stay inside where it's air conditioned. We need to think about how we're going to adapt to this, either by changing policies in schools and preschools, or by

putting more shade up in playgrounds and along streets. There is an equity dimension to this as lower income neighborhoods tend to be hotter than higher income neighborhoods, in part because of greenery and trees. I know there is an NIH-wide focus on climate change research, and I think that childhood obesity-related issues should be part of that.

Q: Now that you've heard each other's priorities, how do we connect the dots between them?

J. Sallis: Scaling up interventions that we know work is a continuing challenge for NCCOR. Over many years of talking about priorities, this has been a major focus. While it is not a new idea, it is one that we have not solved. The excitement about drugs makes people forget about obesity prevention in the first place. While having access to effective drugs is good, it is not an excuse to let obesity run wild. I hope that NCCOR and its members remain strong advocates and enablers of prevention strategies.

R. Brownson: I would layer on top of that, the framing of issues is important. Let's take, for example, the issue of equity and climate change. In different places, you would talk about the issue differently. We have to remember that a one size fits all approach does not work. We need tailored and targeted approaches to prevention that consider treatment options, urgency, and ROI. For example, using the word "equity" with the policy audience in a red state may shut down the conversation. However, they might like the phrase, "leveling the playing field" more. It is the same thing, but it's just framed differently.

T. Robinson: I have a lot of interest in media and technology and its influence on behavior. One of the things that we're seeing with the new technology, and especially AI, is that we are no longer thinking about heterogeneous experiences because they're becoming idiosyncratic experiences. Technology is becoming so personalized that you can't even address major groups or themes as easily as you could before. I'm not sure I have an answer for it, but we may have to rethink the way we think about our interventions because the exposures are so personalized and the way people receive their information is so personalized. How do we develop interventions to help immunize people against the way that information is being driven to them in such a personal way?

Q: With a strong focus on treatment and pharmacotherapy right now, how do we ensure the focus is on prevention while still balancing the importance of tailoring interventions for those who need treatment?

T. Robinson: We need to keep a focus on the whole spectrum. Right now, it feels like we're creating teams – team drugs, team behavioral, and team prevention. We need to make people aware that this is a spectrum of interventions from policy all the way to surgery. If we can reframe in a big picture view, I think that would go a long way in helping us see the different pieces to the puzzle.

R. Brownson: I think there's still a notion out there that weight loss alone equals health. We need to make sure people understand that health is more than weight. In the absence of physical activity and nutrition, the weight loss medications won't have the effect that we'd like them to have. The long-term issues related to stopping use or not being able to afford them will result in a seesawing of weight and the effects of that could be an important area of future research. Then, what does this mean for people who are in the lower income spectrum who aren't going to have the means to pay for these drugs? We need to take an equity focus up front, rather than track equity after the fact.

Q: What about treatment as it relates to childhood health weight programs? How does equity fit?

T. Robinson: I just wrote an editorial relating to this. If we take a step back from a population health perspective, we see a need for all these different types of programs from family healthy weight programs to drugs, surgery, community programs, and policy. It is not just about weight, even though these clinical trials are going to show us that there's a lot of benefits from just losing weight. The medications don't magically make you eat more vegetables and be more physically active, although there's some evidence that maybe it'll make some behaviors less addictive.

J. Sallis: I'd like to see more modeling and economic research predicting economic consequences of levels of success in obesity prevention. It would be useful to have modeling of the potential cost if we put all adults who are overweight on drugs versus taking a prevention approach during childhood. What are the economic consequences of not doing well on prevention? The economic impact of putting millions and millions of people on these drugs for society, I think is a terrible outcome for the drug companies. I think we should have some discussion about the economic consequences for the country to continue to not do well on prevention versus investing in environment and policy changes that would be expected to be effective in prevention and reducing the number of people who need the drugs in the future.

T. Robinson: This is not a new challenge for many of us. A lot of us have worked in heart disease prevention, cancer prevention, and tobacco prevention. These same issues have come up. Capitalism has driven the incentives in a way that there's a lot of investment in these types of quick fix treatments and prevention gets left behind. It is tough to make an economic case for saving money over time, although a lot of people have been trying over the decade.

Q: What could NCCOR do to advance your ideas or fill gaps?

J Sallis: NCCOR could test some of the ideas that we were just discussing. We might expect that outcomes would be better for the drugs when people live in healthier environments where it's more realistic for them to buy healthy foods and it's easy, convenient, and safe for them to be active. I would expect that there would be an interactive effect. If somebody lives in a healthier environment and they're taking the drug, they might get a better outcome than a person who's struggling to stay away from junk food. You could compare people, or kids, who are on the drugs in those communities versus demographically matched communities that do not have the same community-wide interventions.

R. Brownson: A spin off could be to look at the effects, or co-benefits, in the families of individuals who are on the drugs. They would also experience more walkable, healthier communities too. I would agree that there likely is an interaction going on, but are there any spinoff benefits in others in the families who are maybe at risk of becoming obese?

H. Blanck shared the following paper in that chat: The Role of Lifestyle Modification with Second-Generation Anti-obesity Medications: Comparisons, Questions, and Clinical Opportunities

Q: Could you speak a little more about what we should do in terms of research or convening with the commercial sector?

J. Sallis: One starting place is to focus research on understanding what the commercial determinants are and what various industries, or even specific companies, are doing and what are the consequences? We need to understand how companies are marketing differentially to different ethnic and socioeconomic status groups. We need to understand their framing of these issues and what they see as realistic

solutions or alternatives. I think starting with research to guide further action is a good place to go. I think there's lots of opportunities to understand the commercial determinants as they relate to childhood obesity.

R. Brownson: Through research, we could identify industries who are doing this well that we would like others to model. We could then determine how to spread those good practices.

T. Robinson: We need people working at all the extremes and we can't expect companies to go against their own self-interest. We need to bring together the companies doing good work and those that aren't. We need both extremes in the conversation.

Question: In the context of families, how do you think NCCOR might expand its focus to the whole-child?

T. Robinson: This is a natural course for NCCOR. You don't think about kids independent from their parents or independent at a single age. You think about their entire development from conception to adulthood. This means also being focused on pregnant women and the context in which families live.

R. Brownson: I don't see very many state and local public health obesity programs thinking intergenerationally about obesity. We tend to get very siloed in settings, diseases, and risk factors without crossing generations. We don't always pay as much attention to the context for health as we probably should, so that might be a slightly different take on this.

J. Sallis: Every parent wants what is best for their children and they are also working within time and resources constraints. One way that parents could be involved, beyond educating them about how to promote healthy eating and active living for their children, is in making their communities better places for their children to eat healthy and be active. Involve families in not just supporting their children and changing their own behavior, but also in advocating for improvements in their neighborhood. Our group has conducted a couple of studies on this kind of citizen advocacy. We have found that people love advocating to improve their own neighborhood and I think parents would be a particularly enthusiastic target group for this. This is a topic that can be integrated into broader PSE interventions that are ongoing in a community.

Q: Do you have any partnership or collaboration ideas for NCCOR?

J. Sallis: Going back to the Obama administration, you might recall that they called for an all-of-government approach to childhood obesity and instructed each department to figure out what they could do to make a positive contribution. There are opportunities throughout government agencies for partnerships and developing shared objectives to work on together. This might be with the Department of Defense or the Transportation Department, for example.

R. Brownson: Right now, the money is in obesity treatment. I wonder if the payers, Medicare or Medicaid, could somehow begin to build in incentives around prevention that could be layered in with the payment for the medications? For example, what are prevention opportunities for those who are having their medications paid for by some governmental program? This way, the prevention aspect gets a little bit closer to equal footing with the treatment options. That is a little vague because I don't even know how that would be operationalized.

T. Robinson: First, I think that the current membership of NCCOR is amazing. To be able to bring the current membership together in one place and convene is something that we rarely see from government agencies. I hope that NCCOR can keep its identity and its focus around childhood obesity. There are a lot of other agencies that have a stake in childhood obesity and would be extremely helpful. I would think NCCOR's role is to bring them to the table and develop one strategy around childhood obesity. Then also, go and sit at their table and think about what their agendas are and how we can contribute.

Obesity-Related Policy, Systems, and Environmental Research in the U.S. (OPUS) Workshop 1 Recap and Workshop 2 Preview

David Berrigan, PhD, MPH, *National Cancer Institute*

D. Berrigan provided a summary of the Obesity-Related Policy, Systems, and Environmental Research in the U.S. (OPUS) workshop 1 and previewed the agenda for Workshop 2. OPUS is a two-part workshop series exploring how to advance progress toward designing and rigorously evaluating PSE interventions, including those targeting both proximal (e.g., food access) and distal (e.g., housing policy) factors. The goals are to 1) explore key learnings from past research and evaluation, and 2) advance childhood obesity research and inform future directions for the field. The OPUS workshop co-chairs are Jamie F. Chriqui, PhD, MHS; Tamara Dubowitz, ScD, MS, MSc; and Shiriki K. Kumanyika, PhD, MS, MPH. The Workshop Planning Committee included Tanya Agurs-Collins, PhD, RD; Donna Johnson Bailey, MPH, RD; David Berrigan, PhD, MPH; Heidi Blanck, PhD; Susan Czajkowski, PhD; Mary Evans, PhD; Audrey Goldbaum, PhD, MPH; Jill Reedy, PhD, MPH, RDN; Sarah Sliwa, PhD; Susan Vorkoper, MPH, MSW; and Amy Warnock, MPA.

The workshop series is timely for a variety of reasons, including:

- The COVID-19 pandemic and related increases in childhood obesity. For example, pediatric obesity rates in the United States rose from 19.3% in August 2019 to 22.4% in August 2020, (Wang and Gago 2024; Lang et al. 2021).
- Recent approval of GLP-1 agonists, Wegovy and Saxenda, for adolescents aged 12 years and older in December 2020.
- Release of the updated U.S. Preventive Services Task Force and American Academy of Pediatrics guidance for childhood obesity.
- Rapidly evolving discourse about obesity, stigma, and health goals.
- Increased agency interest in obesity over the whole life course. There has been tremendous success with tobacco, however, there has been mixed progress with obesity.
- Renewed calls for "Whole Systems" approaches to diet and healthy weight.

Workshop 1 was held virtually June 4–5, 2024 with the goal to discuss key lessons learned from PSE studies in the United States and internationally. There were 632 workshop registrants total; 579 attended on day one and 375 attended on day two. A workshop summary will be available on the NCCOR website in the future. The agenda included the following sessions:

- Keynote addresses
    - Systems Approaches to Obesity Prevention – Ross Hammond, PhD
    - Applying Systems Thinking in Community-Engaged Participatory Research: Findings from the LIKE Project in Amsterdam – Wilma Waterlander, PhD
- Panel discussions
    - Advancing Success in Obesity Prevention: What Works Where and For Whom?

- Building the Next Generation of Multilevel Interventions to Prevent Obesity
- Authentically Engaging Communities to Maximize Relevance and Impact
- Food and Physical Activity Environments: Thinking Beyond Food Retail and Green Space
- Social Policy as Obesity Policy: The Impact of Addressing Social Determinants of Health
- Where Do We Go Next? Scaling Systems Approaches for Equitable Obesity Prevention

Key takeaways from workshop 1 include:

- There is a critical need to authentically engage community partners and other multisector actors.
- There are many examples of successful PSE approaches but there are few whole-of-system efforts.
- There is potential for complex systems models to strengthen and improve design, implementation, and evaluation of PSE approaches.
- There is a pressing need for demonstration projects addressing multiple influences on childhood obesity.
- It is important to address both proximal (e.g., food retail, parks, and recreation) and distal (e.g., housing, income) factors to have equitable impacts.

The second part of the workshop series will be a hybrid meeting held in Washington, D.C., and will explore key considerations in planning, designing, and evaluating the next generation of equity-centered PSE interventions for childhood obesity. The workshop will address three critical issues for PSE approaches to obesity prevention: 1) effective mobilization of diverse actors across the research continuum, 2) utilization of complex study designs and methods, including natural experiments, implementation evaluations, and systems modeling, and 3) engagement of community partners and application of innovative systems science approaches to ensure sustainability and scalability. The target audiences will be key decision-makers, influencers, researchers, and practitioners. A summary and peer-reviewed publication will be available following part two of the workshop.

Reflections on NCCOR's Future Directions
Karen Hilyard, PhD*, NCCOR Coordinating Center*

Q: Would anyone like to share any thoughts or reflections on the day?

A: One thing that has jumped out to me today is the idea of well-being as it relates to overall health and how to nestle addressing childhood obesity in with addressing well-being and overall health.

A: That is a really important point to bring up, particularly around the communication aspect. As the focus for obesity is on drugs right now, people are forgetting that we eat food for very different reasons. We don't have a lot of nutritional deficiencies now, because we've dealt with those, and so people forget that you eat foods to keep healthy. We need to consider how people define what is healthy and better communicate and rebrand the idea that health does not necessarily equal weight. I worry that if we don't rebrand from that perspective, then nutrition won't be considered important to address.

A: I agree with the idea of moving away from healthy and towards well-being.

Q: In a survey of parents, obesity was not a top ten concern, but mental health was. Are there connections we can make between obesity and some of the other issues that have taken precedence, such as mental health?

A: Rather than focusing on the individual, we need to also think about the overarching systems that are going to ultimately affect children. At the systems level, we can think about the players and partners that we can include and levers that we could pull.

A: One of the speakers this morning talked about how we have a failure to build systems. We talked about this a lot when we were trying to produce the name, OPUS. We wondered whether we should include "obesity" in that terminology because that isn't really the goal. It is so much bigger than obesity. We need to think about how we make our language reflect what we are intending and being intentional.

A: I keep hearing that research is needed about systems approaches. How do we start implementing in ways that are testable and experimental so that we can adapt all while involving communities and engaging the many partners that we heard about today that we should be? Instead of waiting for the perfect systems approach, what can we do now to start to experiment and adapt?

A: There was an interesting tension in the remarks. S. Booth emphasized that more work is needed on child growth and development, but we know enough about it to move in positive directions. A second area of cognitive dissonance for me is this issue of well-being. I kind of endorse this idea, but at the same time, we do know for a fact that BMI and growth percentile of their height and weight is a strong predictor of health outcomes. If we start emphasizing well-being, but don't move the needle on obesity, we're still going to pay the economic and social costs of that. The social cost could be addressed, but the economic costs, not exactly if you need treatment because of these consequences. That issue is confusing to me, and I am not sure how to reconcile the reality of body composition with trying to change the discourse.

A: I agree and think that you have zoomed in on those challenges. I would like to offer a suggestion about what Dr. Booth was talking about with regards to young children. We don't know as much as we should about the very early years in terms of that transition from the milk-based diet to the family table. For example, when is it important that they're eating iron-based foods or when should we introduce a particular fruit or vegetable and how much of an impact does that have on their full eating pattern trajectory as they move through life? There is still more to learn there. We need to define well-being and determine how to demonstrate a focus on well-being that will result in long-term outcomes.

A: We need to meet people where they are and start listening better. The stories and narratives are data points that can't be discounted. These conversations need to be moved upstream. It goes back to how we educate and get people to think about nutrition and health. This is important because people must get connected to their own bodily responses on some level. I agree, we do need to move these conversations upstream. Instead of asking parents to advocate, we need to be talking to the players who are driving the environments in which children live, learn, and play.

A: We will need to determine a definition for well-being which can include physical, social, emotional, and could include factors that are important (including obesity and overweight). Then, when we have determined the definition, we need to have different agencies "endorse" the use and standardize it.

A: I agree with everything that has been said. Another point that resonated with me is that there is a lot of research that has been conducted and programs that really work, in the prevention space. I think we should go back and look at what works, what hasn't, and what are practical interventions to bring to people who are in need? Not every program or intervention works for everyone. Maybe, we need to pause and determine how to reach the people who really need to be reached.

A: When I was attending the OPUS workshop, and then listening today, I was thinking about the NCCOR Childhood Obesity Declines Study. It wasn't a very strong, powerful statistical study. It documented four communities in the United States that had verified BMI decline in kids. The study charted out policies that were in effect in early care and education (ECE), school, and communities. Then the pandemic happened right after the observational studies. Through hearsay, we heard that all the kids who stayed home and didn't have organized activities, like recess or after school activities, were gaining weight. I like the term, well-being, but it is emanating through more of a mental health lens because of the pandemic. We need to make sure that we are distinctive in some fashion so that it is not just limited to mental well-being, but also physiological and biological well-being.

A: I fear that if we call for more observational studies, then we aren't strengthening the evidence base in a way that pushes policy.

A: I have relied on the WHO definition of well-being in the past. This could be a starting point for developing a definition as it is much broader than mental health.

A: There was a lot of conversation about primary level prevention. We should think about the other levels of prevention. The secondary level of prevention is certainly of interest and something that I know our office would fund. I don't want us to dismiss opportunities to talk about prevention and health promotion in this conversation. We are focused on treatment many times but because there are comorbid things that show up with obesity, that secondary level of prevention is still a valid place to be thoughtful and intentional about.

Q: Are there other issues we should be linking to that might be more compelling to certain audiences (e.g., workforce readiness, national security)?

A: The idea that context might moderate the effects of pharmacotherapy for broader health outcomes seems like a compelling research question. It reminds me of the NHLBI ADOPT program which was designed to identify core factors that might influence the success of weight loss programs. One of the domains was the environment and the idea was you could characterize environments and then see how different interventions were depending on context.

A: I've been struggling with the idea of precision nutrition and precision medicine. If we focus on one person, but there's still an environment that doesn't support physical activity or healthy eating, how much are we helping this person? Are we just rearranging deck chairs on a sinking ship? Can we tie the PSE change to that to enhance the effect of individual treatments? Maybe more people would jump on board or see it in a positive light.

A: I think that definition is part of the core definition of precision nutrition, we just don't see that carried out often. We don't have the metrics or know what the key points are to intervene. From a model perspective, the model would include all of that, theoretically. The question is, how do we better actualize that?

A: It has been framed as an implementation science problem. The implementation science community often says they're studying how context moderates the success of these interventions.
The vocabulary differences sometimes make it hard to see. Sometimes I have no idea what the implementation science community is talking about. There is an NCCOR work group on implementation science for this reason.

A: There is a lot of funding for clinical trials, but environment and individual interventions also need to be studied. That underscores this notion of context. It also might be more difficult for traditional funders to accept that because it is almost like a replication study. How do we encourage those different contextual studies that will help us understand how these individual interventions will work better?

A: Is there a framework that exists that might help us determine what studies should be replicated to reach the goal?

A: To go back to Ross' point around urgency and what that means for different audiences, we have a tremendous opportunity to be thoughtful around more real time funding opportunities. We could spend some time being more thoughtful and working with local and state government partners to produce mechanisms in which money can be dispersed much quicker. I think some of the delay or people not seeing results in a certain amount of time starts to then impact the trustworthiness of the results. On a broader external level, we have to figure out ways to show more immediate impact with all the data that we have. At the same time, I do appreciate the recommendation about more longitudinal studies to consider the evolution of community behaviors. We must find a better balance there.

A: In the CDC Division of Cancer Prevention and Control, they are looking at adverse childhood experiences (ACEs) as a causal factor that can lead to cancer in adulthood.

A: ACEs are a big causal factor in chronic disease. There was a vital signs survey that CDC put out several years ago that concluded, "Preventing ACEs could reduce up to 2.5 million cases of overweight/obesity."

Q: Are there any particular collaborations that could help address the issue of well-being, address the translation of research into practice, or the connection between research on prevention and research on treatment? Who else needs to be at the table and whose table should we sit at?

A: We've had an intense engagement with the housing research community and Housing and Urban Development (HUD), in particular. My take is that they care about health in general and they want their work to improve or promote health. It is unclear how to engage them in light of our housing and health workgroup at a more granular level. It has been valuable to work with them to promote research; however, I don't think they want to pay attention to any one particular health issue or topic.

A: I'm a part of that health and housing group as well. I agree with David. In general, a bigger thing for us to understand is what other agencies are doing. I think we should look at the White House Conference on Hunger, Nutrition, and Health report because it includes a lot of commitments from various organizations that can tell us what they are doing (including HUD). The commitments may not all relate directly to obesity but may be relevant.

A: Some people have suggested that NCCOR consider a larger effort to bring sectors together to the table. We haven't had that kind of conversation. The obesity roundtable was intended to be a bit like

that. Organizing a meeting like that has its own challenges and can be hard to determine the deliverables, but sometimes the convening is the deliverable that sparks new collaboration. That would be a chance to bring together various agencies.

A: We do have conversations across those agencies through the Interagency Committee on Human Nutrition Research (ICHNR). That is a place where there is representation from different agencies.

A: Who you invite to the table depends on the question you want addressed. The answer you are trying to find may dictate who should be prioritized at the table.

A: In thinking about the OPUS workshop, there weren't any speakers who were new researchers. In terms of NCCOR, how do we spur interest in the younger scientists? We have heard the same voices for decades. They are wonderful and brilliant, but we need to think about that seriously.

Wrap-Up and Closing
Karen Hilyard, PhD*, NCCOR Coordinating Center*

Upcoming Events:

- NCCOR Senior Leadership Briefing – Monday, September 16, 2024, in Washington, D.C. from 9:30 a.m. to 3:30 p.m. ET.
- Obesity-Related Policy, Systems, and Environmental Research in the U.S. (OPUS) workshop 2 – October 9–10, 2024