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

Wednesday, February 25, 2026
1:00–3:00 p.m. ET
Livestream recording
Meeting binder

CDC: L. Balasuriya, D. Galuska, D. Harris, S. Pierce
NIH: A. Brown, C. Byrd, H. D'Angelo, L. Donze, L. Esposito, M. Evans, K. Herrick, B. Jean-Francois, A. Laposky, J. Reedy, E. Wambogo
USDA: S. Fleishhacker, B. Restrepo
Speakers (in order of appearance): ● Stephen R. Cook, MD, MPH, FAAP, FTOS, *Nationwide Children's Hospital* ● Jeanne Lindros, MPH, *American Academy of Pediatrics (AAP) Institute for Healthy Childhood Weight* ● Amanda E. Staiano, PhD, MPP, FTOS, *Pennington Biomedical Research Center* ● Denise E. Wilfley, PhD, FTOS, *Washington University School of Medicine* ● Jeremiah Salmon (guest) ● Rick Stein (guest)
Coordinating Center (CC): K. Deuman, M. Din, O. Giordano Kean, R. Grimsland, D. Hatfield, K. Hilyard, T. Phillips, A. Sharfman

Welcome and NCCOR's Recent Accomplishments

Karen Hilyard, PhD, *NCCOR Coordinating Center*

K. Hilyard welcomed participants to NCCOR's winter member meeting, reviewed the agenda, introduced the meeting presenters, and highlighted the primary purpose of the meeting—*to understand how family-based treatment (FBT) models can be integrated into real-world primary care to improve childhood obesity outcomes and increase scalability.* K. Hilyard shared NCCOR's recent accomplishments and activities from October 2025 through February 2026:

- **Published Manuscripts:** NCCOR recently published two papers. The first is an article detailing the new Physical Activity Research Opportunities (PARO) framework in the *International Journal of Behavioral Nutrition and Physical Activity*. The article, "Development of the Physical Activity Research Opportunities (PARO) Framework," represents a major step forward in organizing and prioritizing physical activity research opportunities. The second paper is a commentary following the successful Obesity-Related Policy, Systems, and Environmental Research in the U.S (OPUS) workshop, published in the *American Journal of Preventive Medicine*. The commentary, "Advancing Policy, Systems, and Environmental Change Research to Reverse Upward Trends in Obesity Prevalence—A New Call to Action," issues a call to action for the next phase of obesity-related policy, systems, and environmental (PSE) research.

- **Conference Presentations:** NCCOR was represented at three conferences: American Public Health Association (APHA) (November 2025; Washington, DC), ObesityWeek (November 2025; Atlanta, GA), and the Annual Conference on the Science of Dissemination and Implementation in Health (December 2025; National Harbor, MD).
    - NCCOR presented two oral presentations at the APHA conference: 1) "Accelerating Progress in Child Obesity Prevention through Policy, Systems, and Environmental Research" and 2) "A Call to Action to Advancing Policy, Systems, and Environmental Change Research to Reverse Upward Trends in Obesity Prevalence."
    - NCCOR hosted a joint symposium at ObesityWeek, titled "Obesity-Related Policy Systems and Environmental Research in the US," which highlighted NCCOR's work advancing multi-sectoral, community-engaged research to reduce childhood obesity.
    - NCCOR presented two posters at the Annual Conference on the Science of Dissemination and Implementation in Health: 1) "Using Qualitative Document Analysis Combined with Expert Consultation to Consolidate Research Opportunities: Developing the Physical Activity Research Opportunities (PARO) Framework" and 2) "The Development of the Implementation Scorecard: A Decision-Making Companion for Public Health Practitioners."
- **Connect & Explore Webinars:** NCCOR hosted two Connect & Explore webinars. On October 14, 2025, NCCOR hosted a webinar titled "Turning Evidence into Action: Using NCCOR's Implementation Scorecard to Strengthen Childhood Obesity, Nutrition, and Physical Activity Interventions." The webinar featured NCCOR's new Implementation Scorecard, which was informed by the experiences and challenges faced by practitioners implementing childhood nutrition, physical activity, and obesity prevention interventions. On January 27, 2026, NCCOR hosted a webinar titled "Advancing Physical Activity Research and Practice with the PARO Framework." The PARO framework consolidates years of disparate research recommendations into one accessible tool designed to strengthen physical activity research, funding, policy, and practice.
- **2025 Annual Report:** NCCOR released its 2025 Annual Report, "New Horizons in Childhood Obesity Research." The report highlights NCCOR's accomplishments, including 1) new publications and resources; 2) conferences, webinars, and workgroups; and 3) the Clinical Research Gaps in Pediatric Obesity Pharmacotherapy workshop.

Panel: TEAM UP: A Large Comparative Effectiveness Pragmatic Trial of Family-Based Treatment for Youth with Obesity

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

The panel featured a presentation of findings from a pragmatic trial of a family-centered approach to childhood obesity treatment. The purpose of this randomized trial was to compare the effectiveness of two clinical treatment options: 1) an intensive intervention called Family-Based Treatment (FBT) and 2) Enhanced Standard of Care. FBT is an effective intensive health behavior and lifestyle treatment for obesity reduction in children and adolescents. The study population included children aged 6–15 years with obesity and their parent or caregiver across four states, with an emphasis on underserved children and families. Data collection occurred from 2019 to 2024.

Study Design – Stephen R. Cook, MD, MPH, FAAP, FTOS, *Nationwide Children's Hospital*

S. Cook described the design of the TEAM UP study. The primary aim of the study was change from baseline to 12 months in child percent median body mass index (BMI), or percentage above the median BMI in the general U.S. population, normalized for age and sex. The secondary aims focused on parent weight, child psychosocial factors, heterogeneity of treatment effects, and cardiometabolic risk factors. Parent and child outcomes were assessed at baseline, mid-point (6 months), end of intervention (12 months), and follow-up (18 months). Eligibility criteria for the children were as follows: 1) BMI percentile ≥95th for age and sex; 2) aged 6–15 years at baseline; 3) comfortable speaking English language; 4) able to provide written or verbal (based on age and preference) informed assent; 5) willing to change eating behaviors, physical activity, and/or weight; 6) patient of a participating clinic; and 7) able to participate in scheduled sessions. Eligibility criteria for the parent/caregiver were as follows: 1) aged ≥ 18 years; 2) comfortable speaking and reading English language; and 3) child resides with the participating parent/caregiver ≥50% of the time. Families were excluded if the primary care provider (PCP) or site principal investigator believed the study and/or intervention was clinically or medically inappropriate; if the parent or child exhibits purging behavior and/or other significant eating disorder symptomatology; or if children had chronic conditions or were on medications that substantially impact or interfere with growth, appetite, weight, or physical activity participation.

S. Cook explained the two study arms: 1) enhanced Standard of Care (eSOC) and 2) eSOC plus Family-Based Behavioral Treatment (FBT). In total, 730 parent and child dyads were enrolled across 41 clinics in four states (Chicago, IL; St. Louis, MO; Baton Rouge, LA; Rochester, NY); 376 were enrolled in eSOC and 354 in eSOC plus FBT. The eSOC treatment was a staged approach led by the PCP that intensified depending on the child's response (between 6–21 visits with PCP over 12 months) and aligned with the American Medical Association Guidelines at that time. Each 20-minute visit included child weight assessment, standard medical components, and PCP-delivered counseling. The FBT approach aligned with the American Academy of Pediatrics (AAP) Clinical Practice Guidelines for intensive health behavior lifestyle treatment and included 50-minute visits (26–33 visits over 12 months) in addition to child and parent weight assessment and behavioral counselor-delivered FBT to child and parent. The eSOC plus FBT arm was a combination of both approaches. In 2019, prior to the start of the COVID-19 pandemic, the study provided evening and weekend session options to participants. During the pandemic, the study had to switch to a virtual platform to provide the intervention to complete the study. Post-pandemic, some families did want to go back to in-person, while others preferred the virtual option.

Training – Jeanne Lindros, MPH, *American Academy of Pediatrics (AAP) Institute for Healthy Childhood Weight*

J. Lindros described the training the providers received for both treatment arms of the TEAM UP study. The providers in both arms received continuous training and support throughout the duration of the study, including four phases of training. The eSOC arm phases included 1) pre-work, 2) core curriculum, 3) fidelity and sustainability, and 4) ongoing engagement and sustainability. The eSOC plus FBT arm included 1) pre-work, 2) core ECHOS, 3) sustainability ECHOs, and 4) supervision.

J. Lindros explained that due to the PCORI (Patient-Centered Outcomes Research Institute®) funding, the study had considerable stakeholder engagement from a variety of sectors throughout the project. Stakeholder engagement was provided through four advisory boards that included families/parents, multidisciplinary providers, payers, and evidence-based experts. Several barriers were identified through the advisory boards, including billing and insurance coverage, full caseloads and limited staff capacity, and communication of study expectations to clinic staff. J. Lindros explained that, as a study team, they tried to thoughtfully create supports and solutions for these barriers.

Weight and Programmatic Outcomes – Amanda E. Staiano, PhD, MPP, FTOS, *Pennington Biomedical Research Center*

A. Staiano explained the various measurements and outcomes that were evaluated for the TEAM UP study. Data collection included measuring height and weight to calculate percent median BMI, and assessing mental health, family, and quality of life through various survey tools. For the primary outcome, it was hypothesized that children who received eSOC plus FBT would have greater reductions in percent median BMI compared to those who received eSOC. At baseline, the study population had, on average, 130th of the 95th percentile for BMI and a z-score of 2.6. The study population was roughly half females and half males, fairly racially and ethnically diverse (52% identified as white, 48% identified as multi-race or other race), and almost half were insured by Medicaid.

A. Staiano summarized the weight and pragmatic outcomes of the study. For the primary aim (change in percent median BMI), the study team concluded that both intervention groups significantly reduced percent median BMI. However, only the eSOC plus FBT patients achieved a clinically meaningful BMI reduction. The eSOC plus FBT arm reduced percent median BMI to a greater extent at every time point (6-months, 12-months, and 18-month), supporting the hypothesis. For example, at the 12-month timepoint (the end of the intervention), the eSOC arm resulted in a 3.3 unit reduction, while the eSOC plus FBT resulted in a 6.3 unit reduction.

A. Staiano explained that the secondary BMI metrics support the same finding, that both arms showed a reduction in several BMI metrics, with a greater reduction among the eSOC plus FBT arm (see table, *Primary Outcome – Secondary BMI Metrics*). In the eSOC plus FBT arm, nearly half of the participants achieved a meaningful reduction based on a 0.25 BMI z-score reduction. Further, in the eSOC plus FBT arm, there was a 1.9 BMI unit change, which exceeds the 1.3 BMI unit change that is associated with cardiovascular risk improvements. Further, a sensitivity analysis assessing whether telehealth delivery (none vs. some or all telehealth) of FBT impacted treatment effectiveness found no difference in percent median BMI change at any time point.

For the implementation outcomes, A. Staiano explained that the study achieved a diverse reach, had proven effectiveness and widespread adoption, received high scores on both acceptability and fidelity, and showed an indication of maintenance among the providers (68% of providers intended uptake post-intervention). Roughly one-third of the patients attended six or fewer FBT sessions, and one-third attended 26 or more FBT sessions. On average across both arms, patients received about four eSOC visits.

Behavioral/Mental Health and Quality of Life Outcomes – Denise E. Wilfley, PhD, FTOS, *Washington University School of Medicine*

D. Wilfley summarized the behavioral/mental and quality of life outcomes of the TEAM UP study. The mental health data collection measures were pragmatic and included child mental health, family mental health, and child quality of life measures. She noted that 17 children were excluded prior to randomization for mental health reasons and that information was provided to the PCP for ongoing care. Disordered eating was assessed at baseline, 6, 12, and 18 months to evaluate the potential risks of the treatments. During the trial, there were very low rates of anxiety and depression. At follow-up, there were low rates of eating disorder symptomatology in both the parent and the child. Measures of family nutrition and physical activity improved in both treatment arms; however, improvement was

significantly higher among the eSOC plus FBT arm. Similarly, measures of pediatric quality of life improved in both treatment groups, with no significant difference between the two treatment arms. For weight-related quality of life, the eSOC plus FBT arm increased more than eSOC alone.

D. Wilfley described the implications of this comparative effectiveness study. First, these findings inform clinical decision-making. Both the eSOC plus FBT and the eSOC alone were effective; however, she explained that the eSOC plus FBT arm was more effective and had a clinically meaningful reduction. She noted that in the intent-to-treat analysis, about 50% of the children had clinically meaningful effects and that the degree of relative weight reduction is related to prevention of type 2 diabetes, dyslipidemia, and the need for bariatric surgery. Further, this study addresses gaps identified by the U.S. Preventative Services Task Force's 2024 recommendation statement on *High Body Mass Index in Children and Adolescents: Interventions* and AAP's 2023 *Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity*. For example, this study had a highly pragmatic design, involved a diverse patient population, provided proof of percent median BMI improvements out to 18 months, improved quality of life and family-level behaviors, showed no exacerbation of disordered eating or adverse events, and was effective with or without telehealth.

Q&A with Panelists

Q: Can you speak more about the evaluation and flagging of disordered eating and other adverse events?

S. Cook: Our funder, PCORI, wanted us to be practical in terms of the instruments used. For this reason, we limited evaluation to use of the Pediatric Symptom Checklist-17 (PSC-17). This instrument can provide information about attention-deficit/hyperactivity disorder (ADHD), anxiety, and depression. We included a question asking whether a child is on medication for mental health or behavior, to which we found that about 11% of parents responded "yes." Upon reviewing the medication list, we actually found that about 30% of kids were on a medication that was in a class of selective serotonin reuptake inhibitors (SSRI), antidepressants, or similar medications. For these reasons, we wanted to be practical in choosing a tool that pediatricians can easily use.

D. Wilfley: With disordered eating, we tried to assess key behaviors of binge eating, purging, and laxative use. We found in our studies that, when using interview-based methodologies, binge eating decreases. In general, the treatment in the study is so consistent with the treatment for eating disorders. Because of this, I didn't have major concerns about including individuals with binge eating. We were pleased to not see increases in disordered eating and symptomatology over time.

Q: Could you share your experience with the Payer Advisory Board?

S. Cook: We had Centene Health Insurance and Blue Cross Blue Shield of Louisiana on the payer board, who were very helpful partners and continue to help us analyze some of their patient data, specifically. The payers realized that obesity is not a cosmetic disease, but a chronic and progressive disease. For this intervention, we included a variety of licensed, billable providers outside of physicians and nurse practitioners (i.e., dietitians, master's in social work, master's in clinical counseling). At that time, SAMHSA (Substance Abuse and Mental Health Services Administration) and other groups were creating a model of integrated behavioral health, which included behavioral health providers in primary care settings. This was essentially the same kind of model, including master's level providers who can work in primary care. The payers were very helpful because they knew their local community and the rules and

regulations. We could always turn back and say to them, the U.S. Preventive Services says this is actually a Grade-B level of evidence, and according to the Affordable Care Act, it needs to be covered without copay as a standard of care. That was a huge level-set bar; otherwise, payers will push back and not want to cover it.

A. Staiano: Centene and Louisiana Blue believed in the project so much that they gave us additional funding that we passed on to the clinical practices to try to offset the required research activities and training. Blue Cross in Louisiana has a benefit that provides up to 52 weight management and nutrition-related sessions over a child's lifetime. Louisiana Blue sent letters out to all members who had access to this benefit and supported communication between patients and their doctor's office about the benefit. In addition to the effectiveness data that resulted from this trial, we also saw that billing codes work. The clinics in Louisiana hired new contract dietitians to fulfill the role of FBT coach in addition to training social workers, community health workers, and other full-time employees that the clinics already had. The clinics saw this as enhancing their services, and we were able to leave them with trained providers who could go on to bill insurance, making it financially viable for the clinic.

Q: Did parents lose weight during the intervention?

A. Staiano: In the intent-to-treat analysis, we did not see parent weight reduction. We don't have that in our primary outcomes paper, but we're exploring that further. We didn't require the parents to enter the trial with obesity, although many of the prior trials have required that. Since this is truly a family-based approach, it tends to be most successful when the parent and child both have weight loss goals and behavior change goals. We delivered this trial pragmatically through pediatric clinics, so the billing was for the child. This made us rethink chronic disease management and delivery of family-based treatments. I think it's important with the health care system that we are able to simultaneously treat the parent and the child, but that's not how our health care system is set up.

S. Cook: In previous studies for which we have done family-based treatment with parent and child, we've required the parent to at least be overweight, if not obese. In that case, we also gave the parent weight loss goals. For this trial, we had parents focus on tracking behaviors instead. For a prior study that D. Wilfley and I were involved in, called the PLAN (Primary Care Pediatrics, Learning, Activity, and Nutrition With Families) study, we were able to show parent weight loss in addition to child weight loss. However, it was delivered as intended to the parent as well. Our trial was dyadic therapy; if you think about it, two family members were addressing a health issue using the same amount of time and energy, and care was provided for two patients, versus one.

Q: If the study were to be replicated, are there any suggested modifications you would make based on current AAP Clinical Practice Guidelines?

S. Cook: We want primary care to be empowered and trained to provide more care, but this requires an additional level of care. The prior AAP Clinical Practice Guidelines had structured weight management and comprehensive weight management, which are really meant to be tertiary care-based treatment. This model fits with the current AAP Clinical Practice Guidelines, described as an intensive healthy lifestyle behavior intervention that needs to be multidisciplinary and of a certain dose. The current guidelines allow more freedom in that it doesn't have to be delivered in a tertiary care setting or another setting.

J. Lindros: The important thing is that FBT aligns perfectly with intensive health behavioral lifestyle treatment, which is the foundational treatment that is recommended. The eSOC arm aligns with the expert panel recommendation of "do the best you can to bring them back as frequently as you can," individualizing the care within the context of primary care. It was very fortuitous that we aligned very well with the actual AAP Clinical Practice Guidelines that came out.

S. Cook: The U.S. Preventive Services guidelines looked at different studies of various intensities. Low, moderate to high, and moderate to high intensity studies were somewhere in the 30 to 50 or 70 hours of contact time over six months to a year. That is evidence that the U.S. Preventive Services recommendation existed when we rolled out, so we had that. The clinical guideline was written before that and didn't have that specific language, so the U.S. Preventive Services was kind of the guide for this.

Q: Will you be able to survey providers to determine who has continued to implement the program post-intervention?

A. Staiano: That is a wonderful idea that we have not discussed as a team. We do have a lot of provider data that we weren't able to share with you today but will be available in our forthcoming publications. We surveyed providers as they entered and exited the trial. We asked about weight bias, knowledge of the guidelines, and perceived competence of delivering this care. We collected some data as the trial was ending about their intended uptake and continued sustainment, and we could certainly go back and ask them again a couple years later. We have continued Electronic Health Record access, so we will be able to follow some of these children going forward as well.

Q: Given these results, what are your next research questions or interventions? What do you plan next in terms of disseminating this to providers and supporting them in adopting this?

J. Lindros: From an AAP perspective, the takeaway message is that this works. Some of our data from past periodic surveys have indicated that some providers felt like obesity treatment may not be worthwhile, or it's really a hard lift. D. Wilfley shared the quote from Dr. Ed Lewis, in which he said that he had struggled for years and that the support and the experience in this study helped him realize that this is feasible. That is the main message we need to continue to communicate. The other message that we want to continue to broadcast is that intensive health behavior lifestyle treatment works in primary care, and it's important as a foundational treatment. We will be actively disseminating this information to our providers through a number of communication channels.

S. Cook: We are speaking with our funder, PCORI, about next steps. The AAP's involvement and reach to pediatric providers is really important. It takes both political will and local leadership to move forward with this in practice. Unfortunately, it's like systemic weight bias; if hospital leadership doesn't decide to invest, then it's not going to happen. Opportunities to present to groups like NCCOR are really critical for us to help get the message out that this needs to be the standard of care.

A. Staiano: Implementation science and dissemination science are really important, too. We need more Type 2 and Type 3 hybrid implementation effectiveness trials so that we can test implementation strategies. We learned so much from this trial, and we were able to capture quite a lot. Next, we need to identify how to scale out programs to be sustainable beyond the research study.

D. Wilfley: With the rise of GLP-1 medications, it's even more critical to assess eating disorders comprehensively. There is worry and concern that providers are prescribing GLP-1s without assessing

for eating disorders. Additionally, ensuring that these obesity treatments are working with GLP-1s is very important implementation science. I really like the idea of looking into the intergenerational effect. It is a lot to ask a pediatrician, on top of all the work they already do, to consider all the parents' comorbidities and health factors. It would be so great to have a model where this would be seamless though.

Q: Have you thought about ways to incorporate PSE level changes? For example, were there any policy changes during the study that may have had implications?

S. Cook: Coverage for dietitians or other providers to provide this type of care definitely has implications. We had to explain in our application to PCORI that while obesity treatment is recommended by the U.S. Preventive Services, we do not have current payment models or billing codes in place to cover the cost of the services. This was important because PCORI funding doesn't pay for treatment. We had to account for additional funds in our budget to pay for part of the coach time in New York, and I had to get a letter from an insurer in New York indicating that.

J. Lindros: The expansion of telehealth was critical. We did not look at this specifically, but it is possible that food delivery through schools during the COVID-19 pandemic may have had an impact, broadly.

A. Staiano: We were changing clinical practices in these health care systems and training a variety of providers. We learned a lot from working with a variety of clinical practices too, such as in federally qualified health centers, clinics exclusively serving Medicaid patients, clinics exclusively serving commercial patients, etc. We have quite a lot of data we could look at and generate more research questions for the future. We had to adapt and try a lot of different strategies, as well as work with a variety of people that I hadn't anticipated we would need to work with.

S. Cook: Another policy with implications is expanding telehealth to allow behavioral providers to provide obesity care, even if it's not a mental health condition or diagnosis. In Rochester, New York, we had been doing telehealth for a very long time prior to the pandemic. This meant we were able to make that pivot pretty quickly. In Ohio, the Medicaid plan doesn't allow reimbursement for telehealth visits by a behavioral health provider unless it's for a behavioral health or mental health condition. This meant that even though the primary diagnosis was obesity, we had to engage in a workaround to get the visit covered. We have rural health issues, which telemedicine is going to overcome, but it will be wiped out because of this loophole.

A. Staiano: When we first started talking with the clinicians and pediatricians, many of them didn't feel comfortable using the word "obesity," let alone using it in a chart or visit note. With the AAP, we did some fundamental education about how to talk about weight in clinical practice. The providers, many of whom were brand new to obesity medicine, nutrition counseling, and weight management counseling, were really eager to work with us. In Louisiana, I've witnessed a shift. Some of the shift has to do with the AAP clinical practice guidelines and perhaps GLP-1s on the market. Doctors seem to now feel that they must provide care for children with obesity, and so they're now looking to us for help to do so.

D. Wilfley: When we worked with Missouri Medicaid, the Chief Medical Officer was adamant about coding under behavioral health. To Dr. Cook's point, if you've seen one state Medicaid program, you've seen one state Medicaid program. There is a meeting that all the Medicaid directors go to, and I always thought we should present to them. We want to reach the kids who are at highest risk, and I think the

other part of this project that was really great is that we were working with payers who really had the most vulnerable kids front and center.

Q: How were you able to work with practitioners and labeling/stigma?

J. Lindros: It was part of the core pre-work training for both providers, and then we continued that throughout as much as possible. We tried to build a confidence level about respectful, empathetic, compassionate language and an understanding of weight bias and stigma.

Facilitated Discussion with NCCOR Members, moderated by Karen Hilyard:

Q: How can NCCOR support, promote, disseminate, and further the evidence for family-based treatment for youth with obesity?

J. Reedy: NCCOR could support the use of good, better, and best metrics specifically around family-based treatment.

S. Cook (via chat): NCCOR could help integrate obesity medicine training into medical school and psychology training. This is analogous to implementing the Diabetes Prevention Program.

A. Sharfman (via chat): Also, integration into nutrition and dietetics programs.

Workgroup Updates – Karen Hilyard, PhD*, NCCOR Coordinating Center*

Research Gaps in Treatment of Pediatric Obesity with Obesity Medications – presented by A. Sharfman, *NCCOR Coordinating Center*
Workgroup Leads: A. Goodman, *CDC*; L. Balasuriya, *CDC*; V. Osganian, *NIH*

This workgroup was launched to plan a workshop to understand current practice and identify research gaps and priority research questions that, when answered, can help health care practitioners in the process and practice of prescription, maintenance, and discontinuation of GLP-1 and other obesity medications (OMs) for children and adolescents, and support for their caregivers. The four-part *Clinical Research Gaps in Pediatric Obesity Pharmacotherapy* workshop was hosted in September–November 2025, culminating in an in-person meeting during ObesityWeek 2025 in Atlanta, GA. The workgroup is currently working to refine and condense the list of over 100 research questions generated during the workshop, develop a list of outcomes to measure in clinical research studies, develop a list of reporting protocols, and create tools for clinicians and researchers to guide future practice. The workgroup is also drafting a white paper to disseminate key findings. The workgroup is collaborating with Jeanne Lindros of the American Academy of Pediatrics Institute for Healthy Childhood Weight on these efforts.

What Works Best to Ensure High-Quality Sports Opportunities for all Young People – presented by A. Sharfman, *NCCOR Coordinating Center*
Workgroup Leads: S. George, *NIH*; J. Matjasko, *CDC*; M. Polster, *HHS*

This workgroup launched in January 2026 to identify best practice approaches for ensuring broader access to high-quality youth sports programs. The workgroup will conduct a rapid environmental scan (including a literature review and expert interviews) to identify exemplar sports programs and will host a workshop with program representatives in July to discuss best practices. The workgroup is meeting bi-monthly.

Obesity-Related Policy, Systems, and Environmental Research in the U.S. (OPUS) Grantee Learning Network – presented by J. Reedy, *NIH*
Workgroup Lead: J. Reedy, *NIH*

This workgroup launched in January 2026, in response to a newly funded research opportunity through the National Cancer Institute, to build capacity and readiness for the development of whole-of-systems approaches to addressing obesity for cancer prevention and control through policy, systems, and environmental (PSE) approaches. In total, 14 obesity supplements in 13 states were funded ($1.4 million). The workgroup will host monthly calls through September to troubleshoot common topics, issues, and challenges. Topics of the monthly calls will include 1) defining scope while working with communities, 2) measuring community engagement, 3) applying human-centered design, 4) obesity treatment access and capacity, and 5) creating meaningful outputs.

Additional NCCOR workgroup and project updates are available in the meeting binder.

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

2026 Calendar Reminders:

- **2026 Members Calls:** March 18, April 5, May 20, July 15, August 19
- **2026 Member Meetings:** June 10 and September 16
- **Connect & Explore Webinar:** March 10, 2026, from 3–4 p.m. ET titled *Supporting Recess in Schools: Evidence, Health Impact, and Action.*