Leading by Example: A Local Health Department–Community Collaboration to Incorporate Physical Activity Into Organizational Practice

Antronette K. Yancey, Lavonna B. Lewis, David C. Sloane, Joyce Jones Guinyard, Allison L. Diamant, Lori M. Nascimento, and William J. McCarthy

A multisectoral model promoting sociocultural environmental change to increase physical activity levels among African Americans in Los Angeles County, California, was developed and implemented. This model represents a true collaboration between a local health department and a community lead agency. Community organizations serving targeted areas of the county participated in one or more interventions incorporating physical activity into routine organizational practice, which centered around modeling the behaviors promoted ("walking the talk"). In the current study, level of organizational support for physical activity integration was assessed, as reflected in the extent of organizational commitment associated with each intervention. Individual-level data, characterizing the sociodemography, health status, and health behaviors of organization staff, members, and clients, are presented to document the average risk burden in the targeted population. Nearly half of the more than 200 participating organizations actively embraced incorporating physical activity into their regular work routines, with more than 25 percent committed at the highest level of involvement. Broad capacity and support for organizational integration of physical activity was demonstrated, with the observed level of commitment varying by organization type. Similar to the successful evolution of tobacco control, some of the responsibility ("cost") for physical activity adoption and maintenance can and should be shifted from the individual to organizational entities, such as workplaces.

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Correspondence to: Antronette K. (Toni) Yancey, MD, MPH, Division of Cancer Prevention & Control Research, UCLA School of Public Health/JCCC, A2-125 CHS, 650 Charles Young Drive South, Los Angeles, CA 90095–6900.

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Antronette K. Yancey, MD, MPH, is an Associate Professor, Division of Cancer Prevention & Control Research, Department of Health Services, School of Public Health, Jonsson Comprehensive Cancer Center, University of California Los Angeles; and, formerly, Director, Division of Chronic Disease Prevention and Health Promotion, Los Angeles County Department of Health Services.

Lavonna B. Lewis, PhD, is an Assistant Professor, School of Policy, Planning, and Development, University of Southern California, Los Angeles.

David C. Sloane, PhD, is an Associate Professor, School of Policy, Planning, and Development, University of Southern California, Los Angeles.

Joyce Jones Guinyard, DC, is a Project Director, Community Health Councils, Inc., Los Angeles, California.

Allison L. Diamant, MD, MSHS, is an Assistant Professor, Division of General Internal Medicine and Health Services Research, School of Medicine, University of California Los Angeles.

Lori M. Nascimento, MPH, is an Associate Director, Division of Community Health, Department of Family Medicine, Keck School of Medicine, University of Southern California, Los Angeles.

William J. McCarthy, PhD, is an Adjunct Associate Professor, Division of Cancer Prevention & Control Research, Department of Health Services, School of Public Health, Jonsson Comprehensive Cancer Center, University of California Los Angeles.

Obesity has reached epidemic proportions in the United States.[1–3] Communities of color are at greater risk for obesity and concomitant eating and physical activity patterns[3] contributing to this disproportionate chronic disease burden.[4] Of note, sedentariness is an independent risk factor for cardiovascular disease, diabetes, and many other chronic conditions.[5]

In Los Angeles County, California, overweight prevalence was 59 percent among African Americans and 63 percent among Latinos in 1999, rising to 69 percent and 65 percent, respectively, in 2002.[6] In health districts with the highest proportions of African Americans and Latinos, higher overweight rates are documented—the highest in at 73 percent.[6] The physical activity levels in these areas are among the lowest in the county. In the southeastern part of the county, two-thirds of residents are categorized as sedentary, engaging in less than ten minutes of continuous activity *weekly*.[6]

Individually targeted interventions have not generally resulted in sustainable weight-related lifestyle change in samples of relatively affluent and motivated volunteers.[7,8] Worksites would seem to be ideal settings for environmental intervention. However, worksite interventions promoting physical activity have largely been individually targeted, offering such activities as exercise classes on nonpaid employee discretionary time. Further, the studies disproportionately engaged younger, higher socioeconomic level, white males of European descent in large private corporations.[9] Changing the sociocultural environment of organizations to promote physical activity has yet to be systematically explored. To engage higher risk nonvolunteers, capitalizing on organizations' existing internal social support mechanisms and institutional structure to incorporate physical activity into routine business practice is indicated.

The purpose of this article is to demonstrate the feasibility and utility of a multisectoral intervention shifting, from the individual to the organizational level, of some of the responsibility for physical activity adoption/maintenance. A key aspect of this model intervention, changing organizational practice to integrate 10-minute exercise breaks into lengthy meetings and events, was developed by physical activity promotion experts in the Los Angeles County Department of Health Services (LAC–DHS). This model is one component of a CDC-funded, community-based participatory research project *African Americans Building a Legacy of Health* (AABLH), which is part of the national initiative to eliminate ethnic health disparities, Racial & Ethnic Approaches to Community Health (REACH).

Public policy goals can most readily be accomplished by identifying agencies in underserved communities able to develop and implement programs and services responsive to the needs and preferences of their target populations.

Theoretical Framework

AABLH employs a community-based participatory research model described elsewhere.[10] Berger and Neuhaus[11] have asserted that public policy goals can most readily be accomplished by identifying agencies in underserved communities able to develop and implement programs and services responsive to the needs and preferences of their target populations. These agencies mediate between the needs of individuals in a specific locality and the institutional bureaucracies (e.g., local health departments) charged with addressing those needs at a societal level to achieve certain outcomes.[12] Mobilizing the community-based organizations in which individuals work, study, worship, live, create, advocate, and play, may be seen then as a critical vehicle for creating social norm change, in cooperation with government and academic entities. This organizational focus is quite consistent with the shift in the field from a nearly exclusive focus on individual-level intervention to one including social ecological or multilevel intervention approaches. However, less attention has been given to the influence of social features of an individual's environment on physical activity than that accorded to the impact of the physical environment.[13] Greater intervention emphasis on sociocultural environmental change is needed, especially in targeting communities of color.[14]

Role modeling ("walking the talk") was conceptualized as a central element of the AABLH approach to healthy, fitness-related lifestyle promotion. The approach is grounded in social cognitive theory, using sociodemographically similar role models to increase self-efficacy and to model the behaviors promoted.[15] As social support is a major predictor of sustained involvement in physical activity,[8] the supportive and conformity-promoting group dynamics found in organizations may be used to engage more sedentary individuals.[15] Organizational leadership commitment, as manifested in modeling by participation in group physical activities, has also been associated with sustaining physical activity programs in community-based organizations.[16,17]

Methods

In February 1999, the Community Health Councils, Inc. (CHC), a Los Angeles-based nonprofit health

advocacy, health promotion, and education organization, launched a community-based initiative mobilizing a broad coalition of African-American health and social service organizations to address the continuing health disparities within the Black community. In October 1999, CHC received a one-year REACH planning grant from the Centers for Disease Control and Prevention (CDC). The consensus strategic directions in targeting cardiovascular disease and diabetes disparities in southern Los Angeles County included: revising community norms through community education; creating economic parity through community development; and supporting policy and institutional change through community empowerment.[10] Researchers from the University of Southern California (USC) and the University of California Los Angeles (UCLA) participated in and evaluated the planning process, and professionals from those universities and the LAC–DHS also served as subcontractors/advisors to the grant. The county provided data collected in its biannual health survey to assist in focusing project resources on the targeted population. The long-term preexisting relationships between the researchers, county staff, and CHC staff, as well as with other community-based agency staff, facilitated coalition planning and implementation processes. In fact, the county ceded the lead agency role to CHC in pursuing this funding from the outset. In late 2000, the AABLH coalition received a four-year CDC grant to implement a multicomponent demonstration project. The project was set in the three of the four geographic areas of Los Angeles County in which nearly two-thirds of the African-American population of the county (less than 10 percent overall) reside: portions of Inglewood, North Long Beach, and South Los Angeles (city).

This article focuses on an assessment of the level of organizational support for physical activity as reflected in organizations' participation in one or more of the AABLH interventions to increase target area residents' involvement in physical activity: (1) the mandate that fitness breaks be incorporated into all coalition activities and those of their minigrant recipient organizations at meetings or events lasting two hours or more; (2) worksite/organizational wellness training seminars offered to local organizations' staff and clientele; (3) provision of a personal training experience to executive directors of organizations to promote their "leading by example" and to increase their commitment to instituting policy and practice changes within their sites; and (4) a small grants program to train residents, and then subcontract with them to inventory physical activity programs and facilities in their communities or to initiate new or expand existing physical activity programming within the targeted areas.

Most of the organizational level data reported in this article were collected and entered into a commercial spreadsheet program by the study administrative coordinator. All requests by community organizations for AABLH project assistance came through a main contact phone number. The data entry occurred in "real time," that is, at the time that community organizations called in response to outreach efforts (e.g., to request information, materials, or visits by project facilitators). Every time those same organizations called for additional assistance, the information recorded on each organization was immediately updated. A new row in the spreadsheet program was opened as soon as the study administrative coordinator determined that a new organization was calling for project assistance. The organizational level analyses described next were based on data that was entered into the spreadsheet program between October 1999 and August 2002.

An analysis was conducted linking organizational type to level of support, modeled on that performed by Rapkin and colleagues.[18] Organizations were categorized at four levels of support or commitment. Level 1 organizations were those that participated in REACH meetings that consistently included exercise breaks. Level 2 organizations requested that CHC or coalition staff lead an exercise break at their facilities or at events they sponsored. Level 3 organizations participated in the Community-Based Organization (CBO)/Worksite Wellness program. Level 3 also included those organizations whose leaders received the personal training experience. Finally, Level 4 organizations had a formal subcontract with CHC to provide physical activity-related services (e.g., minigrantees, vendors at health fairs). Organizations were categorized on the basis of their highest level of organizational support. For example, an organization that participated in the wellness training and also obtained a subcontract to assess community exercise venues was coded as Level 4. The coding scheme was conservative in that a variety of activities indicative of greater support for physical activity (e.g., conducting exercise breaks on site without AABLH assistance) could not be captured using available data, resulting in a Level 1 assignment.

Incorporation of Fitness Breaks

In longer meetings and events, particularly those in which refreshments were served, 10-minute exercise breaks (*Lift Offs*) were conducted, complemented by providing nutritious refreshments. The strategy is a part of a LAC–DHS social marketing effort, *Fuel Up/Lift Off! LA* (*Sabor y Energia*), supported by the USDA-funded California DHS' Nutrition Network program. The social marketing messages focused on

encouraging increased physical activity and more healthful food choices, rather than on weight control. The exercise breaks, composed of a series of basic aerobic dance/calisthenics movements with catchy titles, were developed by county physical activity promotion experts. They were intentionally targeted to a level of intensity and skill accommodating unfit, sedentary, overweight adults. After a period of pretesting, these breaks were formalized and recorded in English and Spanish videotapes, audiotapes, and holographic mousepads, facilitating their conduct by individuals with no formal exercise training. Materials were culturally tailored to African Americans and Latinos (e.g., through music selection) and featured video subjects representing a broad range of ethnicity, age, weight status, and physical limitations, as well as both genders. An evaluation of this strategy has been conducted, demonstrating its utility in engaging sedentary and overweight adults in exercise.[19] County health promotion staff trained AABLH–community nutrition and fitness workers to conduct breaks and to train others to conduct them, utilizing these *Fuel Up/Lift Off ! LA* materials. The strategy was promulgated by the inclusion of these breaks in every presentation, health fair appearance, and community gathering or event in which AABLH staff participated.

Provision of a Personal Training Experience to Organization Leaders

In order to cultivate leadership for organizational practice change, 10 local executive or program directors from health, education, and service organizations in the targeted areas were invited to participate in the 12-week, hands-on "Heal-the-Healer" pilot intervention; six accepted. Participants were asked to commit to a personal lifestyle improvement program under the direction of an AABLH identified and paid, personal fitness trainer. Participants were also asked to attend two of three monthly support/discussion sessions, educate themselves about the health promotion program and the benefits of integrating wellness into work and social settings, give feedback on the suggested protocol and related program materials, and journal their experiences throughout the program period. Data were collected by AABLH staff, using an open-ended telephone interview format.

Provision of Community-Based Organization/Worksite Wellness Training

An organizational/worksite wellness program was offered to target area organizations. A memorandum of understanding was signed by both the head of the organization and the executive director of CHC, outlining the responsibilities of each. The responsibilities of CHC/AABLH included: (1) provision of weekly training sessions over a 12-week period; (2) provision of a written evaluation of current employee health-related policies; (3) meeting with the organization leader(s) to facilitate adoption of health-related policies; (4) ongoing support through the training sessions and for nine months thereafter; (5) educational support materials for participating staff/members/clients; and (6) performance of quarterly "booster sessions."

Each organization agreed to transform its existing structure to incorporate organizational policy and practice changes fostering a healthy/fit work environment. The organizational leader explicitly indicated at least three policy changes (not in place at their organization) that she or he agreed to implement. Examples of possible changes included: integrating a 10-minute exercise breaks into meeting agendas; facilitating of office-wide exercise breaks at a certain time each day; provision of healthy food choices at meetings or other company gathering (e.g., substitution of fruit for pastries); conducting walking meetings; encouraging more casual dress attire (e.g., no heels, ties, etc.); and providing water at meetings and other work functions. In addition, each organization made additional commitments, such as: scheduling a regular time for training "on the clock;" allowing an AABLH-identified Mkimu (program champion) within the organization to devote 30 minutes per week to orchestrate fitness activities; and providing one hour of company time, quarterly, for "booster" sessions and evaluation questionnaire completion.

The CBO/Worksite Wellness program was implemented in parallel with the LAC–DHS organizational wellness program upon which it was modeled. By design, the programs shared a core curriculum, educational materials, and a core set of survey items used in evaluation. During the planning and early implementation phases, AABLH and county staff regularly exchanged information to address challenges in recruitment, program delivery, and assessment.

Developing a Small Grants Program to Inventory and Seed New Physical Activity Programs

A minigrant program to inventory physical activity resources available to residents in the targeted areas was developed in response to concerns expressed during the planning phase about the lack of safe physical activity options. An ABLH offered community organizations with a history of working in and with African-American communities grants (equal to or less than $7,500) to inventory physical activity sites and existing programs within targeted neighborhoods. In addition to participating in the inventory process, grantees

were required to use some funds to develop or expand active recreational programs open to a wide range of community residents. In keeping with REACH's overarching "walk the talk" strategy, the mini-grantee organizations also agreed to serve nutritious refreshments at meetings and events and to provide 10-minute physical activity breaks at meetings lasting at least two hours.

Results

A process evaluation of the AABLH physical activity promotion effort is presented in the following series of analyses: (1) descriptive data reflecting the categories and characteristics of organizations participating in the planning and implementation phases of the project; (2) characteristics of organization members/clients, as reflected in baseline survey descriptive data on CBO/Worksite Wellness program participants; (3) process data on leaders' personal training experiences; and (4) an assessment of organizational support for physical activity, linking organizational type to level of involvement in physical activity promotion strategies.

Organizational Members, Clients, and Staff Characteristics

CHC health educators and community fitness and nutrition workers worked with the county government, community organizations, a coalition advisory group, and the evaluation team to launch the CBO/Worksite Wellness program. The program officially started in July 2001 at five sites. These sites varied in several respects, including the number of participants. For example, because of the interest in the program at a community college (over 95 at the start of the program), two sessions were provided at this site. The first four sites had an average attendance of 6.5 participants per site, whereas the college site averaged 30 participants in each session. By July 2002, seven organizations had been added. The largest group of participants for the second group of sites was a senior center, which started with 44 and ended with 40. The average attendance for the remaining sites was 11.

Data on a convenience sample of 235 individuals from these organizations who completed the baseline assessment survey are presented to characterize the sociodemography, self-perceived health status and health behaviors of REACH coalition organization members, clients, and staff. The evaluation team adapted survey items taken from the Los Angeles County Health Survey.[20]

Sociodemographic Characteristics

The sample was comprised of 86 percent women with a mean age of 45.6 (± 20). Almost three-quarters of the sample were African American (73%), with 15 percent Latino, 4 percent Asian/Pacific Islander, 3 percent White, and 5 percent "Other." One-quarter of the sample was married (25%); 23 percent had never been married; 27 percent were divorced or separated; 16 percent were widowed; and 5 percent were not married, but lived together. Less than one-quarter had graduated from college (22%), although 42 percent had some college or technical school experience.

Health Status

Among respondents, 75 percent reported their health to be good to excellent and only 7 percent reported feeling sad, blue, or depressed all or most of the time during the preceding four weeks. Participants' mean BMI was 27.6 kg/m^2, with a range of 12.5 kg/m^2 to 51 kg/m^2. Sixty-six percent were overweight, and 30 percent were obese. Twelve percent of respondents had diabetes; 17 percent had heart disease; 26 percent had high blood cholesterol; and 33 percent had hypertension.

Health Behaviors: Physical Activity

Nearly one-third of the sample (30%) were quite sedentary, reporting walking less than 10 minutes without stopping in a routine week for work, recreation, exercise, or transportation. About 37 percent were estimated to have met the minimum CDC/American College of Sports Medicine physical activity recommendation.[5] Respondents also reported spending 3.7 hours, on average, watching TV on a typical day.

Categories and Characteristics of Participating Organizations

The AABLH physical activity promotion effort occurred in three phases: (1) a planning year (Phase I); (2) two years of initial implementation (Phase II); and (3) expansion of the project beyond the original community action plan (Phase III). By the end of Phase II, 217 organizations had participated in at least one facet of AABLH.

Table 1 provides descriptive data on the organizations that participated in the first two phases of the project. The plurality is community service organizations, but every organizational sector is represented.

AABLH has hosted hundreds of meetings with coalition members and other community members. More than nine in ten of these meetings included at least one 10-minute exercise break. The breaks have occurred regardless of topic or location (e.g., CHC offices, churches, universities, community rooms in public buildings, public housing facilities) and have been integrated into

TABLE 1 ● Organizational Participants in Community Action Plan Development and Implementation

Type of Organization	Phase 1–start, *n* (%)	Phase 1–end, *n* (%)	Phase 2, *n* (%)
Community service	7 (41.2%)	12 (27.3%)	89 (41.0%)
Government	3 (17.6%)	8 (18.2%)	26 (12.0%)
Associations	2 (11.8%)	5 (11.4%)	13 (6.0%)
Religious	1 (5.9%)	3 (6.8%)	18 (8.3%)
Private sector	1 (5.9%)	2 (4.5%)	15 (6.9%)
Academics	2 (11.8%)	4 (9.1%)	20 (9.2%)
Health providers	1 (5.9%)	6 (13.6%)	23 (10.6%)
Fraternal/social	—	4 (9.1%)	5 (2.4%)
Media/public relations	—	—	7 (3.2%)
Total	17 (100%)	44 (100%)	217 (100%)

a wide variety of gatherings and functions, such as those for community advisory groups, the coalition, routine staff discussions, conference plenary sessions, and community education/advocacy. The shifting of sites for these meetings is, in itself, a critical strategy—it exposes AABLH "walk the talk" intervention approaches to different parts of the community.

Both the number of project-related meetings and the number of participants have continued to increase over time with the launching of additional project components.

Members of the coalition have subsequently been asked to participate in 16 other initiatives designed to address ethnic health-risk disparities (Phase III). This expansion is a crucial outcome in itself, given the desire to sustain community interest and involvement in physical activity and nutrition after the "official" end of the program. AABLH staff members have repeatedly been asked to participate in Los Angeles-based national conferences, health fairs, and events sponsored by coalition members. Through these events, thousands have been exposed to the "walk the talk" strategy. The level of involvement in these events has included leading breaks, staffing information tables, and delivering formal presentations on project methods and outcomes.

Process Data on Leaders' Personal Training Experiences

Four of the six directors completed the 12-week regimen, and all six reported using the experience to promote wellness within their organizations, either by allowing AABLH to conduct the program at their worksites or social/service programs, or by integrating physical activities and/or healthy nutrition into one or more of their existing programs. Three of the participants reported continuing their personal wellness routines for at least six months after the program ended. Participants' recommendations have been used to modify and strengthen the CBO/Worksite Wellness protocol and to design more creative outreach and recruitment strategies.

Organizational Support for Physical Activity Integration

While representatives of nearly all of the organizations in the coalition have participated in the 10-minute exercise breaks institutionalized by the project, some organizations have far exceeded this basic level of support for physical activity integration. Table 2 presents the distribution of organizational support for physical activity integration among the different types of organizations in the REACH coalition. Community service organizations that have a primary emphasis on physical activity are separated from other types of CBOs (community physical versus community based), given the understandable predominance of such organizations in Level 4.

About half of the organizations demonstrated some level of active support for physical activity integration (Levels 2–4), and more than one-quarter of organizations participated at the highest level. Fifty-six organizations have agreed to some type of formal, contractual relationship with CHC to advance physical activity promotion. There are statistically significant differences in the distribution of level of support for physical activity among organizations of different types. Nearly 75 percent of community service organizations with a focus on physical activity had formal contracts, compared with 50 percent of private sector organizations, 30 percent of religious organizations, and about 30 percent of media organizations. Government organizations were the least likely to have subcontracts with CHC. CBOs

TABLE 2 ● Organizational Support for AABLH Physical Activity

Type of Organization	Level 1 *n* (%)	Level 2 *n* (%)	Level 3 *n* (%)	Level 4 *n* (%)	Total *n*
Community based	36 (60.0)	3 (5.0)	9 (15)	12 (20.0)	60
Community physical	5 (26.3)	—	—	14 (73.7)	19
Government	16 (57.1)	8 (28.6)	1 (3.6)	3 (10.7)	28
Associations	5 (38.5)	6 (46.2)	—	2 (15.4)	13
Religious	11 (55.0)	3 (15.0)	—	6 (30.0)	20
Private sector	12 (50.0)	—	—	12 (50.0)	24
Academics	10 (45.4)	6 (27.3)	2 (9.1)	4 (18.2)	22
Fraternal/social	4 (80.0)	—	—	1 (20.0)	5
Media/public relations	3 (42.9)	2 (28.6)	—	2 (28.6)	7
Other	6 (100.0)	—	—	—	6
Total	108 (52.9)	28 (13.7)	12 (5.9)	56 (27.5)	204

$\chi^2 = 77.6$; $p = 0.0000$.

were the most likely to participate in wellness training, whereas associations were the most likely to request the conduct of exercise breaks at their functions.

Discussion

In summary, the AABLH effort demonstrates the feasibility of a collaborative, multisectoral, community-based participatory research model to engage organizations in sharing the "cost" of physical activity engagement. This collaboration, founded on a history of teamwork and mutual trust, was characterized by sharing power, decision making, and "credit" for accomplishments during every phase of planning and implementation. The multisectoral nature of the model is consistent with the social ecological nature of the intervention. Major elements of the mission of each sector are represented in the project. Local government public health practice, particularly with increasing economic constraints and pressures toward "downsizing," seeks to ensure that certain conditions are met for improving the health status of residents, a core function of local health departments (LHDs).[21] In this case, county expertise and other resources were consistently engaged in the ongoing refinement of intervention strategies. These strategies addressed a community desire to attack the root causes of the chronic diseases that the CDC initiative had focused on. The LHD also provided data that helped to match the needs of and intervention opportunities within the targeted population. Community organizations and individuals directed the level and scope of the attack on the problem. The growing coalition made the initial choice of health disparities to address; selected the primary prevention focus on physical activity and nutrition; identified and recruited partners; embraced the LHD strategy for physical activity promotion as central; and pinpointed gaps and needs leading to the development of complementary approaches. Academic researchers identified the most rigorous tests of the efficacy of the interventions within resource allocation; developed/selected instruments; and managed and analyzed data. The CDC, in its federal government role of addressing health disparities, allowed communities substantial latitude in adopting innovative and less thoroughly tested approaches as a part of the REACH 2010 initiative.

The process data presented demonstrates broad organizational support for this physical activity promotion model. Given the conservative coding scheme used in the analyses, it is not surprising that half of the organizations would appear to demonstrate only a modest commitment to physical activity. However, the more unexpected outcome was that more than one-quarter of the organizations involved in the coalition were committed at the highest level of support for physical activity. The extent of overlap of health promotion with the organization's main mission probably accounts for some of the variability in response. Community service and religious organizations, with their general mission to enhance many elements of community well-being, were, not surprisingly, at the forefront of this involvement. For organizations with little overlap in mission, Level 1's relatively passive support for physical activity integration may represent a major step on the change or "innovation dissemination" continuum. For others with a greater stake in advancing health, procession to Level 3 or 4 should be expected and strongly encouraged.

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Considerable need for this intervention effort is evident from the individual-level data presented. These data showed that the proportion of individuals meeting CDC recommendations for physical activity in the AABLH target population was less than 40 percent, compared to recent national data suggesting a 45 percent adherence level.[22] This prevalence, though fairly low, still *over*estimates that in the larger population reached by this model, given the disproportionate representation of better educated organizational staff among the wellness training participants, compared with end-users of services. The provider/decision-maker roles of many of these organizational staff is also important, in that this sort of training increases the likelihood of them promoting physical activity among their clients.[23] Certainly, social desirability or factors other than true commitment to physical activity promotion may have motivated Level 1 or 2 involvement. However, exploiting human desire for conforming to social norms and expectations is inherent in the intervention design. The lack of outcome data precludes inferences about the efficacy of the intervention in creating sustainable, regular physical activity adherence; this limitation is typical of environmental interventions.[24,25]

These findings suggest a considerable appetite for weight-related lifestyle change at the organizational practice level, encompassing and extending beyond worksites. A parallel may be drawn from the history of tobacco control—in the progression over time from a focus on the individual-level cessation/prevention to an organizational practice and policy level focus to a focus at the legislative policy level. Funding agencies (especially government) required smoke-free workplace policies long before evidence confirmed their effectiveness in decreasing second-hand smoke exposure or

smoking. Given the current climate of recognition of the failure of individual-level intervention alone to stem the epidemic, a similar "leap of faith" in obesity control is needed in adopting organizational practices and policies that incorporate physical activity into the normal conduct of business. Organizations must share in the "cost" of adherence to a healthier lifestyle. Within communities of color, an intervention focus on the sociocultural environment assumes an even greater importance, given their lesser resources in the face of greater challenges (e.g., outdoor safety) and the lesser resonance of mainstream messages and values in promoting lifestyle change. These sociocultural norm changes may not only ultimately be shown to increase physical activity levels, but also to create the political will driving the introduction and passage of supportive legislation.

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