



DRAFT

Physical Activity and Nutrition Study

Prepared by the
Hancock County Planning Commission

In collaboration with

Healthy Acadia
Coastal Hancock Healthy Communities
Healthy Peninsula Project
Schoolic Healthy Communities
Healthy Island Project
Bucksport Bay Healthy Communities

Questions can be addressed to:

James Fisher, Planner
Hancock County Planning Commission
395 State Street
Ellsworth, ME 04605
(207) 667-7131
(207) 667-2099 (fax)
jfisher@hpcme.org

Summary of Findings

The attached spreadsheet provides readers with a summary information on health related organizations and initiatives in classified as School, Community, Health Care and Worksites. The summary is a first step toward the creation of a metric of community and institutional commitment to expanding opportunities for physical activity, nutrition, awareness of the impacts of watching television and breast feeding.

Discussion

Schools

In most of Hancock County's rural towns, the schools are the single largest community organizations and venue for youth activities. School sponsorship of physical activity and nutrition programs and endorsement of PAN objectives through curricula and policy was most often attributed to the efforts of a particular teacher, coach, cook or administrator. Support programs, such as the Healthy Maine Partners provided the opportunity, but the choice to participate varied considerably between schools

School attention to the impacts of TV viewing was also uneven. Many of the respondents were unsure whether their school or classes at their school were addressing this issue. Part of this may be attributed to the periodic nature of a week long event.

Breast feeding did not appear to be a common element in school curricula. The high schools generally did not designate special areas for breast feeding. Some noted that they did not have any students needing this facility, but would create a space if one were requested.

Communities

The largely rural communities of Hancock County provide very limited support for physical activity, nutrition, TV awareness and breast feeding. The smallest towns have few facilities beyond athletic fields. Larger and more affluent towns provided more robust facilities including public and private indoor space for exercise. While this tabulation endeavors to locate an organization within a town, many organizations serve multiple towns. For example, many towns in Hancock County contribute to the maintenance of the Ellsworth City Library rather than attempting to create their own. Few communities have gone beyond formation of recreation committees as a means to promote physical activity.

The relationship between size of an organization and its capacity to provide nutrition information is also evident in restaurants and food stores. The regional and national chains are far more likely to provide customers with information on nutritional content. "Fast food" restaurants like McDonalds, Subway and Burger King provide a uniform product and have had a simple time of assigning nutritional information. In some cases, such as Burger King, the level of detail in labeling can be overwhelming to consumers. In other cases, such as Dunkin Donuts and Pizza Hut, nutritional information was kept behind the counter, but was available upon request.

The “family restaurant” chains, such as Denny’s, did not provide the specificity of information of the fast food restaurants, but in some instances offered a page or two of “low carb” or “low fat” choices in their menus

Local restaurants cannot as easily match the level of sophistication in labeling used by some fast food restaurants. As such, labeling requirements might have unintended consequences such as discouraging innovation in menu planning and efforts to use locally grown or seasonal foods.

Similarly, the large groceries provided more information than small, locally managed food stores. Some of the small store owners expressed interest in providing additional information, but did not have the capacity to produce the information on their own.

Health Care

There was very little variation in responses to the questions asked of health care practices. Virtually all respondents reported addressing PAN objectives internally as well as through referrals. There are many levels on which clinicians can provide information and referrals to clients, but in most cases these practices report covering all the bases. Participation in TV Turnoff week, however, was reported by only a small number of providers.

Worksite

This section of the analysis is perhaps the least adequate. The process of identifying, contacting and interviewing 368 businesses with 10 or more employees would have far exceeded resources at hand. Rather, we chose to focus on worksites with whom the HMPs worked as was specified in the original contract. Determining what constitutes “working with” an HMP also complicated analysis. For instance, the Healthy Peninsula project teamed up with a regional chamber of commerce, distributing pedometers to employees and promoting a walking program. In some instances participation was quite significant, while in others less so. The Healthy Acadia Project has been most engaged in worksite wellness, and as such the numbers appear much higher for the MDI towns. Additional effort is needed in this panel of questions in order to get a more accurate picture of employer commitment to the PAN objectives.

Lessons Learned

Methodology

Lesson 1: Revisions to protocol during an ongoing research process can lead to confusion and delays.

Delays were encountered early in the process when the survey instrument was revised twice after the contract was signed. Each of the revisions resulted in a more complete, but also more demanding protocol. We considered at each juncture whether it would be possible to meet the new requirements within budget and within the time frame. Some elements of the earlier drafts of the protocol were preserved in order to avoid over-commitment.

Lesson 2: A research design must always be very clear about the sample frame, units of analysis, and sample methodology.

The final version of the study instrument used twelve different sample frames based-on different units of analysis. The number of potential respondents in each frame ranged from 6 to 368 in Hancock County. The table below summarizes the sample frame by question.

Frame	Measurement Unit	Labeled Unit	Questions	Estimated Population
1.	Schools (K-12)	School	1 – 7, 9 – 13	42
2.	Community-based service organizations	Community	1, 2, 7 – 9, 16	Unknown
3.	Child Care Centers	Community	3 – 6	37
4.	Communities (as defined in Maine as minor civil divisions)	Community	10, 11, 17	39
5.	Restaurants	Community	12, 13	175
6.	Food Stores	Community	14, 15	83
7.	Family and Pediatric Practices serving youth (excluding alternative and complimentary health care)	Health Care	1	22
8.	Family Practices serving adults	Health Care	2	18
9.	Clinicians serving youth	Health Care	3, 4, 7, 8, 11	Uncertain
10.	Clinicians serving adults	Health Care	5, 6, 9, 10	Uncertain
4.	Communities (See #4)	Health Care	12	39
11.	Healthy Maine Partnerships	Health Care	13	3
	Healthy Community Coalitions (HCC)			3
12.	Worksites (10+ employees)	Worksite	1 – 6	368
Total				778

The “community-based service organization” is actually a catch-all for a variety of town, private, non-profit, and informal organizations and proves to be quite difficult to pin down. Local sources produced very different lists of relevant local organizations. The lack of clarity of this term resulted in unreliable counts. A more valuable outcome is to produce a list of the specific organizations and the kinds of interventions that they are doing or willing to consider.

Lesson #3: Aggregation of responses into a summary table occurs after the “micro-data” have been collected. Attempts to collect data directly to a table were unsuccessful.

The complexity of the protocol is masked by the final reporting sheet which requests all findings be totaled by town. In most cases the sample frame is not geographically related to town-boundaries. For instance many schools in Hancock County serve multiple towns. Their location in a particular town does not imply that they provide a service solely or even primarily to that town. The same is equally true for community-based organizations, child care centers, restaurants, food stores, medical practices and worksites. As such our efforts to count units by town proved frustrating.

Were each town to have a person who could answer these questions for their town, then the summary table would have been easily managed. It was rare that we found anyone who could

answer more than one or two of the questions. Often the responses from different sources were contradictory and could not be reconciled in a summary table by town.

It became clear late in the process that an alternative methodology was needed. Separate databases were required for each of the 12 sample frames. At this point the scope of the project became more daunting, particularly identifying and contacting all of the possible community organizations and interviewing 368 worksites with 10 or more employees. Our compromise was to fall back on the earlier agreed-upon contract that targeted responses about businesses with-who the HMPs and HCCs had worked, particularly in the case of community organizations and businesses.

Lesson #4: Concentrate on issues that are important to your project.

Some of the questions on this survey are clearly related to the goals of the HMPs and HCCs while others are not. It proved more difficult to gather information when there was no local health agent.

From the MDI Team: “Some of the indicators will be very useful, but many are not relevant to achieving a significant public health improvement in our communities.

Troublesome Indicators: Some indicators were vague, or lacked clear definitions. Some examples include: School # 3, and Community #4, 7, 8, 9, 10, 13, 15 & 17.”

Lesson #5: The focus on formal, institutional programs is likely to under-represent the wide network of informal organizations.

The data are drawn from a wide range of information sources and are admittedly a partial view of underlying activity. The sample frame that is most likely to under-represent activities is that of the local organizations. Rural Maine towns have a great deal of activity among informal and familial networks. Tracking the activities of informal networks requires an ethnographic, participatory methodology. While very rewarding, these strategies are difficult to apply in a multi-town study.

Future Steps: Knowing what you know now, would you apply again for these funds?

Given my delays in completing this project, I don't think I would be a likely candidate in the future. On the other hand, a second round would be less difficult given the multiple databases that I have created to complete the first round.

That said, there is much to be gained in building upon the detailed lists of community organizations, town led activities, school and worksite-based programs. The Hancock County Planning Commission will continue to assist the Healthy Maine Partners and Healthy Community Coalitions in Hancock County to build an ongoing system for tracking the impacts of their programs as well as improving networks with complimentary organizations.