



FRESNO METRO MINISTRY • www.fresnometroministry.org

1055 North Van Ness Avenue • Suite H • Fresno, California 93728

PHONE: 559/485.1416 • FAX: 559/485.9109 • EMAIL: metromin@fresnometmin.org

Excerpts and Summary of the 65th Community Hunger and Nutrition Forum

Wednesday, April 12 12:00PM –1:30PM

Trinity Lutheran Church, Fresno

Sponsored by Fresno Metro Ministry

Supported by:

California Dept. of Health, California Nutrition Network

The California Endowment

MAZON: A Jewish Response to Hunger

California Food Policy Advocates

Kaiser Permanente

Vitamin Settlement Cases Consumer Settlement Fund

- to improve the health and nutrition of CA consumers

Occidental College Center for Food and Justice

Fresno County Economic Opportunities Commission Refugee Rural Initiative

Forum Focus: **Obesity and Chronic Disease Prevention
from a Health Providers Perspective
Health Plans and Developing a Toolkit for Doctors**
*Dr. Helen Jones, Co-Chair CMA Foundation Taskforce
on Obesity Provider Toolkit*

The following is a summary of the reports made at the forum compiled by Edie Jessup and Carey Berend.

Hunger and Nutrition Forum Wednesday, April 12, 2006

Edie Jessup, Fresno Metro Ministry: Welcome today to the 65th Community Hunger and Nutrition Forum where we are focusing on Obesity and Chronic Disease Prevention from a Health Providers Perspective. Dr. Helen Jones, Co-Chair CMA Foundation Taskforce on Obesity, will present on her work with Health Plan Providers to develop a Toolkit on Overweight management for Doctors

I want to call your attention to **Hunger Action Day on Tuesday, May 16th**. We are making arrangements to meet with our legislators in Sacramento and discuss the needs their constituents are seeing in terms of Hunger and Nutrition issues. This will be right before the Governor's May Budget Revise, so hopefully we can make a big impact on some of the decision making that goes on.

I recently was in Sacramento to testify on the AB 2205: Three Connections to Healthy Eating, a food stamp bill connecting Medi-Cal, food stamps, and school meals. AB2205 (Evans) was passed out of the Human Services Committee. Juan voted right. I'm going to have Jeremy briefly go over proposed legislation that would affect those before we get into our presentation.

Jeremy Hofer, Fresno Metro Ministry Hunger & Nutrition Project: would call attention to four bills that are being discussed in the state legislature to improve access to healthy food for low income families. **Your understanding of the bills and informed comments to our lawmakers is essential to ending hunger.**

Find Hunger & Nutrition Forum Summaries Online at:

www.fresnometmin.org/fmm/hunger.html

**Want to receive calendars and forum summaries electronically?
Contact the Hunger & Nutrition Project today at:**

metro@fresnometmin.org / 559 485-1416

OBESITY: A HEALTH PROVIDER'S PERSPECTIVE

Apr 12, 2006

AB2205: Three Connections to Healthy Eating. Current law allows people who sign up for food stamps to have their school-age children automatically enrolled in the school meal programs. AB2205 would include Medi-Cal into the categorical eligibility, and connect our health enrollment programs with healthy eating programs: food stamps and school meals. The programs linking of enrollment (Medical, Food Stamps, and School Meals) for eligible families would mean that people won't have to go multiple times to apply for all three programs.

AB 1916: Targeting and Innovation in School Meals. This bill will require low income schools to see that all kids get healthy meals by becoming 'Provision II'. Provision II in schools means that the whole school is eligible to receive free meals, parents are not required to apply yearly for free meals, and it removes paperwork and administrative hassles for schools.. Even if they qualify, a lot of these parents are not getting free meals at school because of barriers, and concern about public charge. It also will require schools that have 40 percent or more of low-income students to offer school breakfast.

AB 3029: Food Stamp Simplification. The Food Stamp Simplification Act is to further remove some of the red tape that is involved in the food stamp nutrition program enrollment process. We went from client monthly reporting of income and expense to the County Employment and Temporary Assistance offices, to quarterly client reporting in 2004. This has already removed a lot of the strain on families because they don't have to go back every month. This bill would move client reporting of changes to income and expenses to every six months, a biannual reporting. Our county and the state would save through less administration costs. We'll be asking Johnnie (Belford, Fresno County E&tA) if she'll endorse this bill. We like to put people on the spot here. The bill will also remove some of the requirements around office visits and require the state to go after all the federal waivers that are available. The federal government puts out waivers that are available to states so that states can limit barriers to food stamp enrollment. And the AB 3029 it would also establish a pilot project, a demonstration project in a county to further simplify and to demonstrate to the federal government the fact that if we were to change some laws at the federal level it would benefit the this nutrition program.

AB 2384: Fresh Fruits and Vegetables in Low-Income Communities. The Fresh Fruits and Vegetables in Low-Income Communities addresses two things. One, it sets up a pilot program in one county, that would offer technical assistance and funding to neighborhood groceries and retail sites so there would be point-of-sale advertising and assistance with getting fresh fruits and vegetables in their store. What we know about these local markets is it's very costly to keep fresh fruits and vegetables and that's one reason why we don't find fresh produce in neighborhood markets. The energy cost is high for cooling, and it also takes technical knowledge of how to display and care for fresh fruits and vegetables. This bill is will fund an effort in one county as a state model to find ways to increase access to fresh, local produce in low income neighborhood stores. The other aspect of AB 2384 is that the state would add an incentive to consumers that use their Food Stamp EBT cards to buy fresh fruits and vegetables. They would offer them a little bit of a reimbursement every time they purchased fresh produce, The idea is that then they would receive a receipt that would show their benefit to them for purchasing those fresh fruits and vegetables. The average amount of food stamps that a recipient receives comes out to about \$2.50 a day/person, which is not a lot. Many low-income families end up buying high-calorie, high-fat foods that stretch their food budget and they do not buy their five-to-nine recommended fruits and vegetables because it is too expensive. AB 2384 would be help these families in purchasing more fruits and vegetables, and help our local farmers with new customers, and improve the health of low income neighbors.

Edie Jessup: We've really had some impact over the years on progressive legislation that has improved the access to good food by low income neighbors here in Fresno. **Fresno County was one of the first California counties to use a government waiver so that single people without dependents could get food stamps for more than three months in their lifetime, as long as they were looking for work.** What a concept! Fresno started applying for that waiver. It worked so well, we're now getting the state is now automatically applying for the waiver for all eligible counties. More hungry people are getting food Stamps until they have good jobs.

After two years of 25 stakeholders working intensely the **Fresno Unified School District Board of Trustees unanimously adopted a comprehensive Healthy School Environment Wellness Policy. Dr. Helen Jones was the chair of that committee.**

OBESITY: A HEALTH PROVIDER'S PERSPECTIVE

Apr 12, 2006

We all are aware of the obesity epidemic and the chronic disease by diet which people are suffer in Fresno. One way we could make an impact, is by changing what food and activities are available and accessible to our kids in school. Children are in school for two meals and nearly 8 hours a day. There will be an appointed Wellness implementation committee and there will be stakeholders including parents, community organizations, students, teachers, custodians and all of the people who are going to be involved in terms of changing the environment in our schools.

Luisa Medina, Chairperson, Fresno Unified School District Board of Trustees: Refresh my memory on the implementation plan. Is that a board appointed committee or is that a superintendent?

Edie Jessup: The Superintendent appoints the committee. Something really unique happened with the development and spearheading of this comprehensive school district nutrition and physical activity policy in the fourth largest school district in California. Paul Igswood, who is Fresno Unified's food service director, has been very instrumental in working within the district on this policy. Just before we went to the board, the Healthy School Environment Wellness Committee, Paul and the directors of physical education, nutrition education, and health services all met with us, and the committee and FUSD directors agreed on the policy recommendation to the board. That cross-department work and leadership was unique in school districts.

Now, Dr. Helen Jones is going to share with us. I'm going to let her tell you exactly what it is she has done since beginning to work as Chair of the Healthy School Environment Policy Committee. I'm very excited that she's here. Welcome, Helen.

Dr. Helen Jones, Fresno Internist, Fellow with Healthcare Policy Leadership Institute: I do have a personal interest in a healthy school environment. I have a child in elementary school, junior high, and high school and so I do hear about the food every day.

I want to play on the topic I was given, and part of it is "What's the face of the physician in obesity prevention?" I don't see any doctors in the audience and it probably is an obvious kind of an 'elephant missing from the room'. On surveys, most patients say they want to get their health information from a physician. What is our role, where do we fit, and what's our report card? I see my general role as an advocate. I'm from San Francisco, and Fresno sometimes has a small town reputation; but I have to tell you, on this front Fresno has been very innovative and very progressive.

PHYSICIAN'S OBESITY PREVENTION TOOLKIT

At a state level, physicians are organized by the California Medical Association (CMA), and California leads the way for the rest of the country in wellness and nutrition. The CMA is in progress of developing this 'Obesity Tool Kit Project'. Most likely the tool kit we develop will be the standard of care for the rest of the country. We plan to have this tool kit (and I'll go into what the tool kit is later) to be endorsed by national physician organizations, dietetic associations, etc. So, it is by no means a small deal. Whatever we do today, here, I will take back to the CMA Obesity Prevention group, and what the CMA develops as a standard of care for patients with this toolkit, will in all likelihood really happen, at both a state and national level as the new physician obesity management protocol.

For an overview, the CMA 'Expert Committee' just met for the first time on April 8th, so I've actually pilfered information that hasn't even been put into minutes yet. This Hunger & Nutrition Forum, I'm getting the impression, has a lot of grassroots leadership in it with intimate delivery of nutrition education skills, with a heart for improving food and food products available.

So let's look at what happened at that California Medical Association expert meeting. In the room with the physicians on the committee were representatives of the 41 health plans in the country. The doctors on the committee represented specialty obesity clinics where they have to deal with 700-plus-pound folks and the bariatric surgeons were there. These are the people who will write the guidelines and develop protocols for a standard of treatment for obesity.

Those are interesting partners: Doctors and Health Plans. It gets challenging as doctors begin to talk about how Health Plans will help underwrite doctor's efforts in working with non-insured people. It was really hard

OBESITY: A HEALTH PROVIDER'S PERSPECTIVE

Apr 12, 2006

to get the conversation started. The first questions were "What do you mean by a tool kit?" and "Who is the tool kit for?" I think the best answer we got is that the Tool Kit is for patient care, and we're going to develop best practice information for physicians, on behalf of patients at risk of obesity and chronic disease. We physicians are trying to get consensus on what the appropriate advice for patients is on obesity, and how to follow through on it so that patient health improves. **If you think about back to old black and white film footage, you can probably see Dr. Smith telling Mrs. Jones, "You need to eat healthy and exercise more." That is being duplicated across the country, and has been done so for the past 50 years; but we are just getting bigger and heavier. The advice from doctors is just not working.**

Now, does it mean doing those things doesn't work? Not necessarily. But, how we're approaching preventing obesity and chronic disease is not working. **We physicians are not giving you what you need in terms of practical, personal advice on benchmarks and weight management for good health. You are just something else to feel guilty about from doctors.** So, we're trying to get a doctor's tool that says people with a BMI over 70 *all* need to be referred to a specialty clinic, and then give patients the addresses of the closest clinics.

It sounds like most people here are aware of the statistics on obesity, but **two-thirds of the country is overweight, and one-third of our overweight people fit into the obese category.** All of these things are associated with elevated blood pressure, elevated cholesterol, and certainly diabetes. Now, only about **20 percent of our children are overweight or obese. However, 75 percent of that group will move on to be overweight or obese adults,** and we don't want to see that. That's almost a sure outcome of overweight children: obesity in adulthood. You also see that we have more healthcare disparity here in the San Joaquin Valley and Fresno. We have increased risk and rates of obesity and chronic diseases in minority communities.

The reasons why we need to talk are clear. Doctors are getting an F grade as physicians in terms of identifying people as obese and generating their BMI. **The goal of the CMA is to get BMI, body mass index, as a vital sign.** So all doctors will figure a patient's BMI when they take your pulse and blood pressure. You will probably see this happen within the next two years.

Economically, we see obesity causes losses in the short term and long term. Let's start with school. We have a problem with self-esteem and bullying, if we want to call that a loss, but also it can lead to workplace discrimination, getting lower wages, increased time off for illnesses, and there is much comorbidity (additional illness) that goes with obesity, including arthritis, and joint strain. Estimates on the healthcare dollar annually easily go between \$70 billion to \$100 billion per year nationally. California spends about \$28 billion at this time.

I think **the emphasis from your doctor needs to be on activity and the way we eat.** It sounds fundamental, but to state it and make it a line item agenda is a big thing, because in practice we have made healthy eating and activity a small agenda item. When you get a physical, doctors have not made eating and activity important to a patient's health.

The CMA wants to focus on children's activity. And that's why it was unfortunate that the Physical Activity part of our Wellness Policy was not adopted as recommended. However, the federal and state regulations are going to require 4 years of PE.

We want adults to be active daily, and I don't mean parking far out in the parking lot from shopping. It means scheduled activity.

We want to limit our schools to only healthy foods. And, we want the school's leadership on this in the marketplace. We want something affordable, and with the legislative ventures that's becoming a reality. The CMA doctors want to partner with others and have a coherent message for people from the medical profession, health plans, schools, etc. I have to tell you something funny that happened at the meeting. There were a few physicians that complained, "Well, you know what? There is no billing code for when we educate patients on obesity. There is no reimbursable message or number we send to insurance companies to say we talked to this patient and spent some time on their weight and diet. It doesn't matter what their size is. There is no billing code to cover obesity." So there became a side conversation with the physicians where one would lean over and say, "Well, you know, you can charge for metabolic syndrome if they meet that. Well, yeah, if their cholesterol is up you could actually bring them in for cholesterol and talk about their weight." On the other side of the room were the insurers. Theoretically the doctors and the insurers had the

OBESITY: A HEALTH PROVIDER'S PERSPECTIVE

Apr 12, 2006

same agenda. At some point, one very encouraged, excited doctor leaned forward and said to the insurers, "Can you tell us what the code is so that we can bill you for counseling on obesity?" Well, of course the Health Plans didn't give the doctors a code. I mean, why would they give us the code? They would have to pay physicians more. Curious bed fellows, but we are trying to work out a good standard of care for weight management.

Doctors need access in a broad array of arenas to communicate about weight, food and activity: i.e. restaurants, groceries, workplaces, schools, and to promote the activity. As a mother, **I would hope that our local medical society could do something.** There are going to be few physicians they call champions who are going to go out and volunteer. You really can't ask that of a whole medical organization, but I do feel it's fair to say, look, Docs, you have kids too. Every school in the fall is going to have an orientation session. Ask physicians for five minutes to go to school and say, "At P.E. you're not just having fun. We expect you to be active. This is going to be a lifelong skill you are learning, and so you exercise every day here and now and when you get out of school and no one is telling you to, you need continue to be active daily for your good health." Simple messages. "And when you go to the cafeteria and no one is watching you, you will get your plate delivered to you but we expect you to make healthy choices and to continue to do that at school and away." It's very simple. One doctor could show up at every school. Doctors don't need a Power Point. Doctors don't have to be a bariatric specialist. I think that is something that **the Fresno Madera Medical Society should arrange and have one doctor go to a school and deliver this message to kids**, if nothing else. Employee access to physical activity and healthy foods is as important as school site wellness. Doctors have a role in delivering that clear message also.

The tool kit for physicians on weight management must contain strategies. We want this tool kit to be linguistically and culturally appropriate. I was the only African-American there, and I said, "Well, if you name something "healthy soul food" we're not going to eat it." Maybe "healing soul food" or something, but you know, what I'm saying is to work on that.

We are trying to get to consistent messages about weight for doctors. Right now, I couldn't even tell you in my ten-physician group what the guy in the next cubicle or suite is doing about counseling their patients on weight management. So the CMA is trying to get the obesity prevention agenda very broad and also consistent. Then, once the physicians have the toolkit with consistent standard of care for obesity and overweight, we hope to see some individual independent regional creativity and innovation superimposed on those consistent messages.

In terms of the national and state obesity prevention efforts, I think they really overlap what we're doing here locally. CMA doesn't want to see too much inefficient duplication of work already done, with everybody trying to find out the same thing. With the health plans we went over every health plan's wellness benefit. Some health plans will underwrite Weight Watchers for certain clientele. They may be targeting certain groups that have cost center issues for them. Right thing, wrong reason, but who cares? If you get access to the weight management program, you will personally and individually get the health benefit. There are some people who have weight counselors for children that require that the parents participate because parents cook at home and are going to make the ultimate budget choices. And some health plans have covered benefits in terms of exercise programs, and even discounts off bariatric surgery. Health Plans are very, very interested in what they can do on the front end to prevent obesity for their own reasons, but the Health Plans were so variable. It was interesting that there was not an evaluation on the best aspects of a program, and this is the most fascinating thing to me. Do these weight loss programs covered by insurance even work? There's no evidence in scientific literature that says Weight Watchers is working. When I say that, I don't mean that if people sweat and starve they don't lose weight. The only concrete scientific research on obesity reduction in the literature right now is bariatric surgery. Do not take home that I said only surgery works. That's very different. But doctors get concerned because the CMA as a reputable organization wants to put out recommendations for treatment of obesity and overweight that is evidence-based. These kinds of unknowns are what we're working with. Clinicians are going to want evidence-based standards of care for their patients.

NUTRITION ATTRITION

The health plan efforts –some are doing well. But as far as accountability for good results, the CMA is calling the insurers to task on that. In fact, **at the CMA meeting, a question was asked: "Does anyone**

want to share the results of their success with weight management or treatment? It was very quiet. You can have individual patient success without being clear what percent of your program is working and how that compares with other weight programs. There were interesting numbers about: 'We have this many people on the roster, or this many signed up for the program, or this many continued with the program. Weight management programs traditionally have high rates of attrition. So, it gets real difficult to pick out what is working well.

The California Medical Association has been doing some of this obesity prevention work already at the advocacy level. The California Association of Health Plans main thing is to target physicians to document and get that BMI in the medical report because a lot of the medical literature is stratified not necessarily by weight or by waist but by BMI. Does every physician need to get the special calculator that calculates BMI? Does everybody have one? No. Would it be better to just get a tape measure and do a waist measurement? Even if it wasn't the scientific gold standard as far as practicality and cost, do we need to do that? The CMA Committee, people that have a career in patient care, were all over the map on this. Personally I don't use either a calculator or a tape measure to assess overweight in patients. I use a wheel. There is a little dealie-wheel that shows your BMI. I actually have my patients use to calculate their own BMI while I'm charting. For me that's good because it is active learning for my patients, rather than passive learning. It's painless and it's not rude because the BMI number goes 20 to 70. So as long as it's not pounds people are pretty happy, so I record that BMI number and go on to the next question.

Specialized tool kits will need to be developed by CMA for subpopulations and overweight.

The CMA Committee spent quite a bit of time on pediatrics, and asks the question whether we need separate standards of care for adolescents. We need to be sensitive to eating disorders if we do not create recommendations that address the issue of overweight in the right way. People with disabilities, seniors, and minority population have specific issues, as we talk about appropriate treatment and prevention of obesity. There will be a global physician standard of care developed, and then the toolkit will customize care delivery to special populations.

Our target, which is extremely ambitious, is to have the tool kit ready within eight months starting from Saturday. The next step the following year to have that ready for the rest of the country. A lot of people develop pamphlets and tools that are inefficiently or minimally used, so we've got to figure out once they're in somebody's hands how and when they use it and how to make it functional. Otherwise we feel it would be a waste. But we have tried to narrow our focus at this time to get the kit realizing that that next step has to follow.

Puran Nozetti, Fresno County Health Department: I am with CHDP program so we work with pediatric patients and we are very active regarding children's health and weight and whatever is related to that. All of our statistics go to CDC and comes back to us and it shows every year to us how our low-income community who are eligible for CHDP and who are 200 percent of poverty level, their weight, BMI, all the measurements, all the health problems that they have. That comes back to us so we know how our pediatricians are working and everything because that's the outcome that we receive. I got the impression that you were criticizing the physicians because they're not involved or they don't actually take the initiative to go to schools or talk to some school sessions. When our providers are asking about the codes they are right in asking about the codes, so they cannot lie. If we say, "go ahead and ask them to come in for cholesterol, but talk about obesity," -not that they are not related, they can be related and they may not be related- but if this is actually telling them to lie to get some money from the insurance companies by coding in a way that is not correct.

Dr. Helen Jones: You're talking about fraud. I don't want to leave that impression. That was a sidebar conversations about what people are doing, but it is not advice.

Puran Nozetti: So when they say they do not have a code, they are right. They have to have a code. That means **we need to have very serious discussions between the health plans and clinicians to come up with a way to pay for advice for obesity or weight.** That's one thing on the physician's behalf. The other thing is on the clinic's behalf or on the office's behalf, meaning that they don't even have the permission to

OBESITY: A HEALTH PROVIDER'S PERSPECTIVE

Apr 12, 2006

refer. They don't have referral sources. They don't have permission to refer this child, who they know because of their family background or whatever they can be helped now that they're at risk, to a dietitian or a gym because the health plan is not going to pay for that. Even dietitians at the hospital, even when they are paid by the hospital, if they code that they are doing counseling for weight management, again, they are not being paid. That's a major problem there, and I support our physicians 100 percent. They're right. That is a problem which has to be solved, and we cannot expect them to say more than just "do some activities" or "watch what you eat." The other thing is I had a question that you said that you guys are developing a tool kit and you call that a provider tool kit. Maybe you should be calling that a client or patient tool kit because it's not a provider tool kit. A provider tool kit usually is the one that provider uses for diagnosing, for management, for whatever.

Dr. Helen Jones: That's what we're going to use it for on behalf of the patient. That's the whole thing. The more linguistically sensitive we make it, that part is not necessarily for the doctor, but **the doctor is the steward of getting whatever it is that we develop to the patient.** I think something where the patient is direct recipient may look a little different, but I think it will spin off to those kinds of things.

Puran Nozetti: Have you looked around to see what is available? Such as Blue Cross, LA Care, etc?

Dr. Helen Jones: Yes, we looked at everything. We had a table with everything on it that there is and we have it collated and crunched into a grid and we have what comes in a different language, what's for pediatric, what's for adult, whether it's for physical fitness or nutrition, and we have it all. We have a student that researched everything. I brought some samples. So that's where we're starting from and we're going to find a common thread. We have all the tool kits. We have every health plan because the California Association of Health Plans is our partner so their organization is bonding with our organization.

Puran Nozetti: What encouraged you to come up with a tool kit, when you say that there's no evidence that any one of these works?

Dr. Helen Jones: Sure. I think it's a starting point. I think it's a report card. I think it's an assessment on what works and what doesn't work and what we can advise at all legitimately, what can ground us. What is happening is if these tables were different groups each table is coming up with what we are going to do about this obesity epidemic. Because it's epidemic level it makes people want to problem solve and we have a variety of problem-solver approaches and we have no idea if I'm a doctor and you have The Zone, Atkins, Jenny Craig, Weight Watchers, go to the gym, lift a can for five minutes, at this time I can't stratify those for you. I can't say for you with a BMI of such and such, "This is going to be where you're going to get the most bang for your buck," or "All these three things work about the same. Why don't you pick one?" We don't have our information organized that way. **There's such a data and information explosion that it's coming out in an undigested form, and so we are trying to digest all that information.** With that guideline, somebody who wants to redo their tool kit may make theirs more culturally sensitive now; because they realize on the checklist they were missing that. There will be best practices. There will be a standard of care developed, which is absent now. When you talked about delivering and rendering the service for weight loss, it is happening now. We know we're supposed to talk about it; and we do the best we can. But right now, state of the art of obesity management through physicians is voluntary opinions. The reimbursement is an issue, but it was a small part of our dialogue; because even if we were reimbursed, we would still be overwhelmed and under-prepared for how to counsel for that. The level of scrutiny may be disturbing the status quo, but we will be looking at that. We're looking for justification, because we only have a certain amount of time, and we want to give you the best information.

Participant question: I have a question in regards to your slide where you had shown the state efforts. Are you going to be inviting local representatives to the roundtable to share in the discussion with their expertise on the subject?

OBESITY: A HEALTH PROVIDER'S PERSPECTIVE

Apr 12, 2006

Dr. Helen Jones: The expert panel right now I don't think is doing that. I have a funny feeling that they may get to a place where they realize that they would like to have it go past those areas because to get endorsements I'm sure at the national organization, be it dietetics, bariatrics, whatever, they are going to be seeking those kinds of endorsements to have printed along the side, and that kind of collaboration patients and physicians alike get comfortable with. There was a strong feeling that the insurers should not just be listed alone because there was a level of skepticism and distrust about the motives for that, but in bulk it would be very powerful and I have a funny feeling more of the kinds of roundtable town halls you're talking about are going to be happening like this. As people get the tool kit they're going to do something a little different in their area or in their neighborhood or in their county.

I have to tell you something funny. There's a program at one of the hospitals I attend at where the dietician will do a little field trip during the day, go to the store, give you a little folder, take a tour, and teach you read labels. So I took my husband off work, I pulled my kids out of school, and I was having a mother moment. "You're going to this field trip and you're going to like it." And so it was two hours, 10 to 12, after breakfast, before lunch, and we were walking. Actually, we were unusual in the group. There were a few other people that had been sent there by a cardiac rehabilitation program after a heart attack or bypass or lung specialist. One guy was even on a scooter, but we were a little younger and at least healthier looking, whatever that means, and so we went on the tour. Not even half way through my husband breaks out for the deli and he comes back with I think everything she said not to eat, and he's eating it walking on the tour. And he's like, "What? What?" So we're just trying to teach people about wellness, but nobody has arrived.

Rosemarie Amaral, Fresno County Dept of Community Health: Did I hear you right where the provider tool kit will consist of some anticipatory guidance for the providers?

Dr. Helen Jones: I hope so. We're looking at prevention, and we're looking at early management. There is no prototype draft yet, but I have a feeling it's going to be something like BMI, then on the side it will have the subpopulation you're looking at and then will give a little bullet about 30 minutes of exercise a day, walking preferred. Review the plate. We call it the plate now and it's simple. It's a plate that has the colored stuff on half of it and carbohydrates and protein on the other two quarters of it. You know, simple, simple, straightforward things. There are no drugs on it. It's like this much walking a day and eating like this, and we'd have to sign off on them all. Just simple ideas put into practice and people are like, "Wow, that's a good idea! That's a thought." Again, that's a kind of tool, but we're looking for a guideline. It may say something like everybody who's BMI is over 30; you need to call a special resource for them.

Laurie Misaki: I work for the county and one of my major focuses is the obstetrical community. So I'm looking at your tool kit. Will there be one specifically addressed to that provider classification? I know there will be internists and it sounds like pediatrics.

Dr. Helen Jones: You know, I'm actually going to jot that down because I didn't hear that at the state meeting. We said we're going to have subpopulations, but we didn't get into what they were.

Laurie Misaki: Well, **we actually only have four perinatologists in this community and their concern is that the majority of the referrals that they get, high-risk pregnancy, is obese women**, obese women who may even have had the bariatric and are now pregnant, so I would hope that that would be thought about as you're putting together your expert panel. They may have already been convened. The second part of that is that I've been working with the OB community trying to educate them about breastfeeding because that decision is made prenatal. I know the CDC has got a campaign going to increase breastfeeding because of the link to increased risk to obesity in the children; but, in addition, mothers who don't breastfeed have the post-pregnancy weight that's cumulative. I'm hoping that in your expert panel that there would be those kinds of considerations.

Laurie Misaki: OB populations are mothers. They shop. They're preparing, and so if they're looking at how they can have a healthier pregnancy that hopefully will spill over longterm.

Dr. Helen Jones: And there's so much to do on just the culture we have. Not ethnicity culture, the culture of obesity that we have. I think somebody used the term obesogenic. There are all these terms now that you're not just trying to get ahead, you're trying to just stay neutral against a huge tide that somehow, we haven't taken the time to figure out, is the perfect formula for obesity.

Laurie Misaki: Well, as you mentioned formula, one of my other hats is a breastfeeding promotion coordinator, if you haven't guessed that already; but actually I think we forget that **artificial baby milk or formula is the first junk food**. It is not species specific nutrition.

Rev. Walt Parry: You referred to the Fresno Unified School District Wellness Policy in a number of ways. Would you just summarize what you feel best about, related to that policy and the passing of that policy; and what you're most disappointed in and what the future might hold in dealing with those disappointments?

Dr. Helen Jones: I would say we were the first in the state to finish our Wellness Policy and have it adopted with regulations. And then in terms of what I'm disappointed with, I am disappointed about there being information available that is well established, that has been embraced at other levels, but not here. That is disappointing. I just don't even understand, if next year we're going to need to do something, why we would decide against exercise in kindergarten? Maybe I don't know enough about how much time it takes somebody to go out and supervise. Maybe there's something I don't know, but some of the no-brainer things are a struggle for me, but again, there may be something intimate about actually doing it that's more sophisticated that I'm not privy to.

Luisa Medina: I almost feel compelled to provide some kind of a response here since Walt called me out as the president of Fresno Unified. First of all, I do want to thank Edie and her committee for the two years of work that went into the establishment of the recommendation of the policy. And I want to encourage those of you who were involved in the establishment of that policy, just because it's there, doesn't mean it's there. Like everything else, you have to advocate and make certain that it gets implemented. It's my understanding at this point in time they are developing the administrative regulations that go with that. I think one of the overriding concerns was the requirement of four years of physical education, which would be a major policy change for Fresno Unified; and I think that caused some hesitation. The other piece had to do with parent education and the prohibition of some marketing that raised some concerns for at least one or two board members. We were first in the state, but I think the real work now starts to make certain that the policy translates into a program implementation that is meaningful for our students. Everyone looks to the schools to implement and educate. I will tell you what I say to parent groups when I go out to speak. "We have them, but for less than one-third of the time. They're in the community, and they're in homes the other two-thirds of the time, and to the extent that we can create and advocate for a healthy environment in our communities."

You know, when I went to one of these student advisory board meetings that looked at the policy somebody said, "oh, we'll just bring sodas in from the 7-Eleven around the corner," or "we'll bring our snacks in," so those are the kinds of things that we need to take a look at overall from a healthy community environmental kind of thing and continue the education and the advocacy.

Edie Jessup: I want to thank you again, Helen, for taking your time and for taking your time to work on this so heartily. The other thing is I think that we need to recognize is that this has been a real honor for us to be able to hear the very beginnings of a struggle with the medical profession and to have the opportunity to talk to someone who is just beginning with it and who can take some of the concrete issues that we have as providers and patients. It is nice to be at the forefront of something rather than behind it. Thank you, Helen. We will be talking with you more.