

## **MCHB/ DHSPS March 15, 2005 Webcast**

### **Promoting Healthy Weight in Women**

LISA KING: Good afternoon, everyone. Thank you for joining us today. I'm Lisa King, the women's health program director for the Maternal and Child Health Bureau and HRSA. We're here today to talk about a very important risk factor that threatens -- even overtakes smoking as one of the leading preventable causes of morbidity and mortality today, overweight and obesity. More specifically we'll be discussing approaches to reducing the incidence of overweight and obesity in women and in particular women of color. As many of you know, or may know, reducing the incidence of overweight and obesity primarily through proper nutrition, appropriate levels of exercise and routine preventive health checkups is a major priority for the Department of Health and Human Services. Today we're highlighting a program that is funded by the Maternal and Child Health Bureau. In September of 2004 that addresses this issue from a women's health perspective called innovative approaches to promoting a healthy weight in women. A chief Tenet of a comprehensive women's health approach is to view health across a continuum or across the life span with a focus on prevention.

So today in addition to hearing from the three grantees who were awarded this new grant you'll also hear from Dr. Barbara Schneeman, the director of the food and drug administration Office of nutritional products, labeling and dietary supplements and she'll discuss the newly revised dietary guidelines for Americans announced about a month ago. After Barbara, you're going to hear from the three innovative approaches grantees

beginning with Sylvia Crixell in San Marcos, then Joye Toombs from the northeast Ohio neighborhood health services in Cleveland, Ohio and Maria Fessia of the Holyoke health center in Massachusetts. Lastly, but certainly not least you'll hear from Sabrina Matoff, the acting director of HRSA Office of Women's Health and she'll talk to you about the bright futures for women in physical activity and healthy eating tools for young women. In the interest of time, because we have so much information to present to you today, we're going to need to hold the questions until the end. So if you just please would make note of your questions during the presentation, we'll answer them at the end of all of the presentations. Next we're going to have Johannie Escarne go over some technical issues and then we'll get started.

JOHANNIE ESCARNE: The slide changes are synchronized with the speaker's presentation. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window at the right of the interface, select question for the speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you are participating from. The questions will be relayed to the speakers periodically throughout the broadcast. If we do not have the opportunity to respond to your question during the broadcast we'll email you afterwards. We encourage you to submit questions at any time during the broadcast. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider, which you can access by clicking on the loudspeaker icon. Those of you who selected

accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, interface will close automatically and you'll have an opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

LISA KING: Thank you. So we're going to get started now and our first presenter is Dr. Barbara Schneeman.

BARBARA SCHNEEMAN: Thank you very much, thank you, Lisa. Good afternoon or good morning to everyone who is out there. What I'm going to be talking about are the recently released dietary guidelines for Americans. These were released January of this year. So in my presentation, I'm going to give you an outline of the process that was used to develop the 2005 guidelines and also give you some overview of the content. And at the end we'll have the website so you can get more information.

So if we could have the next slide. What are the dietary guidelines? This is science-based advice for ages two years and older. Their goal is to promote health and prevent chronic disease or lower the risk of chronic disease. And the dietary guidelines for Americans do serve as the basis for federal nutrition policy and programs and they're done jointly by the Department of Health and Human Services and the Department of Agriculture every five years.

If we could have the next slide, please. This slide just shows you the guidelines that have been released between 1980 and 2000. 1980 was the first time the dietary guidelines were released and we've had a new bulletin every five years, which updates the guidelines. And so now we're going to be talking about the 2005 dietary guidelines. First of all, just to speak a little bit about the process. Because the process for 2005 differed in important ways from previous cycles of the dietary guidelines. So on this slide what I've shown you, the first step in the process, the secretaries of agriculture and the Secretary of Health and Human Services appoint an advisory committee. These are experts from around the country. Experts in nutrition, physical activity, and the kind of information that is needed for the guidelines. This committee is charged with reviewing information to develop an evidence-based report.

So one type of information they review are the dietary reference intake reports that are published by the Institute of Medicine. They also look at the previous version of the guidelines to see what needs to be updated. And they also look at the scientific literature, the peer reviewed published scientific literature to see if there are new studies that need to be considered. The committee then produced a report, which is the report of the advisory committee, and this was the first time that this committee used an evidence-based scientific review process in terms of looking at the literature and deciding what kind of recommendations needed to be in the guidelines.

So if we go to the next slide, that report was made available publicly and there was a period of time where comments were received. We received comments from a wide

variety of groups. Consumer groups, industry groups, private citizens, health professionals, provided a vast array of comments. These were assessed and analyzed by a group of federal nutrition scientists and then a drafting committee of federal scientists was put together to draft the document that you see in this slide. The dietary guidelines for Americans. The 2005 version. And it's important to realize that this version of the guidelines is, in fact, a more technical version of the guidelines and it is aimed at healthcare providers, nutritionists, educators and policymakers.

If we go to the next slide, once the document had been drafted, then there was a process put in place to test the kind of messages from this -- from the guidelines that would work with consumers. And to make sure that there were -- there was information presented in a way that consumers would understand and see the importance in terms of adopting what is in the guidelines. So with that consumer testing, one of the first products from the guidelines is a consumer bulletin.

If we go to the next slide, now because the dietary guidelines are the basis of federal policy and nutrition, there are a variety of other programs that will use the dietary guidelines to develop their messages. There is obviously feedback. The guidelines refer to things like the DASH diet, USDA food guidance system. The FDA nutrition facts panel that shows up on products. But also when those are revised or updated they'll look to the information that's in the guidelines.

So next slide. Just to summarize, then, these three publications illustrate the three phases of the dietary guidelines process. First there was a scientific advisory committee that produced an evidence-based review of the science. This was then used to develop a policy document, which was drafted and peer reviewed by federal agencies. And then one of the first products from this policy document is a consumer brochure. We'll talk a little bit about that later. And so the dietary guidelines themselves are targeted toward policymakers, educators and healthcare providers. Hopefully will provide a wealth of information for those target groups.

If we go to the next slide, if we start to look at what is in the 2005 dietary guidelines, this slide just summarizes the various chapters. There is an executive summary in the document, which brings the recommendations together. And then there are ten chapters in the guidelines. Nine areas with specific recommendations and one that is more introductory. Within each of those chapters there are several key recommendations. And these are the heart and soul of the dietary guidelines. There are 23 key recommendations for the general public and 41 key recommendations all together. So some are actually for specific populations. There are a set of appendixes on sources of new trends and more detailed information on the USDA food guidance system as well as the DASH eating plan and provide handy reference material. There is also a glossary recognizing this is a more technical document the glossary gives more information on the terms used.

If we go to the next slide, this just highlights the title of each of the chapters that give the key recommendations. And rather than go through it here, I'm going to try and highlight

what I regard as an important feature of each one of these. Obviously in the limited time we have available we're not going to go through 41 key recommendations. So I want to just highlight what I regard are some key messages in each of these chapters.

So if we go to the table that is shown on that next slide, I think we're up to about slide 11 now, this one summarizes the first -- this table summarizes the first five chapters with a highlight. So again the background just simply gives the introduction and the purpose of these guidelines. Chapter 2, which is the adequate nutrients within calorie needs identifies certain nutrients that are a concern. It gives two examples of a healthy eating pattern. One is the USDA food guidance system. And the other is the DASH diet or the dietary approaches to stop hypertension. It uses both of those throughout the document to illustrate what is a pattern of food that is associated with promoting health and decreasing risk for chronic disease. In the weight management chapter, more the focus of this one, obviously the key message here is calorie balance. One has to balance what you eat with physical activity. But it also focuses on a new message, which is the importance of making small changes. Small changes, whether it's decreasing the amount of food consumed or small changes in terms of increasing physical activity. That those small changes do make a difference. Chapter 4 on physical activity emphasizes the time needed to achieve different health benefits. So it gives the standard recommendation we're all familiar with of 30 minutes to lower risk for chronic disease. But it also points out that 60 minutes of physical activity may be needed to prevent weight gain and in individuals who are lost weight and want to maintain weight loss 60 to 90 minutes of activity may be needed. Chapter 5 talks about food groups to emphasize. These include fruits, vegetables, whole

grains and milk. Either low fat or fat-free milk and in talking about the number of servings of these different foods that need to be emphasized, it uses cups, household measures rather than servings. So again, one needs to look in those chapters to see more of the detail.

Now, the -- if we go to the next slide, chapter 6 is the chapter on fat and probably the important highlight of this message is the emphasis on saturated fat, transfat and cholesterol that need to be limited in the diet to lower risk for heart disease and it gives a key recommendation that encourages people to emphasize sources of polyunsaturated and mono unsaturated fats such as fish, nuts and vegetable oils. In chapter 7 there is a two-part message on carbohydrates. One to encourage foods that provide dietary fiber and the second to limit the amount of added sugars that is in the daily diet. The chapter on sodium and potassium has a new number for sodium. It uses the 2300 milligrams of sodium that was in the IOM report. It also talks about individuals who are at risk for hypertension who may need to restrict their sodium intake even more to 1500 milligrams per day. It does -- this chapter also puts much more emphasis on potassium with very specific sets of information to increase potassium intake. Again, there are some tables in the back that give sources of potassium. The message on alcoholic beverages is similar to what the dietary guidelines have had in past years as are the principles for food safety.

Now, if we go to the next slide, I did want to highlight there are several key recommendations that are aimed at specific populations. And again, we don't have time to go into all of these key recommendations, but I thought you would be interested to know

the range of key populations that are targeted. Older adults, children, women who may become pregnant, those who might need to lose weight. There are a variety of different target groups that are focused on.

So in the next slide what I've done is I've just tried to give you an example of how the dietary guidelines evolve. I've taken one message and shown an evolution. We could do it with all of them if we had more time. So between 1980 and 1995 we gave the message eat a variety of foods. Then in 2000 we said let the pyramid guide your food choices. In 2005 we have a much more detailed and focused message. We talk about adequate nutrients within calorie needs. We talk about dietary patterns that one should try to follow. We give messages for specific population groups. We talk about which of the food groups need to be encouraged. So there is much more detail that is being given in that message compared to previous years. Now, I want to spend a little bit of time to talk about the consumer bulletin.

So again, that next slide is just to remind you that the consumer bulletin was developed from the dietary guidelines and used consumer testing to make sure the messages resonated with consumers.

So if we go to the next slide, the one titled, finding your way to a healthier you, that's the title of the consumer bulletin and the key message there is feel better today, stay healthy for tomorrow. And that was identified as a motivational message that consumers would resonate with. And that message then is built up with three themes. Make smart choices

from every food group and that will eventually link to the food guidance system that USDA plans to release later in the spring. The second theme is find your balance between food and physical activity. And then the third one is get the most nutrition out of your food choices.

So if we go to the next slide, that first one making smart choices, I've put on the slide an insert from the middle of the bulletin and you can see what it highlights. Focus on fruits, vary your vegetables. Get your calcium rich food, make half your grains whole grains. Go lean with protein and know the limits on fat, salt and sugar. Again it's giving an illustration of smart food choices and eventually this will link in with the USDA food guidance system.

If we go to the next slide, shows the nutrition facts panel and this colored version of the nutrition facts panel is what you find in the consumer bulletin. You can also find it on the FDA website. It is built up with the idea of using the daily values in the nutrition facts panel for nutrition education. What nutrients do we want to encourage. What nutrients would we like to see consumers limit or be more cautious of in their diet.

The next slide, then, just to highlight from the consumer research associated with the dietary guidelines, we learn that motivation is essential. Consumers want to know why should I follow these guidelines? Trust is important. The more an individual knows, the more choices they have. And it's helping them have that knowledge that can be very valuable. In trying to convey the information, keep it simple but true to the science. Those were the principles for developing that consumer brochure. If you're using the dietary

guidelines in an educational program, the Department of Health and Human Services is working on implementation tools. We already have the DASH eating plan. You can get that information from N.I.H. We have the food label. There is information on FDA's website on how to use the food label. USDA will be releasing their new food guidance system and then there is a toolkit that is being developed, a notebook that will include fact sheets as well as a variety of information on using the dietary guidelines. So if we go to the last slide, then, again you see the cover of the dietary guidelines and the cover of the consumer brochure. And at the top of the page there is the website where you can download those documents if you haven't had a chance to get them already. [WWW.healthierUS.gov/dietaryguidelines](http://WWW.healthierUS.gov/dietaryguidelines). I hope I've encouraged you to go to the website and download the documents if you haven't had a chance to do that. We'll move to our next speaker which is Sylvia Crixell from Texas state university in San Marcos.

LISA KING: Are you ready?

SYLVIA CRIXELL: I am. Good afternoon. I'm Sylvia, one of the directors in San Marcos. We're developing this program to serve as a model to improve the body weight and the health of Mexican American women in our community. This is one of the innovative approaches to improving body weight in women.

This next slide shows the project directors. The project is directed by an interdisciplinary team at Texas state university in San Marcos. Dr. Eric Schmidt is a professor in professional counseling and I'm on the right, a nutritionist and registered dietitian. Several

community partners are working with us to implement the program but by far the most significant is the City of San Marcos parks and recreation. They have provided free use of this building, a recreation center located within one of the target communities. In this building we have a permanent office plus a large exercise room and smaller room to use for classes as well as childcare.

The next slide shows an overview. This presentation will briefly summarize the purpose of our program including some background information and the outline of the overall structure of the intervention and a description of a few challenges that we've encountered along with some creative solutions. To date we have completed a short pilot and one full eight-week intervention. This presentation will include some preliminary results.

The, please. It's no surprise anymore that the incidence of obesity in the U.S. is rising. According to the CDC around 25% of women in Texas are obese with a body mass index greater than or equal to 30. What is surprising is that some populations are hit so hard by this epidemic. According to a study we conducted in 2003, over half of the low income Mexican American women participating in WIC in San Marcos were clinically obese. The purpose of this project was to create and implement a culturally appropriate for this segment of women.

Next slide, please. Very few studies have described interventions with low income Mexican American women. But attrition or dropout is always a primary concern in any program. As you will see, we have already encountered some small attrition and taken

steps to address it. A major goal, then, is to reach and retain participants. Beyond that, this program is designed to fill in the missing link in healthcare, to offer an avenue by which women can work to improve their body weight and health outlook by exercising and eating a healthier diet. A goal which we've already realized is help to coordinate healthcare and provide healthcare referrals when needed. We plan to run a formal intervention four times a year using the research model shown here including extensive pre and post testing for effectiveness. Therefore, for each intervention we'll recruit, then pretest and pretesting involves a battery of instruments, all kinds of measurements of fitness and strength including aerobic fitness, muscular strength, in depth dietary analysis and scales that measure knowledge and attitude about physical activity. Following that we'll run our eight-week intervention involving exercise classes and lessons. At the end of that intervention then we run a post test and during that time we repeat the pretest measures listed above. And then number five, we've modified the program and in so doing we incorporate lessons we learned into the next program.

Next slide, please. The intervention has three components including a friendly, non-threatening exercise class conducted to music and fun activities with strength training, step aerobics, kick boxing, group dance and outdoor walks and activities. We also have nutrition lessons that are always accompanied with snacks and recipes. And then also supportive counseling. Has the third component.

The next slide, please. This slide lists the education sessions used in the intervention that we just completed. The first lesson was introductory and we used it to explain the

consequences of overweight and obesity. Again, this is a motivational approach. Before the second lesson we analyzed each participant's three-day diet record and provided feedback about nutrient intake. Each person was given a handout with their personal information. Then during that lesson we emphasized the basics. Calories, fat, choosing whole grains, increasing intakes of fruits and vegetables. All nutrition and vice and information is based on 2005 dietary guidelines. Other lessons were more specific focusing on choosing low glycemic index food and healthy fats. Two days ago we compiled feedback from participants who had just completed a program and found that across the board the lessons were very positive for them.

Next slide, please. The snacks were designed to introduce new foods and create healthy remakes of more traditional fare. The underlying theme included emphasis of whole foods, nutrient density and controlled portion size. The snacks provided with recipes were a major hit. As you can see we have some of the snacks we listed here and a lot of snacks we provided were things that people could build on at home. For example we showed how to build a salad and that may seem obvious but we included lots of different types of greens and nuts and things that could be added on salad with also a lesson on how to make salad dressings and so forth.

Next slide. We started this program literally within a day or two of notification of funding last fall. We submitted IRB paperwork to the university and to the Texas Department of State health services to obtain human subjects approval. Set up the office and created forms in English and Spanish. Developed a website. Set up childcare and hired and set up

staff. By November we were ready to conduct our first pilot. The pilot ran for four weeks and enrolled only nine women because of the holidays. We wanted to get their input as quickly as possible before moving forward with the program.

Next slide, please. The most effective strategy for project coordination has been the organization of our materials online using black boards. All data collection documents, presentations, spreadsheets, schedules, contact information for staff, etc., are posted for access by project directors. By this process, we took what could have been an organizational nightmare and instead created a well organized pool that we can access from anywhere.

This next slide is another shot of black boards that appears when you hit the top button on this slide, data collection documents.

Next slide, please. Here we see the first documents posted. In reality we've just about run out of the alphabet. Not counting the Spanish translation. Again, continual access to program documents is a major strength of this research design.

Next slide, please. Selected outcomes from our four-week pilot are indicated here. Clearly, measures of fitness and body size and composition support effectiveness of the intervention. We hoped for an even greater improvement in the longer sessions.

Next slide, please. The first full eight week program, for that first program we use weight lifting individuals as controls. These are women who have expressed interest and participated in the two-day pre-testing but not yet involved in intervention. The two intervention groups exercised together but were educated separately. For one group, exercise and education, we offered the weekly nutrition education classes in addition to exercise. For the other group, we added an extra 30 minute group supportive counseling session. The purpose was to measure overall effectiveness of the intervention and also to see if adding a group counseling component made a difference. The size of each group is indicated on the slide. With attrition, we ended with seven in exercise and education group and six in the supportive counseling group. We were address attrition on a future slide.

Next slide, please. At the time this presentation was made, the post-testing was not complete. However, based on attendance reports and weekly weigh-ins, the program appears to be a success. The women were attending 3.1 exercise classes a week meeting the minimum physical activity goals. The women experienced a 2.3% weight loss ranging from 0 to 9 1/2 pounds per person.

Next slide, please. Back to attrition. 13 of 19 women completed the program. However, this statistic is not as bleak as it sounds because of reasons for dropout. Three experienced healthcare problems, including accelerated heart rate and dizziness. We referred them to healthcare providers. One of our goals. Two had scheduling conflicts with work and only one quit because she didn't feel younger. She was substantially younger than the other people. We have several strategies to combat the potential of attrition. First,

during the next intervention which begins next week we have enrolled 35 women. Second, during the pre-test week we'll had motivational counseling regarding participation. Third, we'll employ more incentives to encourage attendance and then host an awards night. A social event where women can invite friends and family members.

Next slide, please. During the pilot, when two women showed up with eight children we learned that childcare was going to be a challenge. We met the challenge by involving more interns from Texas state university and by providing active childcare. While mom is exercising, the children are exercising, too. Our hope is the overall impact of the program will be strengthened considerably by this approach. Body image is important. The women prefer no mirrors. And they, according to them, prefer chunkier aerobics instructors and feel uncomfortable doing the walk program outdoors out of this secluded indoor environment. We'll provide supportive counseling for attending the walk fit. Incentives have been an important hit and have included bags donated by parks and recreation, CD's with exercise music, pedometers and so forth. We've learned that food is a hit with the women. Not surprising. Also not surprisingly they don't want men in the classroom.

Next slide, please. This program is fun and effective. We're starting a new section next week. The new session is designed to clarify whether counseling is best offered to the group or in individual sessions. The session will also incorporate the traditional exercise classes and nutrition lessons.

The next slide, please. We'd like to thank the staff and volunteers who care about this program. Some of these people are students that are just want to help and are just interested in learning and helping.

Next slide, please. We would also like to thank the Maternal and Child Health Bureau for funding this project. We're working with a team of committed people at Texas state and from within the community working with participants behind the scenes. Without the funds provided, this project would not have been possible and we really appreciate it. Many of the participants have expressed interest in becoming group leaders. Next year, we'll report how the program has benefited from their participation in leadership. Thank you.

LISA King: Next I would like to introduce Joye Toombs from the northeast Ohio neighborhood health service.

JOYE TOOMBS: Good afternoon, everybody. It's a pleasure for us to be here today to present to you the WOW! program, the women of wellness program of northeast Ohio women's health services. I would like to introduce you to the WOW! staff. With me is Letitia who is the nutrition coach for all five of our NEON sites. Next is Kimberly sanders, the program director for the National Center for community excellence in women's health who did a focus group that led to the inception of the WOW! program. Coming back around, I would like to introduce you sitting next to me is Naja Muhammad. The administrative assistant for the program. First before we talk about the WOW! program I would like to take a moment, if we could go to slide number two, please, and tell you a

little bit about northeast Ohio neighborhood health services incorporated whose mission is to achieve healthy families and healthy communities.

Our mission is to lead the local healthcare industry in providing quality patient-centered, family oriented and comprehensive health services around the identified needs of this service population. We were organized in 1967 as a private, non-profit. At that time our funding was through the Office of economic opportunity. We have a total of five health centers. We have four clinics in the City of Cleveland and one in the City of east Cleveland, all of our clinics are in urban areas which are predominantly African-American. As of 2004, NEON served over 40,500 users amongst our five sites. Our services, we try to have a life span approach, maximize, prevention, focus and holistic models. We try to incorporate. We have a variety of service. If we go to slide eight. We have primary care services for adults and children. We have prenatal care. Gynecology and family planning. We do H.I.V. testing and laboratory and x-ray as well. Just to name a few of our other services we have dental, pharmacy, we have behavioral health. Nutrition, health education, social work and referral services.

Next slide, please. Some of our other programs include our comprehensive perinatal with sport -- support services for women who use our OB services. Well the job corps wellness center. We have a seniors in touch program which is a provision program for senior citizens. We have programs in all of our five sites, WIC programs. We have the community center of excellence in women's health who conducted the focus group at Cleveland state

university with mothers and daughters, which led to development of the WOW! program, the women of wellness program.

Slide 11 indicates the mission for the WOW! program. Our goal is to promote the healthy weight of African-American women, females through a generational approach to learning about proper nutrition and physical fitness. Our mission was designed to partner mothers and daughters and that would give families opportunities to have that in-home support, the support of someone who -- that they were used to. Our goals and objectives of our program, we want to encourage African-American and girls to achieve and maintain a healthy weight, as well as to increase the number of African-American females who are making progress in achieving a healthy weight. This is the model for our program. We have four components to the WOW! program, which are the workshops, primary care services, our learning centers and providers training.

Next slide. Number one, our provider training. We have provided training to all of the NEON clinical staff using the practical guide of identification, evaluation and treatment of overweight and obesity of adults, which they were -- which we focus on obesity guidelines, weight, height, circumference, if the patient was ready and, of course, we use the BMI guidelines. Those with the BMI greater than 25 which is an overweight status, to those which, if over 40, which is severely obese. We also included behavior modification as part of our provider training. So our -- in addition to the obesity guidelines, our providers fee will be where the patient was mentally. We used two models. We used behavior change

so the providers could determine which stage of this model the patient was in be it pre-contemplation, contemplation, action, maintenance or transformation.

Then we used what we call the five As, assess, advise, agree, by using the five A's the provider can obtain all the needed information to best serve the patient by making the appropriate referral. Whether it be the WOW! program or another one of NEON's services. The method of evaluation for provider training is attendance records. Each provider has done a pre and post of the learning objectives and they will also complete an evaluation survey. Primary care services, the NEON providers will provide a more enhanced emphasis on obesity assessment and management for women in growth and in each visit they'll assess each patient. Proper recommendation and/or referrals will be given to overweight and obese women by their primary care provider. Once a year chart reviews will be given to see if adherence has been kept as far as the obesity guidelines that the providers learn in their training and at the patient's charts are documented properly. Patient learning centers, this is something that has been and will be computerized kiosks and information booths. We're currently looking at several systems in our target data to have that completed by the end of May. It will be designed for WOW! participants specifically to interact in a self-paced learning environment. Materials will be available to them like Power Point presentations and also wellness websites will be available where they can get information on wellness, physical activity, recipes and so forth. Our goal with the learning centers is to reach 10%, which is 1400 of the 14,000 women who are -- who access the services of NEON and the benefits of the center will be that they'll be interactive, time efficient, self-paced for the patient. We'll keep a log on the patients will be

pre and post tests on the computers and we'll do interview surveys with the patients within six months so they can see the benefits they've gained from the learning center. Our WOW! workshops are 12 week sessions, 90 minutes once a week. Currently we are conducting two workshops per week, two different groups. The three components of the workshops are nutrition, physical fitness activity and wellness.

The next slide, please. Our goal is to increase knowledge of nutrition and physical activity, establishment of personal weight and fitness goals for our participants involved with wellness activities on an ongoing basis. Just an overall increased commitment to their personal health. We begin our workshops on the last Tuesday where we did our initial assessment of each of our participants. Last week we had a total of 32 participants of the workshops. We did the MBI, we figured their BMI because we weighed each participant. We took their height. We did surveys to gain knowledge of their nutrition, what their exercise practices were. Just how they felt about their body image, what their self-esteem levels were. We asked questions about their family such as their eating habits and how did they eat as far as scheduling.

Did they eat at the same time every day? Did they sit down together? Just trying to get an idea of what their family culture is around their eating habits. Patients also did registration forms as well as they did a pre-test. The other component of the workshops will be our nutrition classes. Over the next 12 weeks they will cover such topics as the risk of obesity, which was discussed last week. They'll learn about the food guide pyramid, portion control, labeling. Healthy snacks, disease, develop meal plans, shop on a budget. Safety

eating. The basics of eating and will end their session with the overall nutrition review. They were also -- there will also be a group fitness challenge that will be for -- that will include nutrition label game. Team building of a food pyramid. They'll design a one-minute commercial and also do a program like the price is right but it's shopping to make it more interactive, make it more fun as they're learning. We will also have a -- what we're calling our traveling kitchen where there will be cooking demonstrations of healthy meals and snacks. And the students will be able to test taste these and receive recipes on how to prepare them. We will have physical activity, physical activities will include high and low aerobics, kick boxing, Pilates, stretch, we'll be doing some weight training and muscle strength training. Walking and jogging, tai chi.

Next slide. Wellness activities. We realize that in battling obesity it's more than just the eating and the physical activity. We've included wellness activities, things such as the healing benefits and meditation and the different types of relaxation techniques. We're going to do body image analysis for our participants. They are journaling each and every day and we're going to talk about stress management because we realize that a lot of obesity issues are related to stress. We are planning some field trips for our participants as well. We will go to one of our big markets once they've learned how to shop and do the shopping at the market on how to buy fresh meats and produce. We'll help them learn about overall health and the body and so forth. It is our goal for each area that we're in in our program for them to visit different recreational facilities in their area to see what is available to each one of them. Our message will be evaluations for our well workshops is our referrals that we've received from our doctors, initial intake forms, attendance records,

our pre and post test and participant survey forms and we'll be doing six-month follow up. Our patients will be weighed on a weekly basis. We'll look at their weekly journals, the food intake and the amount of physical activity that they incorporated into their program and we'll also assess their feelings about themselves and their participation in the program. Our accomplishments to date is we have established our advisory board. We have begun our provider training and we have gotten over 100 referrals to date based on the provider training between our providers and nutritionists and our WOW! workshops, they begin on the last week so we're excited about that. We are promoting our program community-wide. We're talking to other community groups and sending notices to local churches and so forth. And we're proud that we've been able to continue our collaboration with the national community center of excellence in women. So with that I have presented you the WOW! programs, the women's wellness program. Now I would like to introduce you to Maria Fessia. She's with the Holyoke health center in Massachusetts. Maria.

MARIA FESSIA: Thank you. Good afternoon, everyone. I would like to start sharing some information about Holyoke health center. May I have the first slide, please? Holyoke health center provides care in downtown Holyoke, Massachusetts. We have 150 employees, five medical and dental providers. On site we have a pharmacy. 16,000 visit per year on average. Our community is the poorest community in the State of Massachusetts. They have the highest -- the highest mortality rate from heart disease, highest rate of teen births. Highest rate of aids and H.I.V. related deaths. Highest alcohol and drug-related deaths. Highest rate in homicide and the fifth in cancer death rates. Our project goal is to work with obesity Latino women between 18 and 35 years old to improve and maintain

behavioral changes and lose weight. Improve health through education, improved access and participation in physical activities, establish support groups and support behavioral change through counseling and stress reduction.

The next slide. We have a very high motivated team. The first one is the nutritionist. They there is a health educator in nutrition and fitness and a certified aerobics inductor working with us for the first two months of the program and a lifestyle coordinator.

Next slide, please. The findings were the following. Our women went to put them on a low calorie recipes that are easy to prepare. There was a discussion particularly on how to become physically active, also at home. They want a yoga activities. Information about nutritional values of food and they want to have fun.

The next slide, please. Other training is ongoing nine-week training program in Spanish. They help in the recruitment for candidates for the program. They also help to identify and so far excellent volunteers are doing very well in the training. We have a close working relationship with our programs for training and support and we used the curriculum -- this is the national heart, lung and they main objective is to prevent risk factors.

Next slide, please. The recruitment and enrollment for the program is in-house referrals. When we did the start point we had 54 referrals. Today we have 78. We have referrals from healthcare providers for women between 18 and 35 years old. You have to be a Holyoke resident.

[Inaudible] They need to make permanent changes and we also need to -- we learned this from the provider. The experience is part of the in-house referral. They have -- every patient has an appointment with a nutritionist. We do this every month. It includes the body composition analysis and we need to follow the protocol to make sure the patient, that we have act -- the patient has to be fasting for four hours, no fluid intake and with empty bladders. The other things include fat percentage, fat mass, pre-fat mass which is muscle, bone and tissue. When we enter the height, the scale also calculates. We see if patient has to do their own measurement like waist and hips and we use a 24 hour recall. We also follow the assessment we need to know if there are any eating disorders. We like to know with reference for the guide how many meals they do a day. We need to follow on owe of that data because we have some patients that -- nutrition education is bilingual and bicultural.

We have a breakfast and lunch club. So these alternate every week. We have the first breakfast club and during the first session the program is how it's important to have a well-balanced meal. There are people that don't have breakfast at all. The next week we do the lunch club. After their breakfast session we have one hour of the class and then a half hour is an exercise. So as I said before, they are well trained. They also teach [inaudible] and the exercise class is already established. As you can see in the six year the lady in the front is -- this program is adding an additional continuing education to our -- [inaudible] she has a program starting next month. At the beginning we have the YMCA that they can start working with her so she can increase her skills in aerobic instruction. At the end of

the intervention we have a supermarket that they can use everything that they learn and we provide group counseling and the staff training is ongoing.

The next slide, please. The breakfast and lunch club component or breakdown is as follows. Food portion control, cooking techniques for losing weight. Puerto Rican people eat a lot of fried food. They need to modify the way they eat. They're happy to know about different possibilities for them. [Inaudible] low calorie recipes. This is where they have fun. Every single member of the team wears whistles and every ten minutes we change activities. Do the share game and we do other things and they realize -- [inaudible]. The incentive for the program participants, the participant receive pedometers. This is a good - - they have no idea -- how can they keep track of their own steps? They get a measure and they also a card to keep track of goals and weight. Getting motivated and ready for action in March 2005. We start the program last week and -- We have a kickoff with a walk with the mayor and the city council. The mayor of Holyoke lost a lot of weight last year and he was a big supporter for our program. He was a big supporter in his own motivational speech about the way he did. We also have community involvement with local sponsors providing free food smoothies and raffling for gift certificates. We had it on two TV Channels -- channels, you can see this was an article that was published in the paper. And also the YMCA aerobic instructor.

Next slide, please. This is the weekly calendar of the program. On Mondays we do intervention and the exercise class is at 2:30 by the YMCA instructor and in the afternoon we have the staff training. Tuesday is a class day and they have their last half hour is an

exercise component. On Wednesday we have nutritional intervention for the rest of the clients. We have a 2:30 small walking group and we provide transportation. I have a meeting with the staff in the afternoon. Then we have intervention in the morning. Exercise class with the YMCA and that's in the morning. In the afternoon we have training. On Friday's we alternate. I have two groups. We have 25 patients with interventions done. Group one is taking to the classes. Going to the exercise class and the group number two is a true group also and we go to exercise class as well. The class is already established, the exercise class is at the health center. We do it there because this is one of the findings of our focus groups.

Next slide, please. The future. Within this last month most of these items are already a come -- accomplished. We want to hire a nutritionist who would help me. I would like to have more training, teaching tools how to do evaluation, group sessions with the clients. Our lifestyle coordinator will start with her training next month. And we already have a set of referrals from the referral associates that meet at the beginning of this month and we have a coordination agreement, a mental health organization from Holyoke that will provide stress reduction management for our patients in need. We're very happy. We will have these by referrals. We will have people identified. And right now I would like to introduce Sabrina Matoff.

SABRINA MATOFF: Thank you for the introduction and for having them. I'm Sabrina and I'm here to talk with you briefly about a program that is funded out of my office called Bright Futures for women's health and wellness. What this is an initiative that we started

back in 2001 that focuses on improving prevention and focusing on how to raise awareness about preventive health for women across life spans. We're focusing on three particular target audiences. Women as consumers, healthcare providers, and communities. We're developing materials for those three audiences.

Slide, please. Our first set of materials is a program that focuses on healthy eating. These tools will be available in stages. Our first school focused on self-assessment for young women and adult women. The adolescent materials also include an adolescent wallet card. We're also developing a community toolkit around healthy eating. We're developing some tip sheets to help women reach their goal and developing some provider training and counselor training support. I'll hold out our actual published pools. Some of the tools are still in the development process. I am delighted to you what the young women's tool looks like. It is 28 pages and includes questions for a young woman to fill out herself, take it in with her to her healthcare provider. Go over her answers and then the two of them would engage in a critical conversation and talk about the answers and ways she can improve her healthy eating and physical activity. The two of them would set goals together and she would have to take home a resource book with her. It includes a lot of healthy tips, good ideas on how to gradually build in healthy eating and physical activity into her daily life.

The other component that is on this slide to hold up for you is very small but I'll hold it up anyways. It's a little wallet card that young women keep in their backpacks, they can keep in their purse, a little reference cards and see the five top ways to healthy eating. Five

ways to keep physically active. It is laminated and it is also available individually or with the guide and these materials are all available through the HRSA information center and I'll be showing you on the last slide how you might be able to order these. I just briefly wanted to mention still on the slide that Bright Futures is looking at other health topics including mental health and wellness and perinatal health and wellness and we're in the process of developing and going through some expensive background and evidence-based to make sure we develop tools that are research-based and support the evidence for these two topics. You'll be seeing additional schools come from the Bright Futures initiatives on these topics in the next year or so. This slide includes a little bit more detail about the physical activity and healthy eating card that I just shared with you. As I mentioned, the real purpose of this tool is to help adolescent young women ages 11-20 engage in a clinical conversation with their healthcare providers about healthy eating and physical activity. It includes a few sections as stated here. It has some patient assessment questions that are circled. You circle the answer.

There is a multiple choice question. There are some sections of the tool that include a place for providers to write in some clinical measurements such as height and weight, B.M.I., blood pressure, etc. It also includes a place for the providers to write in recommendations and to discuss those briefly with the adolescent young woman. So while the card is another take-home reinforcement on tools for young girls to take with them and perhaps share with their friends and family members. As you see on this third bullet, these materials are available right now at the HRSA information center and there is the phone number on how to order them. We also have these tools available online that is the guide

in the wallet card and there is the URL where you can actually get down loads of these tools as we speak. We're trying right now to do a lot of promotion and marketing to a variety of different organizations and trying to get the word out about these materials. So if you're interested, please let me know. We would be glad to partner with you in making these more available to your groups and audiences.

The other thing I would like to mention, too, here is that we're also in the process of developing these tools in Spanish because we recognize the importance of having the tools for young women who are primarily Spanish speaking. Those tools will be coming along shortly. They'll be translated and they will also look a little different in terms of the color combinations in terms of the pictures and we just finished focus group testing and got some interesting information from the group of young Hispanic girls on what kinds of book and feel these materials would appeal to them. You'll be seeing those problem within the next six months or so, if not sooner.

Next slide, please. This slide gives you a diagram, a flow chart almost that will hopefully help you get a feel for how we envision these tools being used in an actual clinical study. If you follow the arrows around, the concept here that we envision, which you could adopt or modify as you see necessary, would be that these tools would be available primarily through healthcare providers but certainly could be available in other locations. Back to the clinical providers setting the idea being the clinic staff would have these tools at the front desk and the young woman checks in she would be able to pick up one of the guides and while she's waiting to see her provider, she could fill out her section about seven or

eight questions around physical activity, healthy eating. When she's called into her visit, she would hand this to her provider and they would have a discussion again about some of her answers to the questions. Her provider would then use some training materials that we're developing also to accompany this to help her understand how she might improve her physical activity and eating behaviors.

Together they would set some simple goals and all of these pieces are in the guide itself. It is all self-contained and she would then take this with her as she's leaving and check out and have this as her resource to take home with her. So we sort of wanted to give an idea about how this might be used. There could be other ways these tools are used but we wanted to encourage the dialogue, that this is part of shared decision making in the healthcare setting and that young women can really play a part in their healthcare from early ages. Particularly around behaviors as important as physical activity and healthy eating. So this is really a very, very brief snapshot that I wanted to bring to your attention about some tools that are available for you right now. If you have other questions about Bright Futures or you would like to download. Again these tools are available in PDF format as well as HTML and they're available in hard copy. Feel free to get in touch with us and avail yourselves of these tools. Additional tools, as they become available, will be posted as well on our website and we'll get information out to our various networks to make sure you're aware of them as well. Thank you very much.

JOHANNIE ESCARNE: Now we'll begin the question and answer session. We probably won't have enough time to answer all the questions but we have a list of everyone's

questions here and we'll get to as many as we can in the next seven minutes or so. The first question, I believe, is directed to our first speaker. The question is how do we -- what is the cost? On the dietary guidelines.

BARBARA SCHNEEMAN: Sorry, I was muted. I was muted. You can get the brochure from the website. It is a downloadable form. That's one way to get it. I think for ordering you would probably have to contact ODPH within the Department of Health and Human Services or work through USDA if there is a USDA contact for the program.

JOHANNIE ESCARNE: Thank you. The next question is for our second speakers from San Marcos, Texas. The question is, what models form the basis of this project?

SYLVIA CHRIXELL: I'm sorry, I can't hear you.

JOHANNIE ESCARNE: Oh. What behavior change models form the basis of your project?

SYLVIA CHRIXELL: I'm not sure if I understand the question. In terms of what we're looking for, is that the question?

JOHANNIE ESCARNE: I think the question was asking if you use a particular behavior change model.

SYLVIA CHRIXELL: There are stages of change. We're aware of those but not at this point, no.

JOHANNIE ESCARNE: Thank you. This question is directed to Joye Toombs. How are you going to conduct a body image analysis and what methodologies are you going to use, and why?

JOYE TOOMBS: What we did in the developing our workshops, our wellness instructor is a -- not only a physical fitness trainer but also a wellness trainer as well and she has a model in which she used to do body analysis. What was the second part of your question?

JOHANNIE ESCARNE: The second part of the question was what methodologies are you going to use and why?

JOYE TOOMBS: As far as—

JOHANNIE ESCARNE: To measure the body image -- conduct the body image analysis.

JOYE TOOMBS: The instructor has a model that she is using. Exactly what it is, I can't tell you at this moment.

JOHANNIE ESCARNE: Thank you.

JOYE TOOMBS: You're welcome.

JOHANNIE ESCARNE: I believe we have a couple of other questions. This is also directed to Joye. The holistic approach to your program is terrific. Have you considered how you'll accommodate women with physical disabilities?

JOYE TOOMBS: Great question because we had two ladies last week, one was on a walker, the other was on oxygen. Their physical activity will be developed based on their needs and each trainer that we have is specifically designed for those. We recognize we do have women with disabilities or handicaps who wanted to be part of our program. So if we're doing aerobics they'll be modified to do something in their chairs. In our warm-up in our first session they sat that their chairs and did modified things sitting. Where they weren't able to do them standing up.

JOHANNIE ESCARNE: We'll go back to a question, Barbara. Do women with chronic physically disabling health conditions such as lupus, rheumatoid arthritis comprise a specific group in terms of these recommendations?

BARBARA SCHNEEMAN: The major thrust of the dietary guidelines are for healthy Americans. So individuals who have a specific disease or disorder, they would need to get more targeted information through their healthcare provider for any particular dietary choices. It's the general population and then within that general healthy population it's

targeted around age group or life stage, pregnant or could become pregnant. That's more the targeting of specific populations.

JOHANNIE ESCARNE: Thank you. This question actually is for Sabrina. OK. Were the providers involved in the development of this pool for the adolescents, did the providers agree they would spend the needed time with the adolescents that are in this tool?

SABRINA MATOFF: The question had to do with the providers, whether we basically pilot tested the tools with providers and we did. We did a number of focus groups and pilot testing with both adolescent girls and providers and we were well aware that provider time is very limited. That having a clinical conversation takes -- could take a long time. We're not expecting long, long conversations. We were inform, though, that asking a couple of questions would only add perhaps an extra three to five minutes and that this could be an ongoing dialogue with adolescent girls and the provider could continue to come back to the questions as girls come to come in for their healthcare provider visits. So we know we aren't going to change the healthcare system and have longer visits but we're encouraging that providers spend those few minutes bringing up topics that are important like healthy eating and physical activities and other preventive health topics.

JOHANNIE ESCARNE: This is the last question. And the question is for Barbara again. Is the importance of the glycemic index discussed in the dietary guidelines?

BARBARA SCHNEEMAN: That specific topic is not in the guidelines. The advisory committee actually looked at some of the scientific evidence around glycemic index, glycemic load and did not recommend that that move into the dietary guidelines, as did the IOM when they looked at that evidence. I think what's important under carbohydrates, there is discussion about the types of foods, the types of carbohydrates one is trying to encourage consumption of, specifically dietary fiber and also a recognition that many foods have added sugars and that those would be an item where we would want consumers to pay more attention and try to limit those within the diet. The guidelines introduce the concept of discretionary calories. Sort of calories over and above what you need to meet your nutrient need. Sugars, those types of extra calories are discussed under discretionary calories.

JOHANNIE ESCARNE: All right. I'll go back to Lisa for closing remarks.

LISA KING: I just would like to thank first of all, all of our presenters for presenting the information today. It was very quick and there were a lot of questions, which is a good thing. What I'll do is try to distribute the questions as I can and answer those others that I can to make sure everyone has been heard. I would like to thank everybody for joining us today for the webcast. Have a nice afternoon. Thank you again. Thank you, everyone.