



**CHAMPION  
PROVIDER**  
FELLOWSHIP

*A Powerful Approach to Healthier Communities*

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**University of California, San Francisco**

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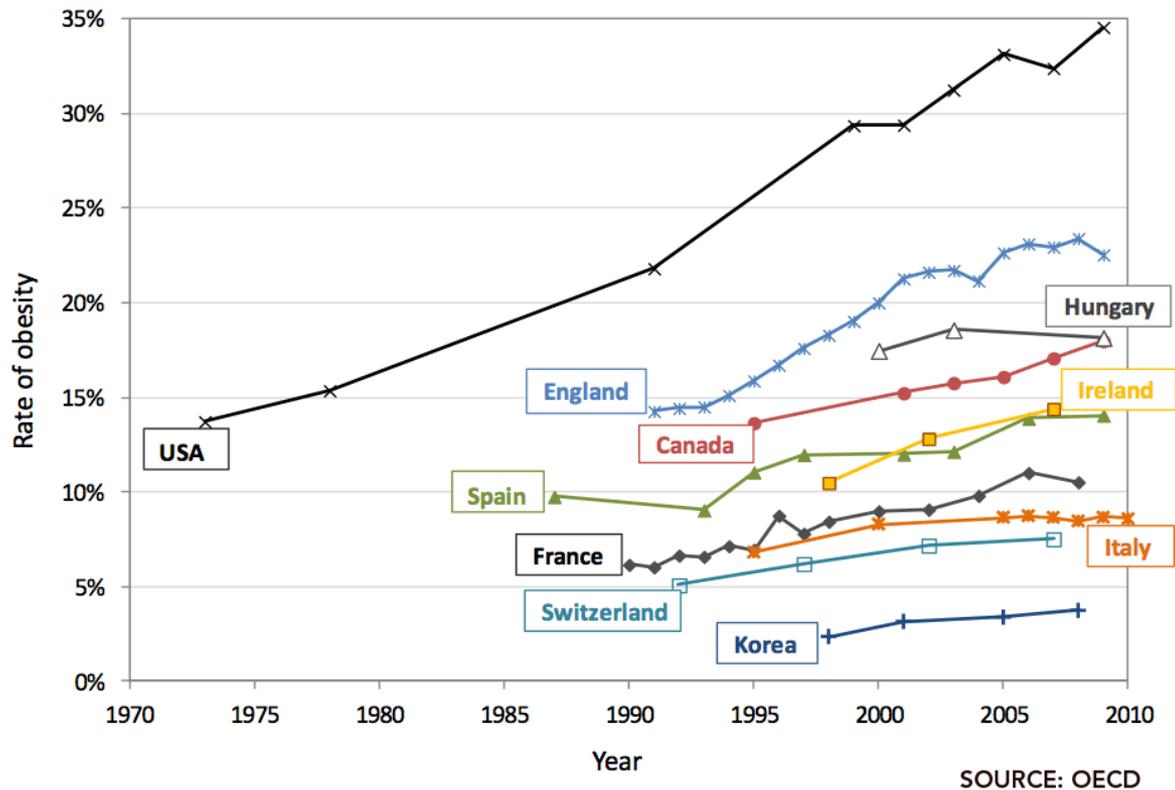


**A VISION OF CHANGE: HEALTH  
CARE PROVIDERS & THE OBESITY  
EPIDEMIC**



# Obesity: The Global Epidemic

## Obesity Rates



# Obesity: The Global Epidemic

Other maps available

[Socioeconomic Status](#)

[Age](#)

[Education](#)

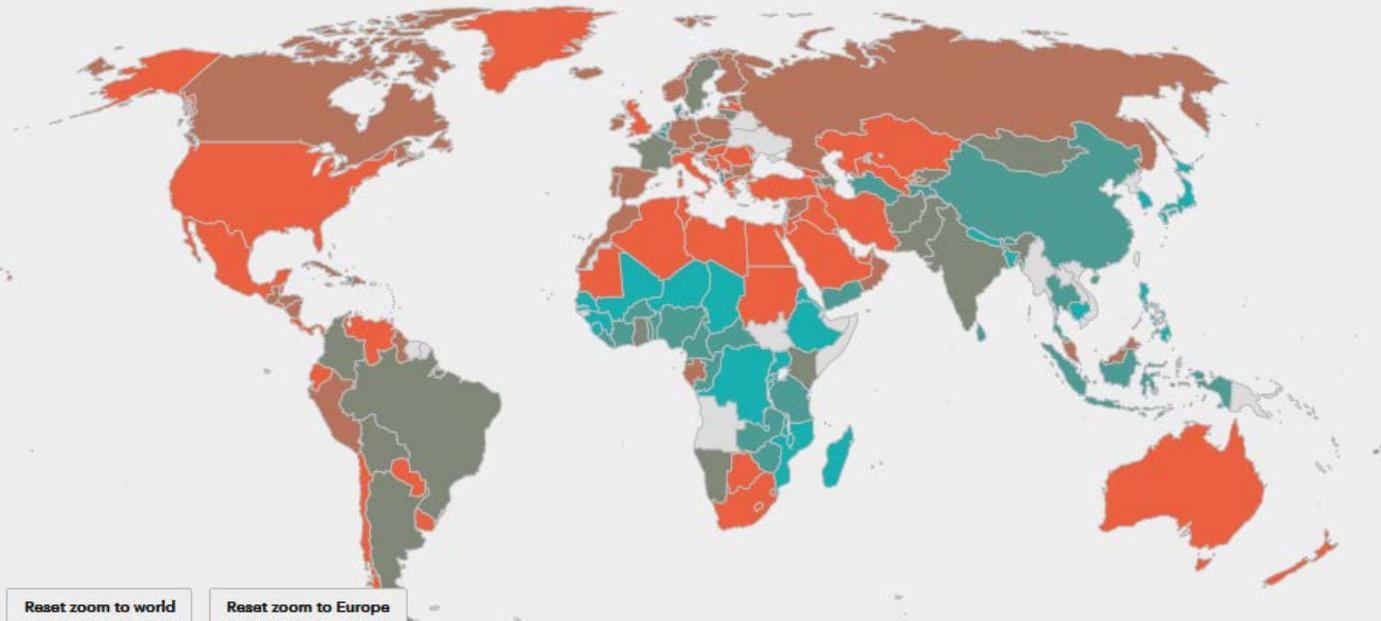
[Region](#)

[Trend](#)

[Policy & Interventions](#)

Obesity prevalence worldwide - Women

[women](#) [men](#) [girls](#) [boys](#)

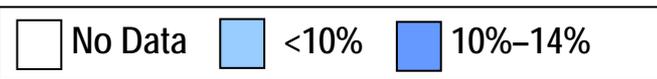
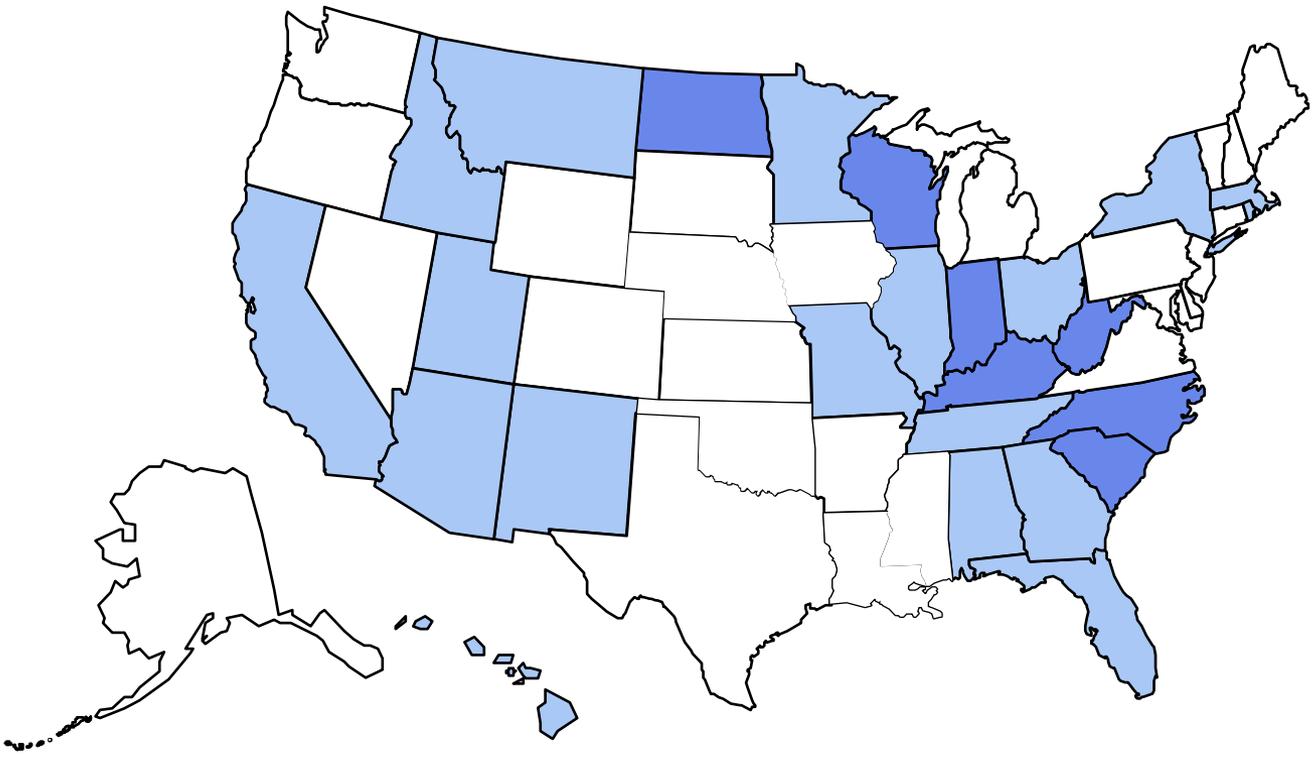




# Obesity Trends\* Among U.S. Adults

BRFSS, 1986

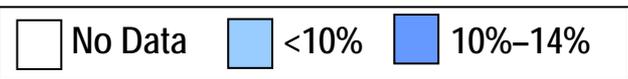
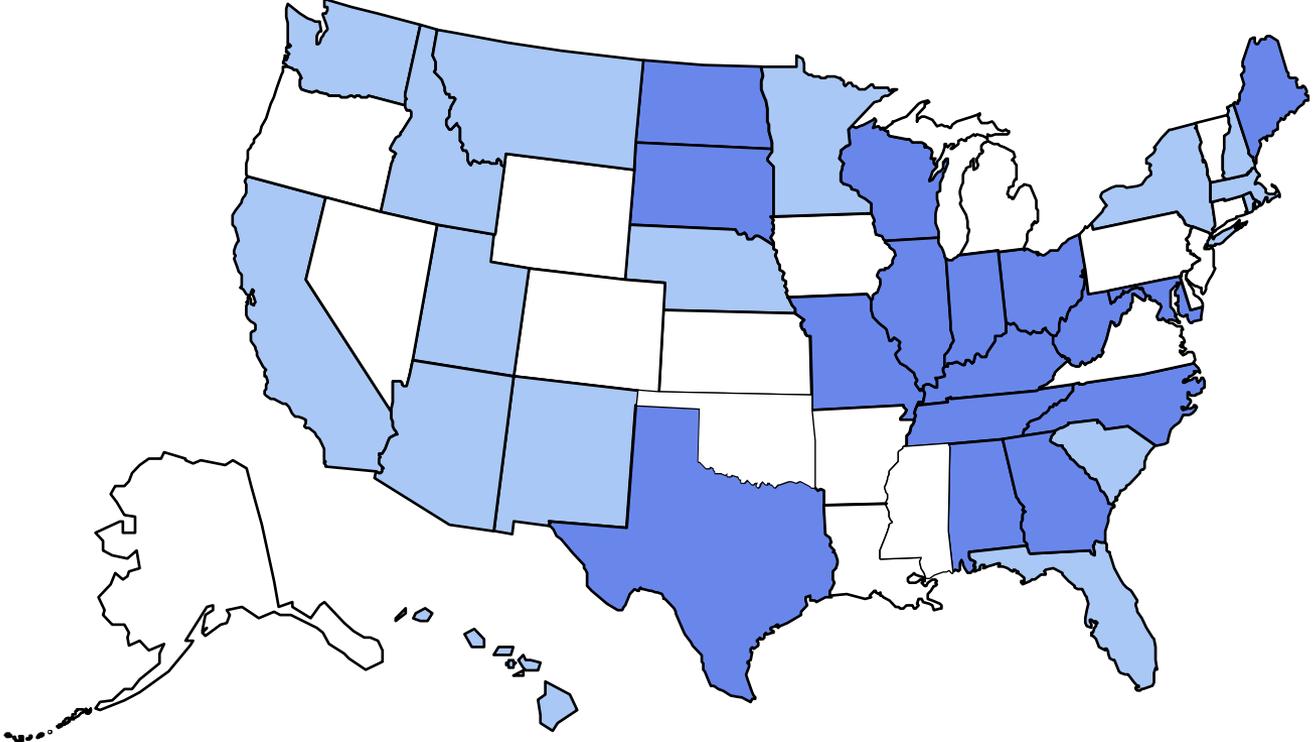
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 1987

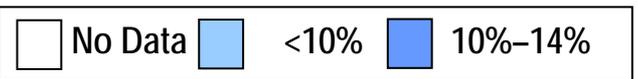
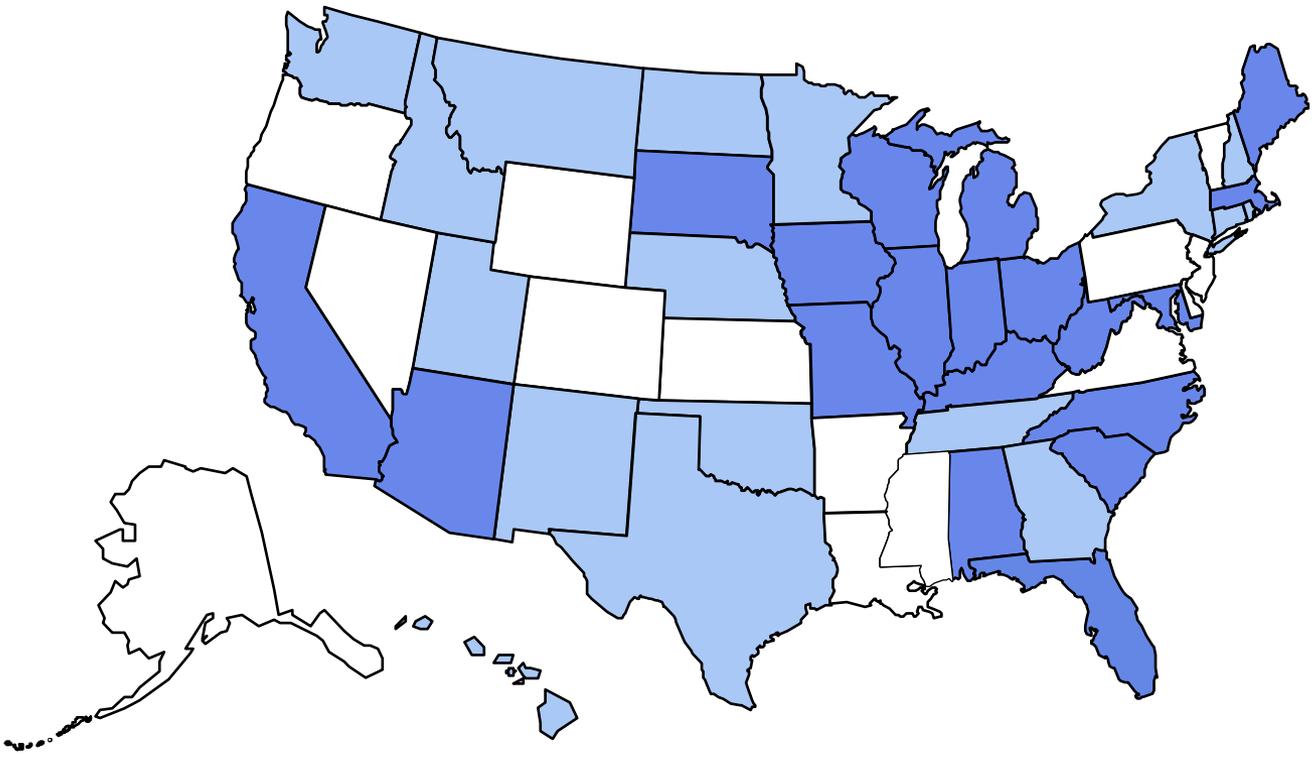
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 1988

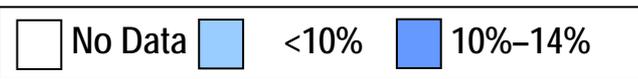
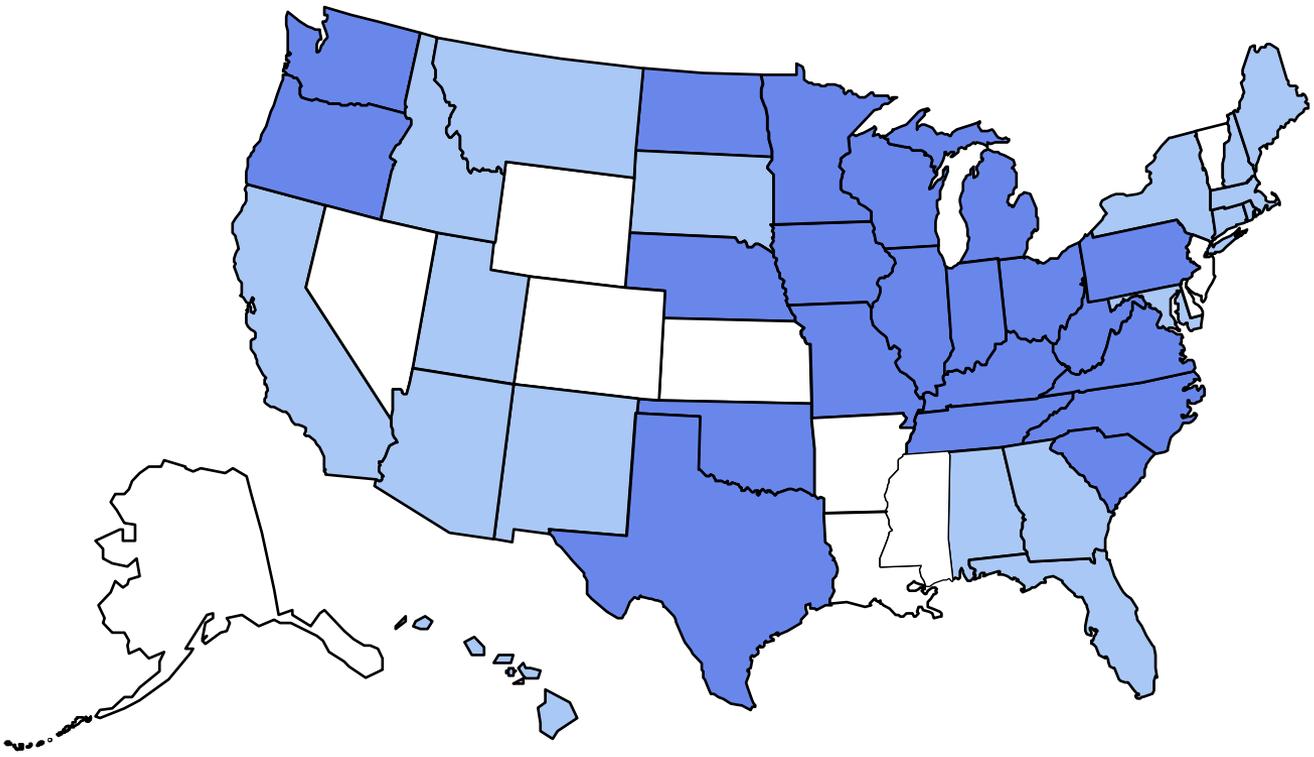
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 1989

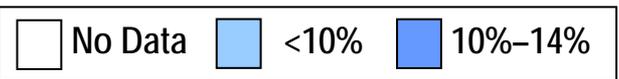
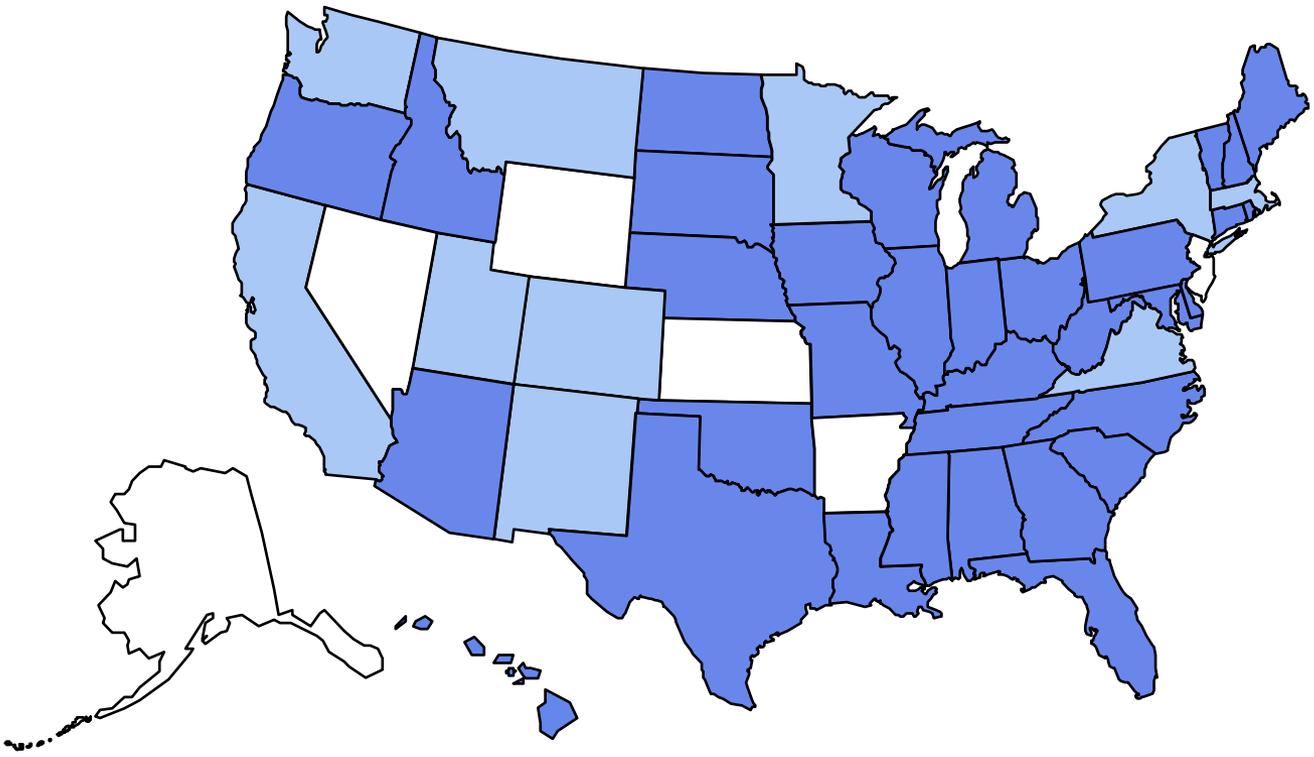
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 1990

(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



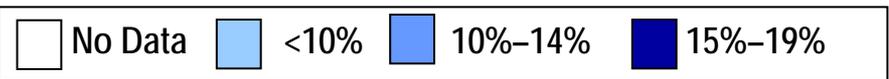
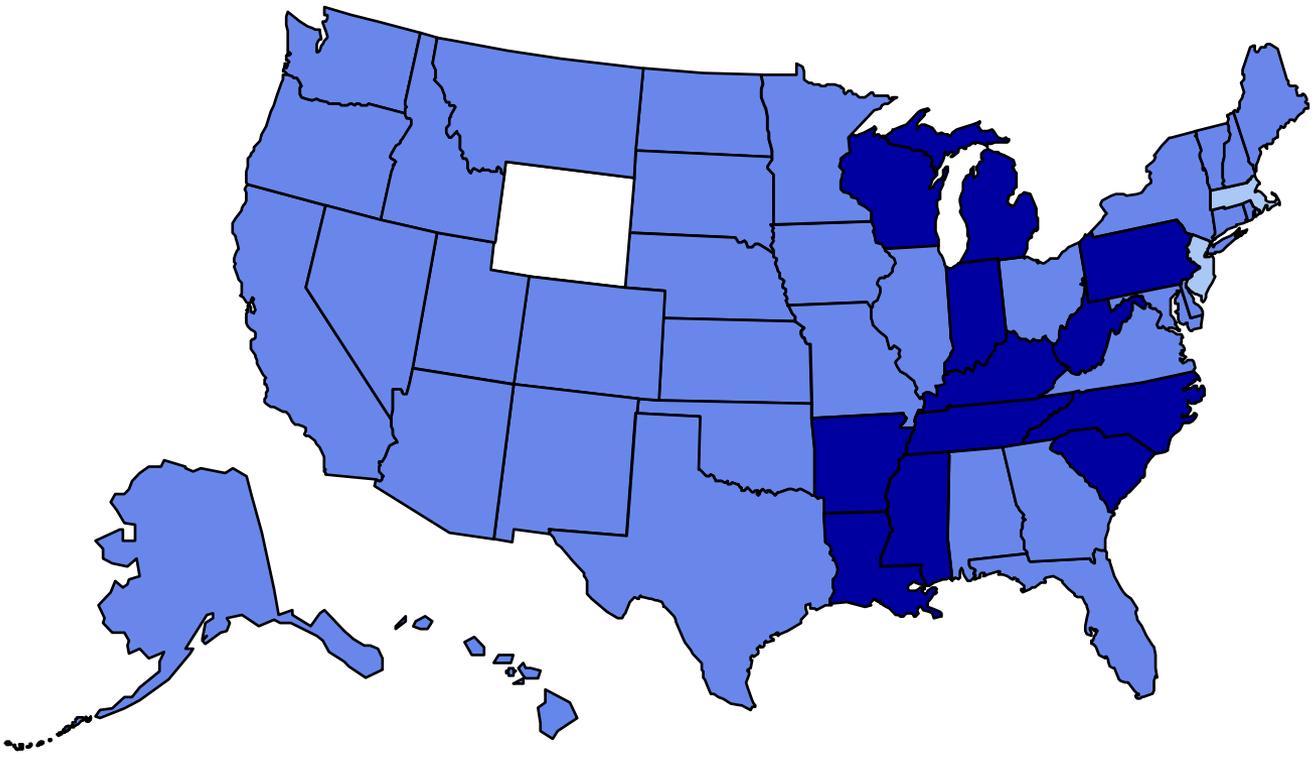




# Obesity Trends\* Among U.S. Adults

BRFSS, 1993

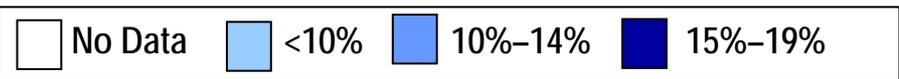
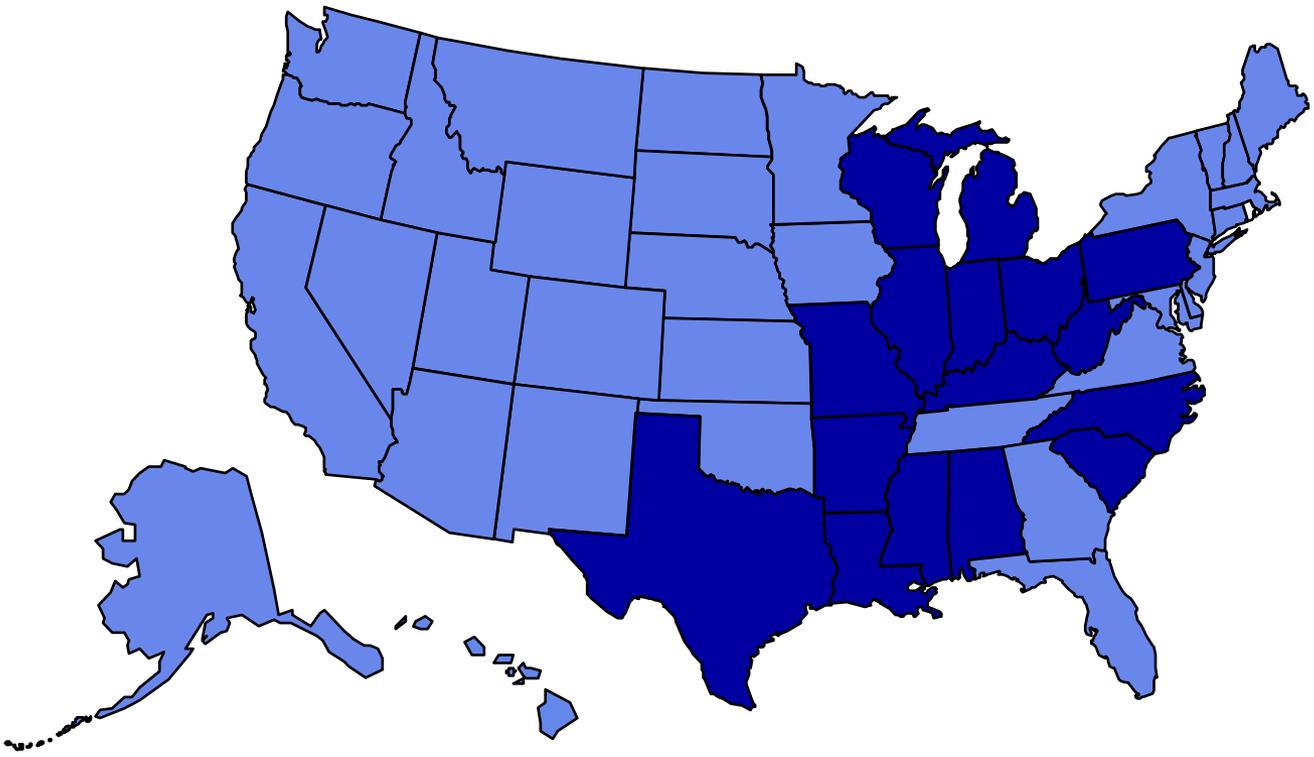
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 1994

(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



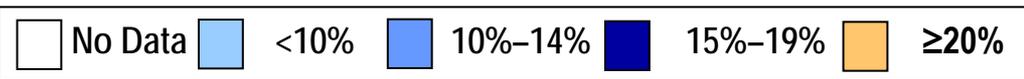
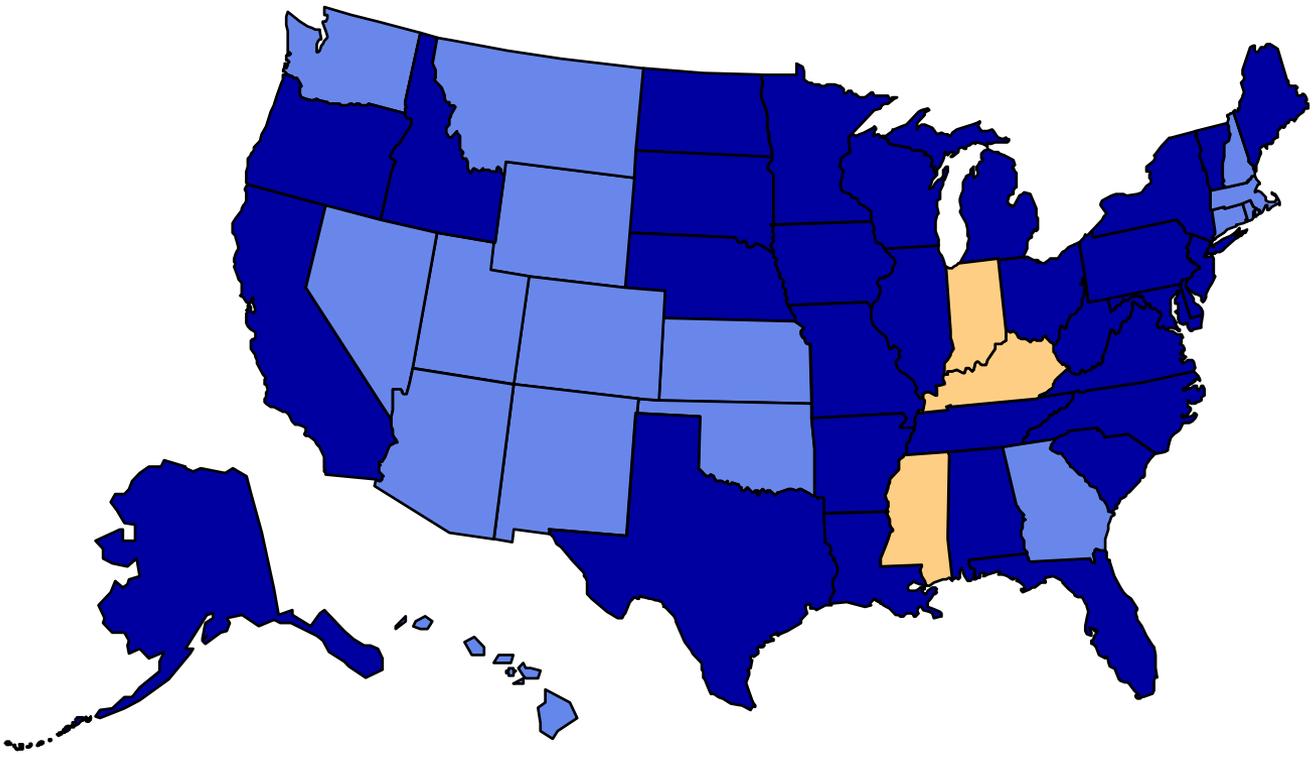




# Obesity Trends\* Among U.S. Adults

BRFSS, 1997

(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



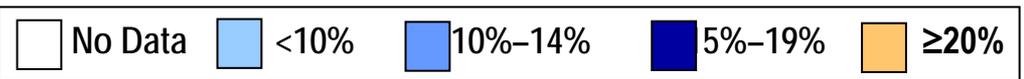
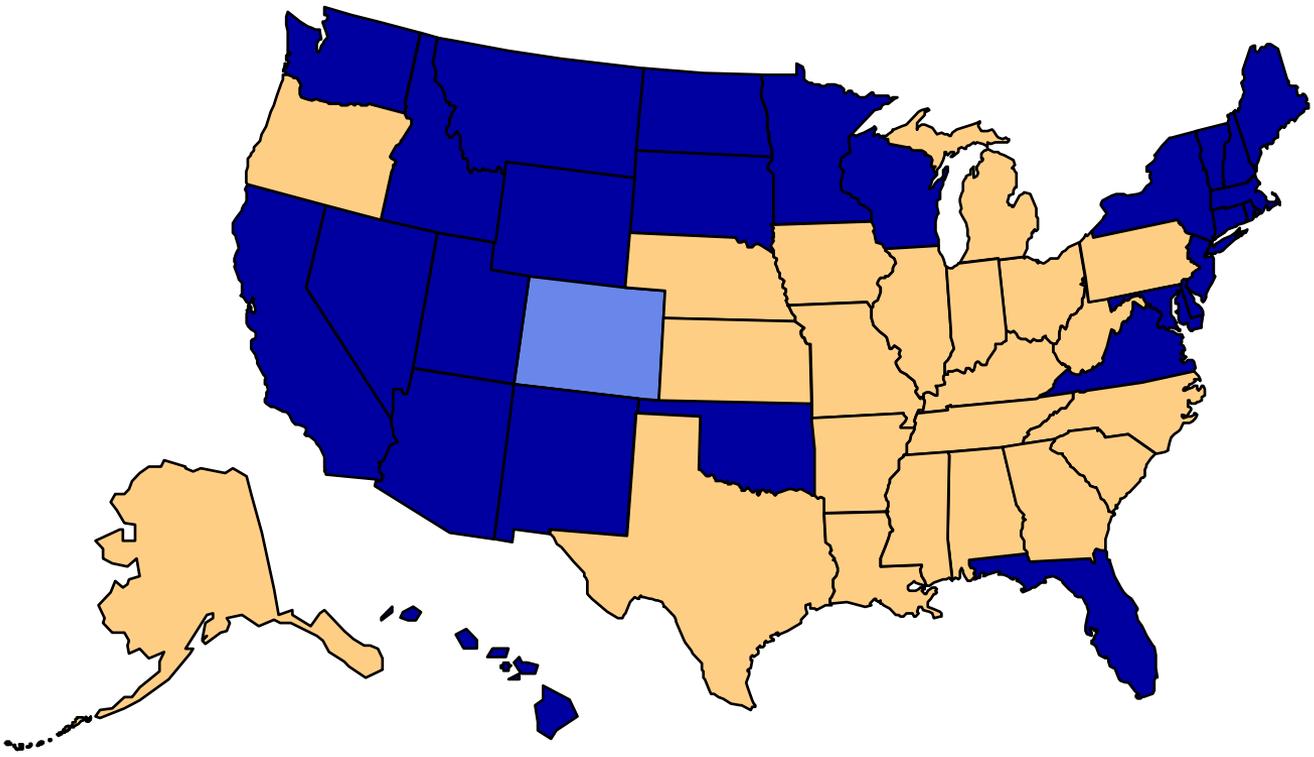




# Obesity Trends\* Among U.S. Adults

BRFSS, 2000

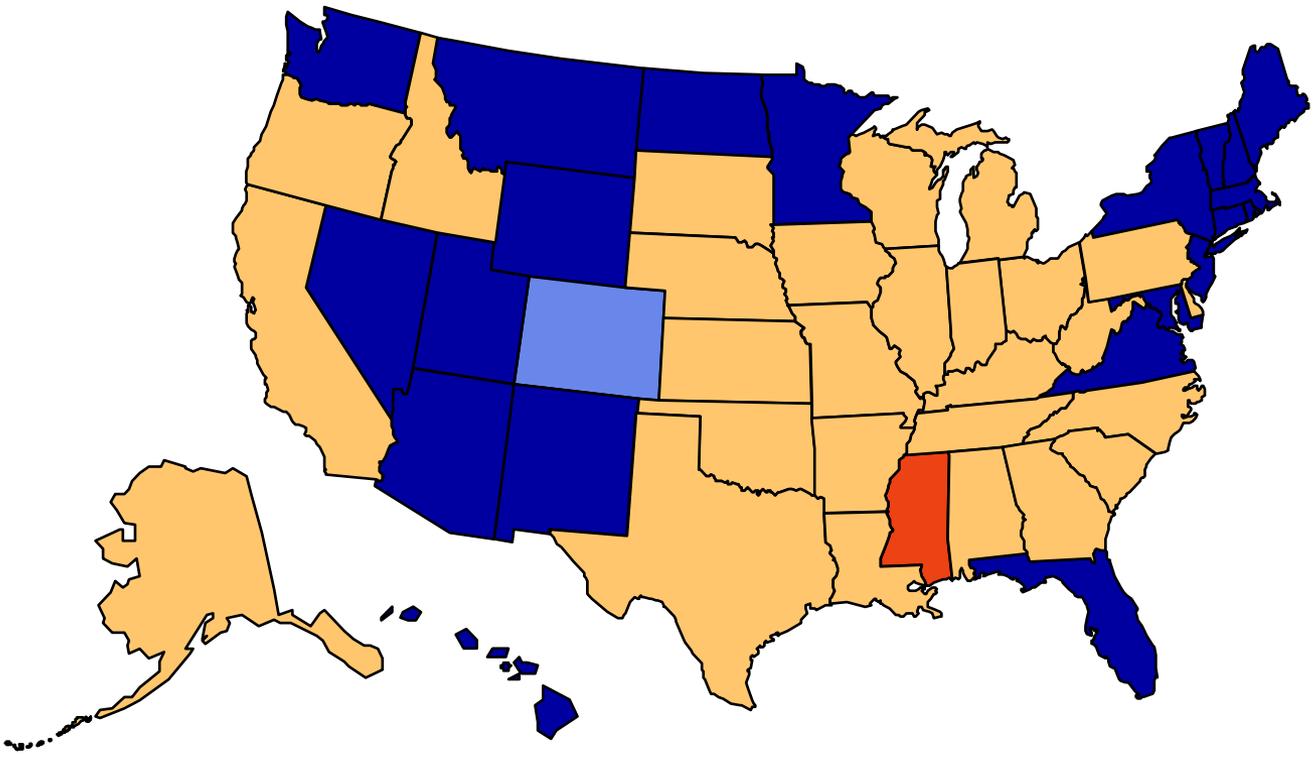
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 2001

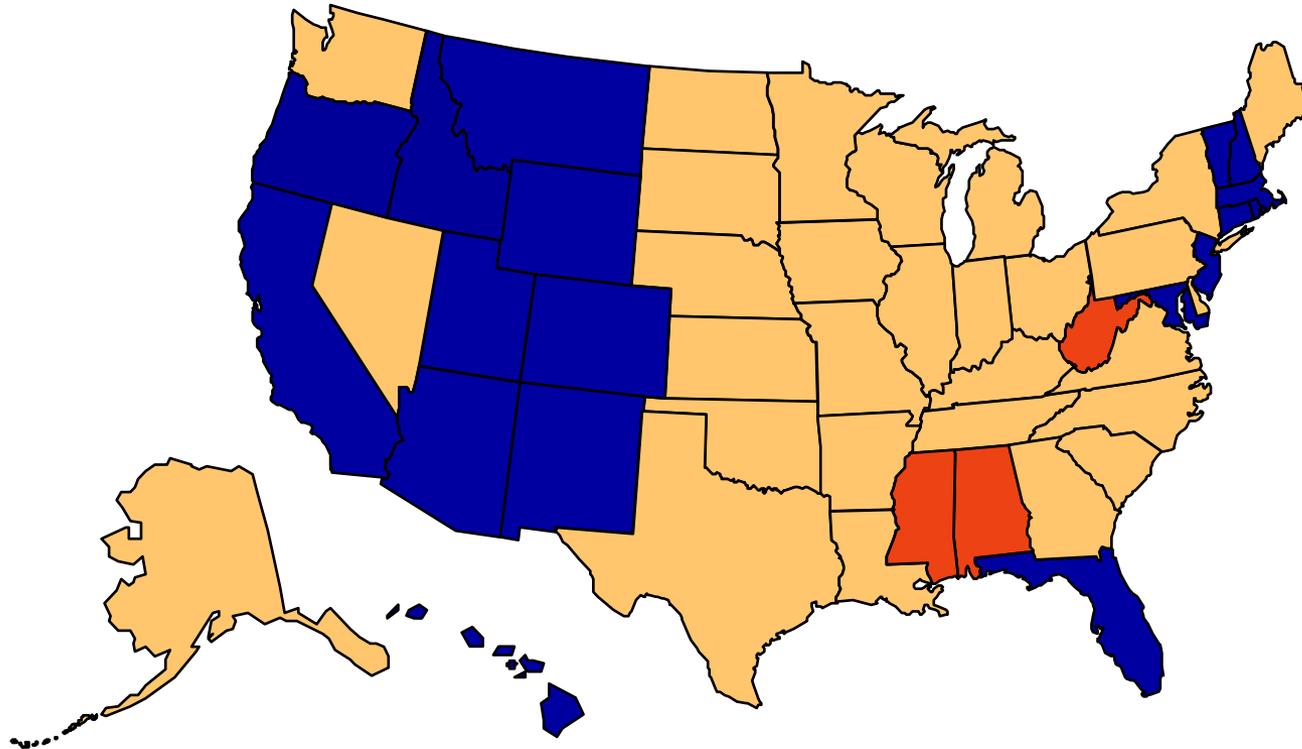
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

## BRFSS, 2002

(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



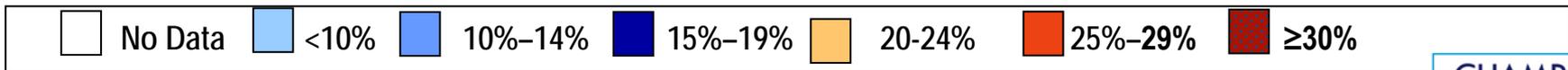
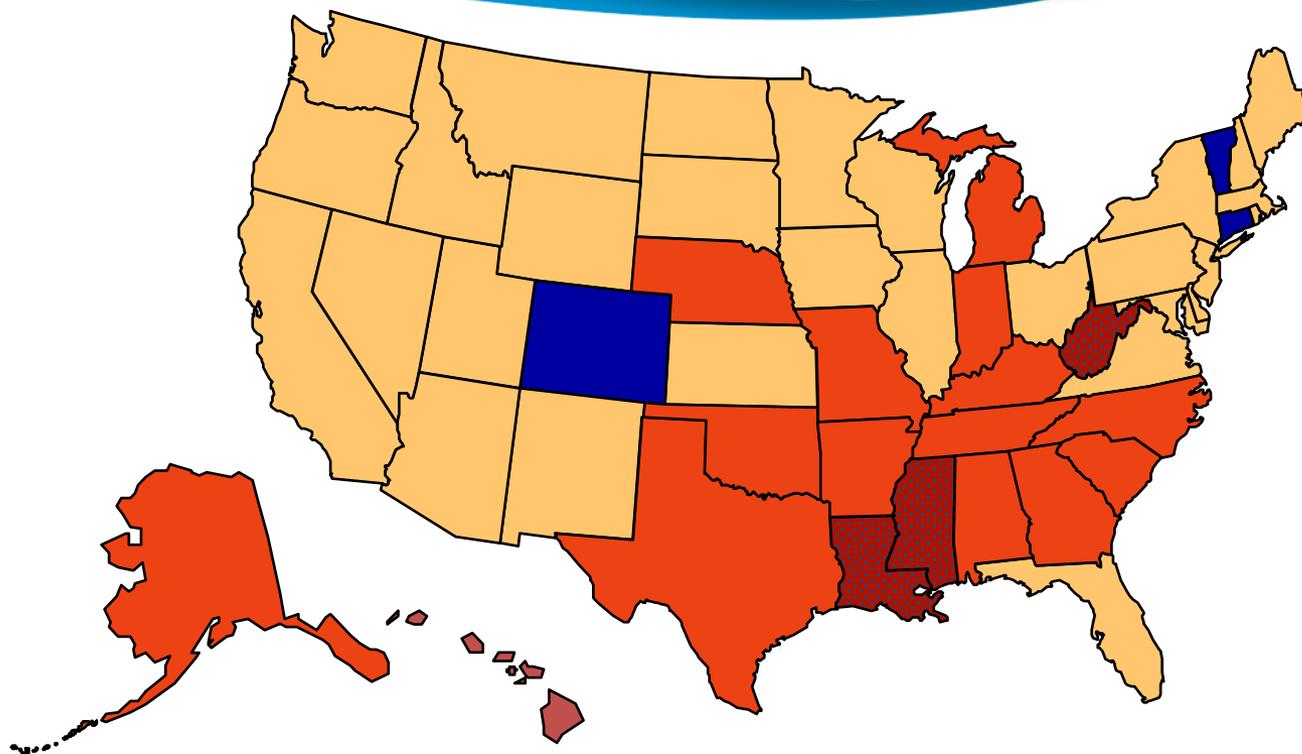




# Obesity Trends\* Among U.S. Adults

BRFSS, 2005

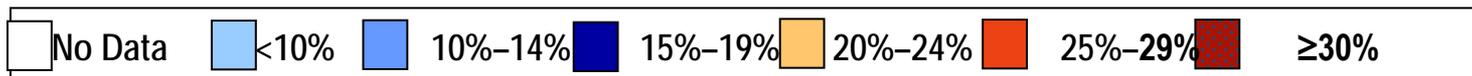
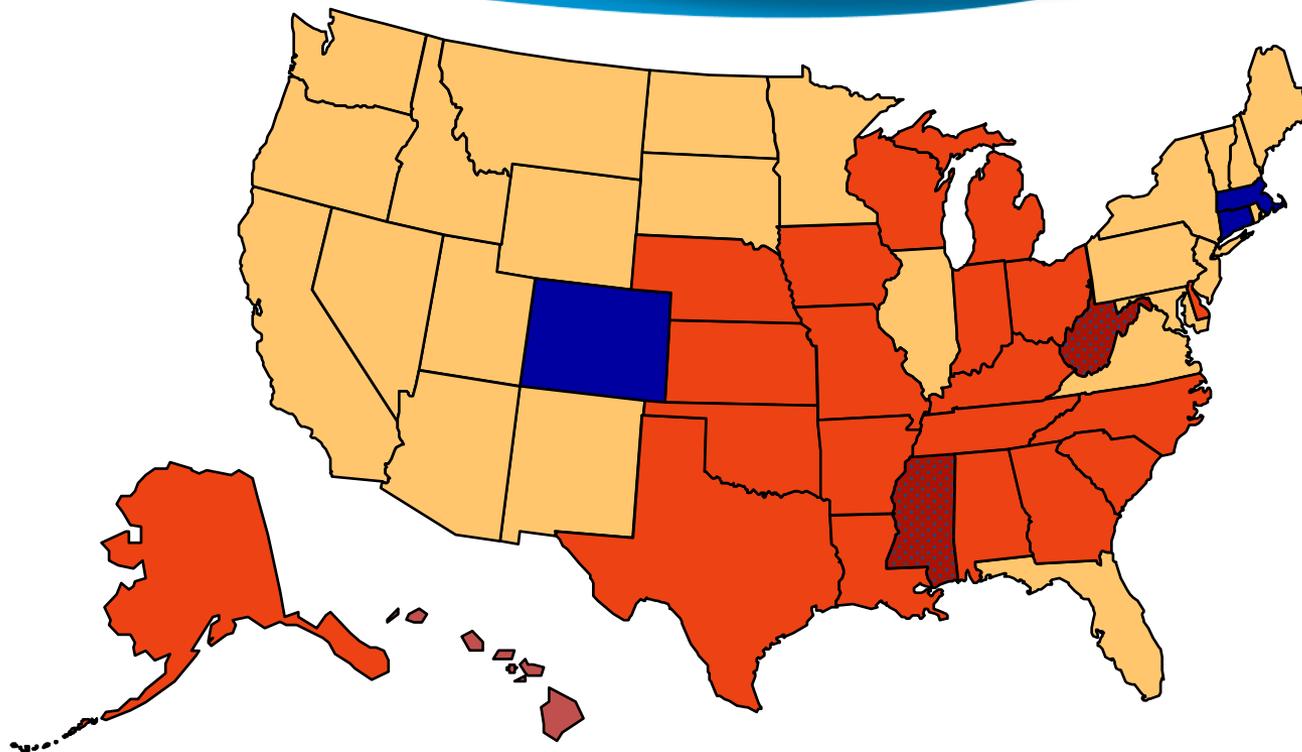
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 2006

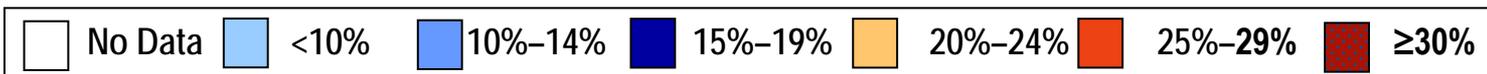
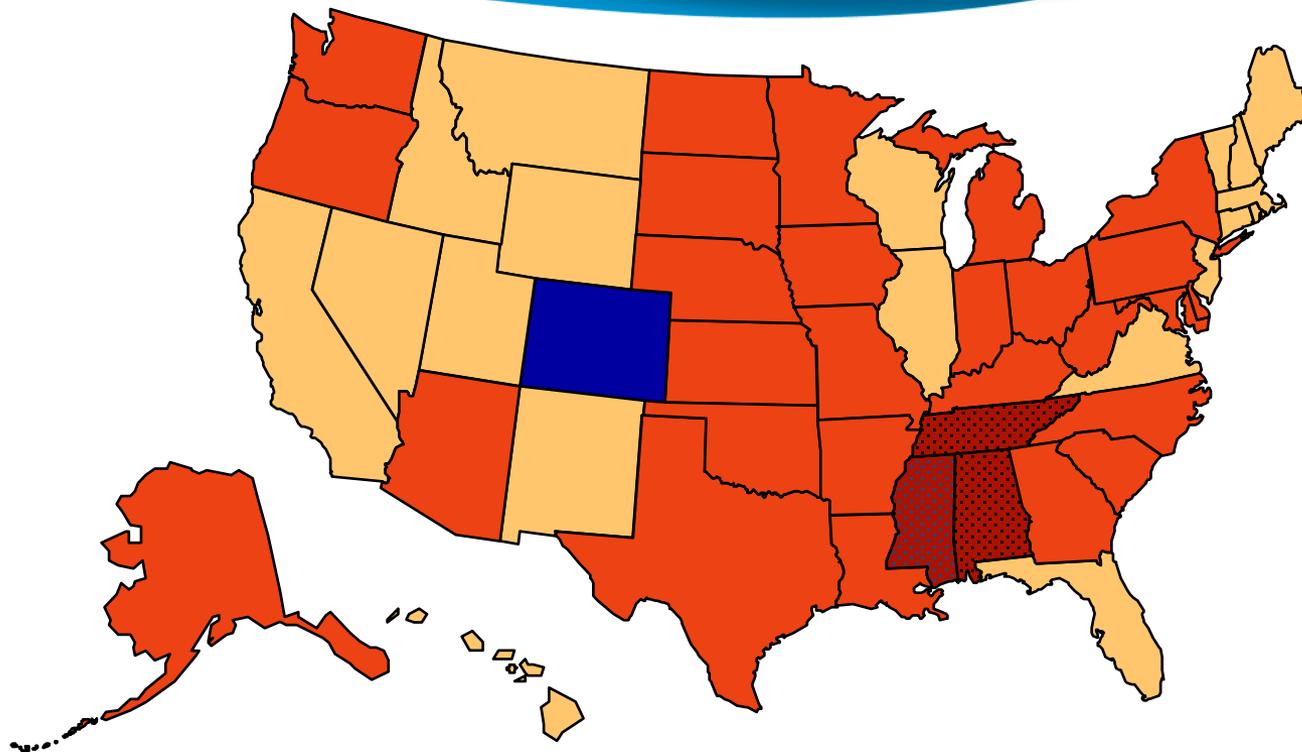
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 2007

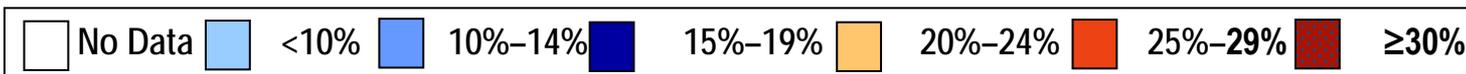
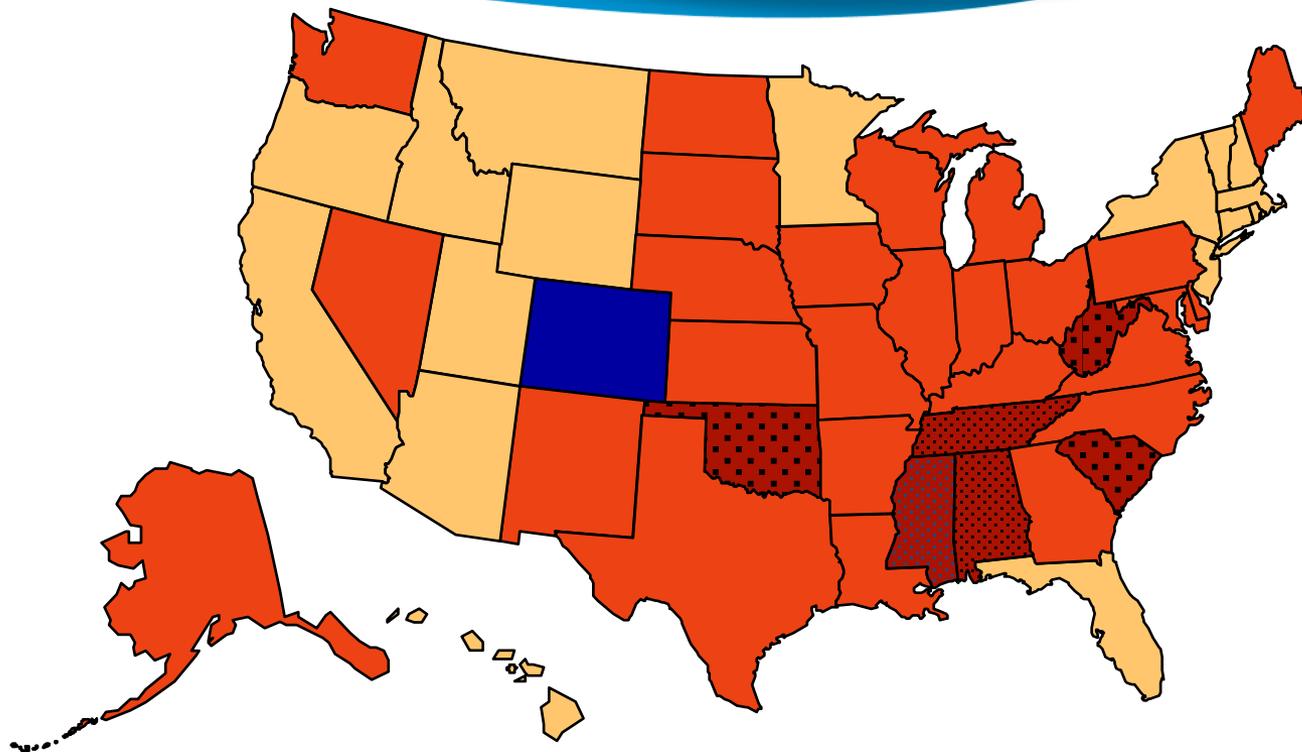
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 2008

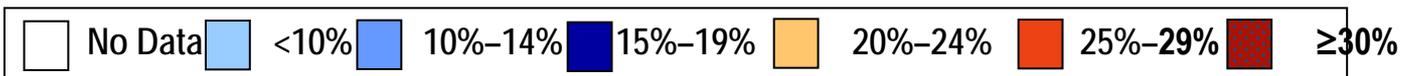
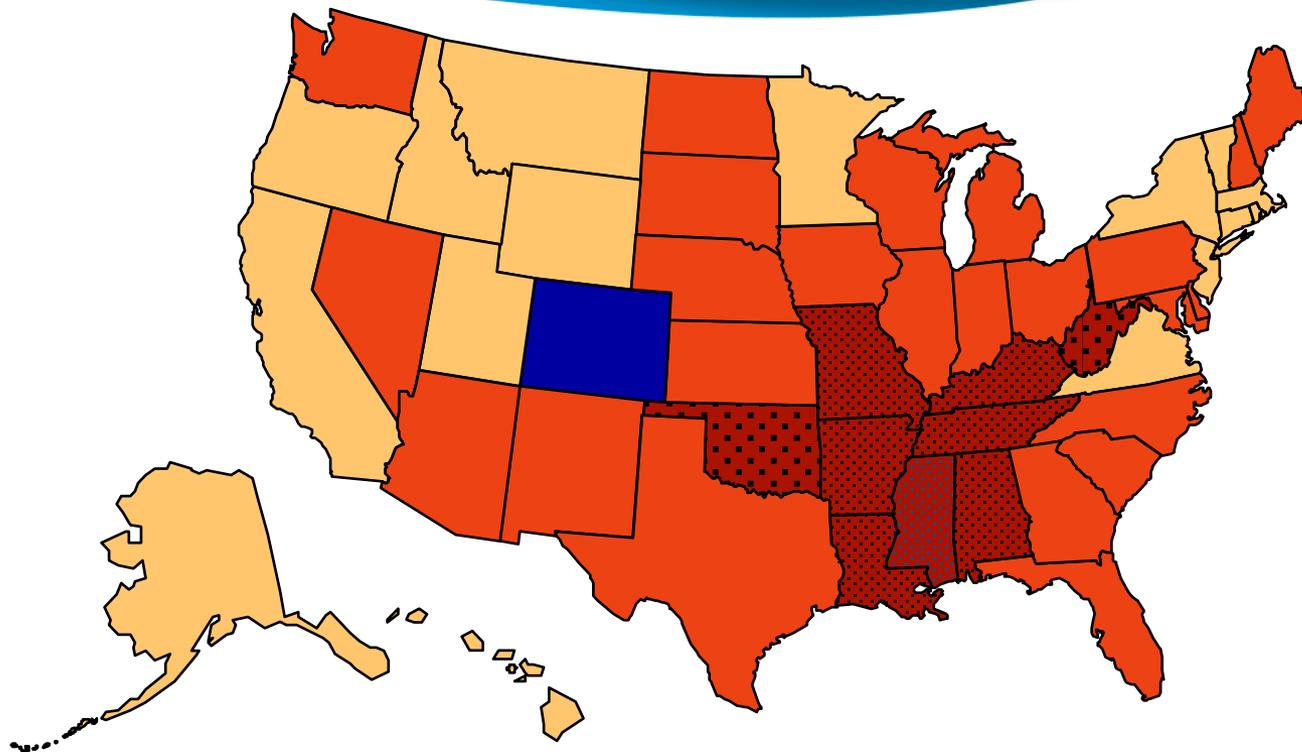
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 2009

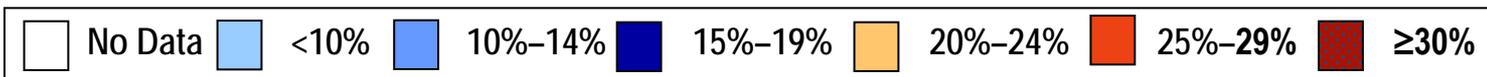
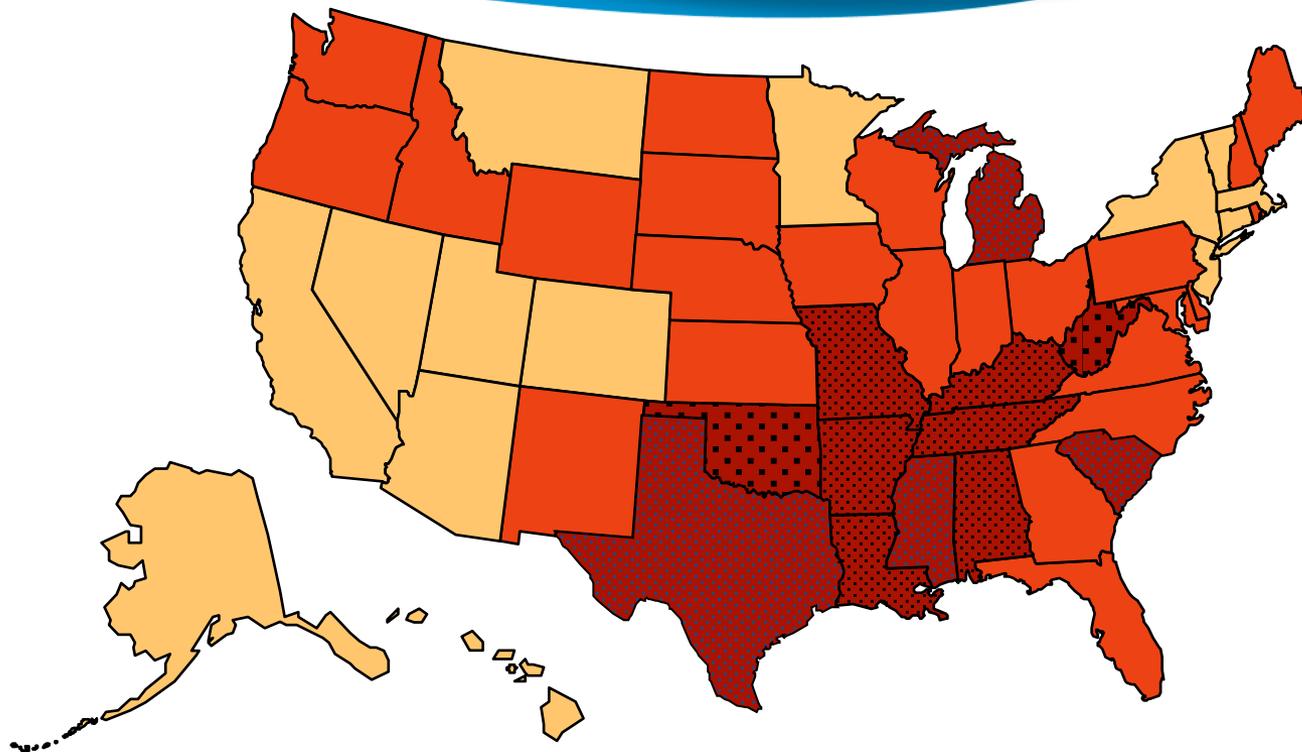
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

BRFSS, 2010

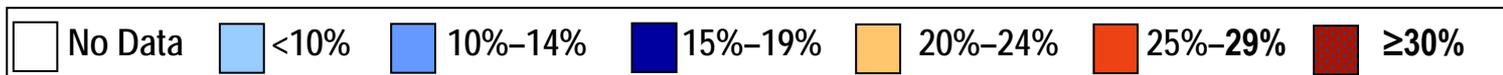
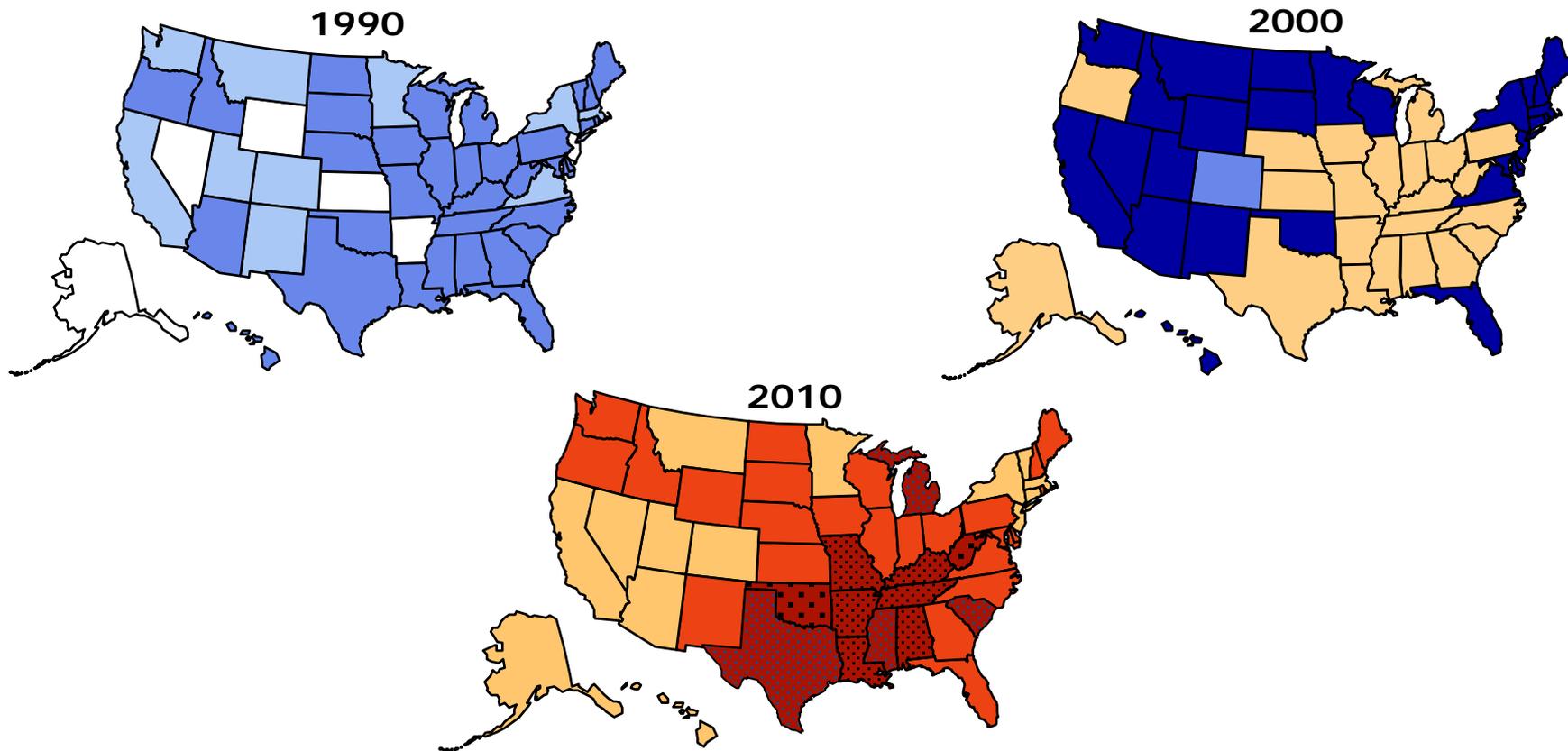
(\*BMI  $\geq 30$ , or  $\sim 30$  lbs. overweight for 5' 4" person)



# Obesity Trends\* Among U.S. Adults

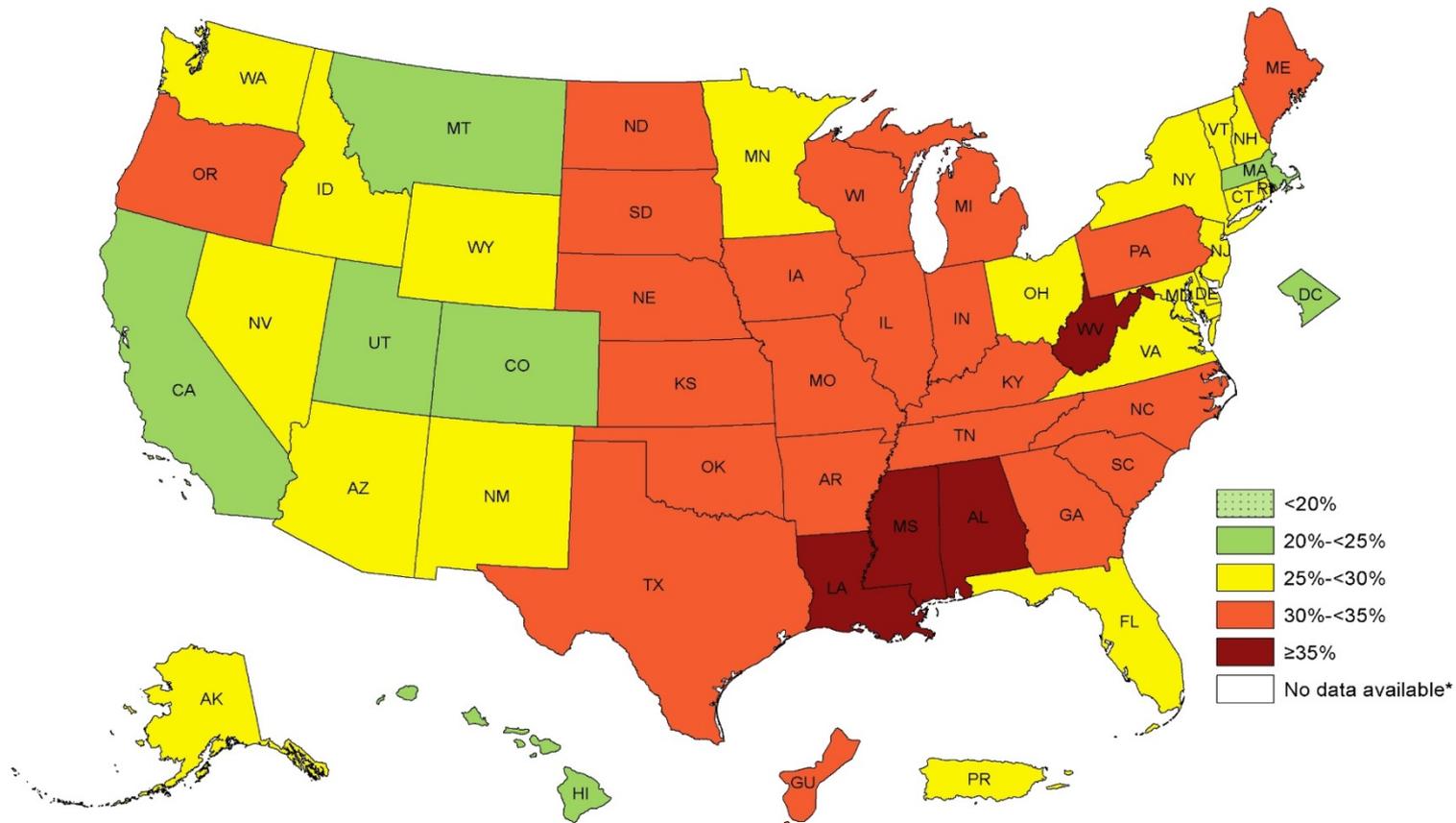
## BRFSS, 1990, 2000, 2010

(\*BMI  $\geq 30$ , or about 30 lbs. overweight for 5'4" person)



# Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2015

† Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.



\*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.

# PLACE Matters

# Place Matters

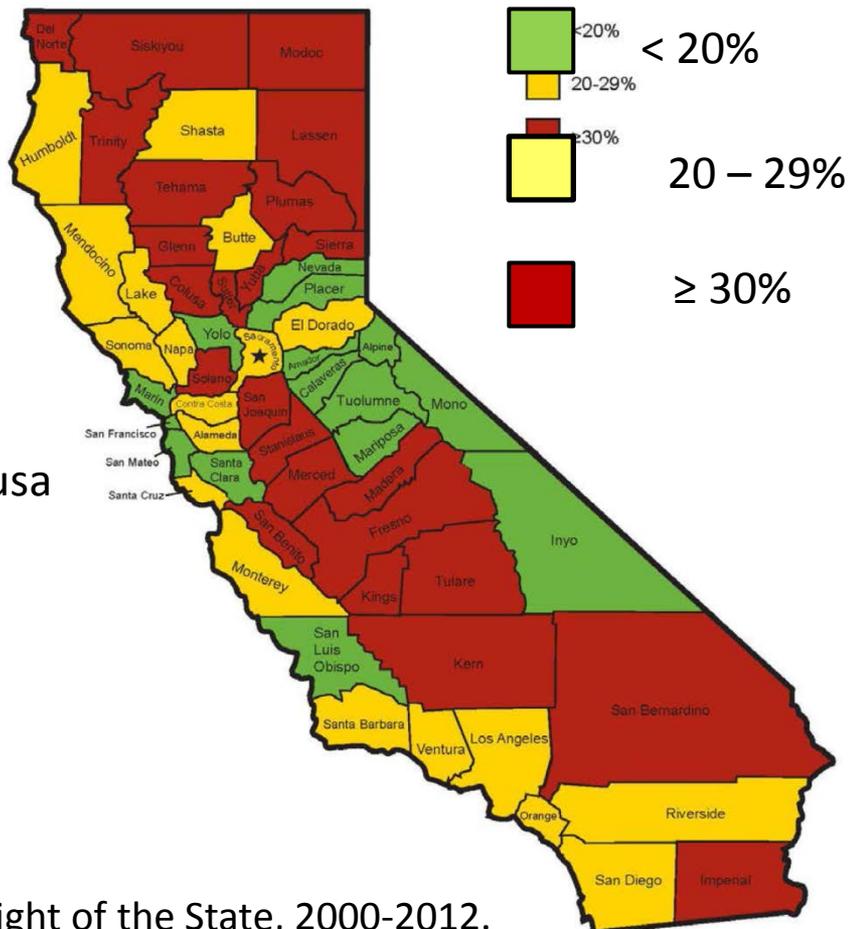
## Percentage of Adults in California Who are Obese (BMI ≥ 30) by County, 2011 - 2012

### Lowest

1. San Francisco
2. San Luis
3. Marin
4. San Mateo
5. Yolo

### Highest

1. Imperial
2. **San Benito**
3. Tehama, Glenn, Colusa
4. **Tulare**
5. **Kings**



Source: Obesity in California: The Weight of the State, 2000-2012. CDPH-NEOPB. 2014

# Place Matters

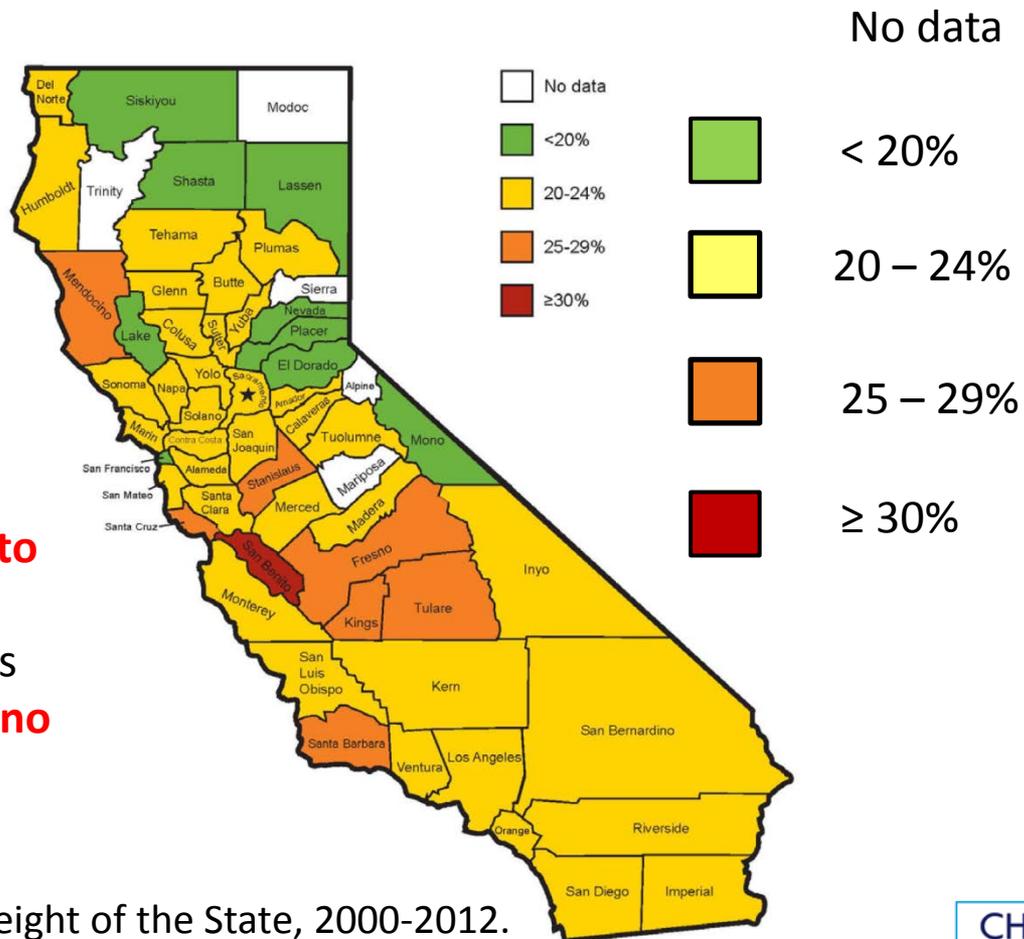
## Percentage of Low Income School-Age Children (5 – 19 years) Who are Obese (BMI ≥ 95<sup>th</sup> percentile) by County, 2010 PedNSS

### Lowest

1. Nevada
2. Mono
3. Lassen
4. Placer
5. Siskiyou

### Highest

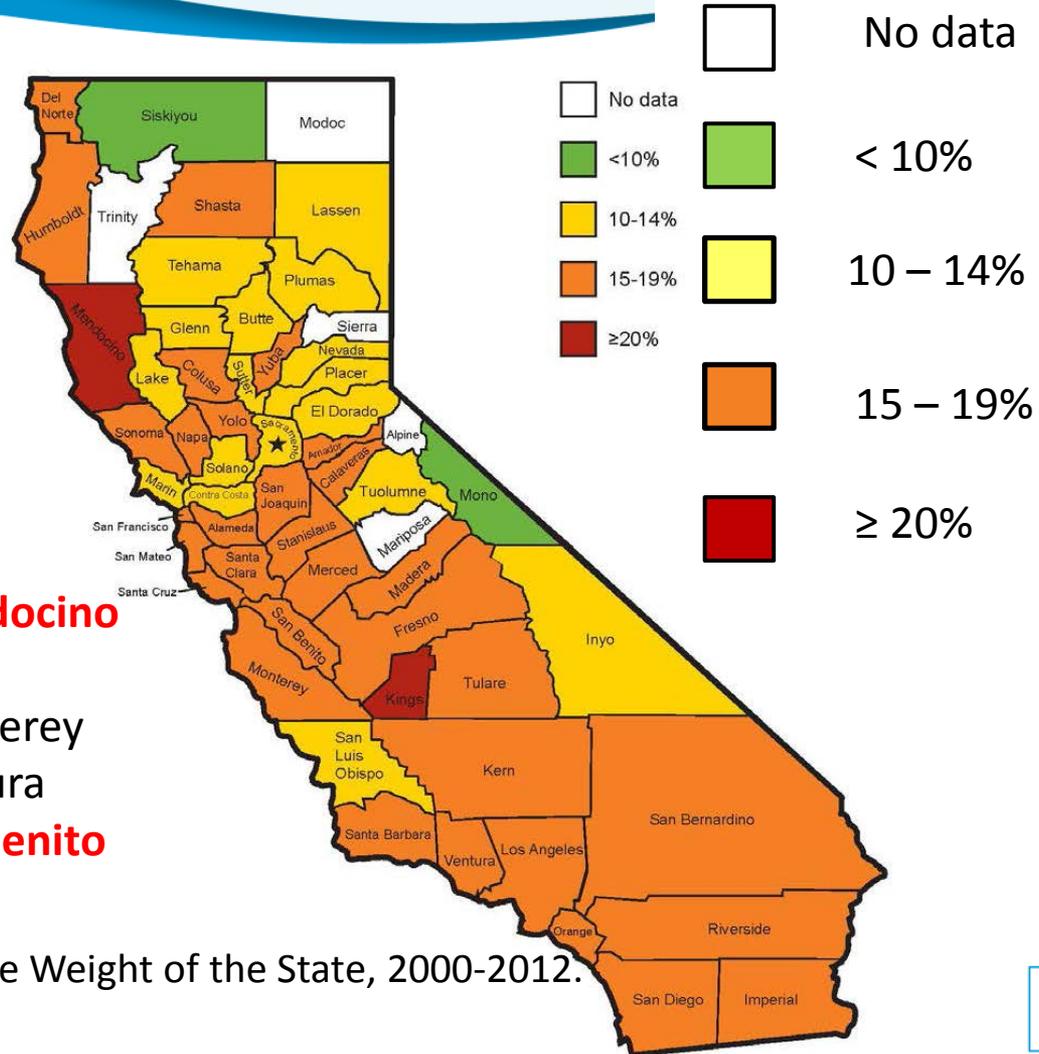
1. **San Benito**
2. **Tulare**
3. Stanislaus
4. **Mendocino**
5. **Kings & Fresno**



Source: Obesity in California: The Weight of the State, 2000-2012. CDPH-NEOPB. 2014

# Place Matters

**Percentage of Low Income  
Preschool Children (2 – 4  
years) who are Obese (BMI  
≥ 95<sup>th</sup> percentile) by  
County, 2010 PedNSS**



**Lowest**

1. Mono
2. Siskiyou
3. Nevada
4. Tuolumne
5. El Dorado

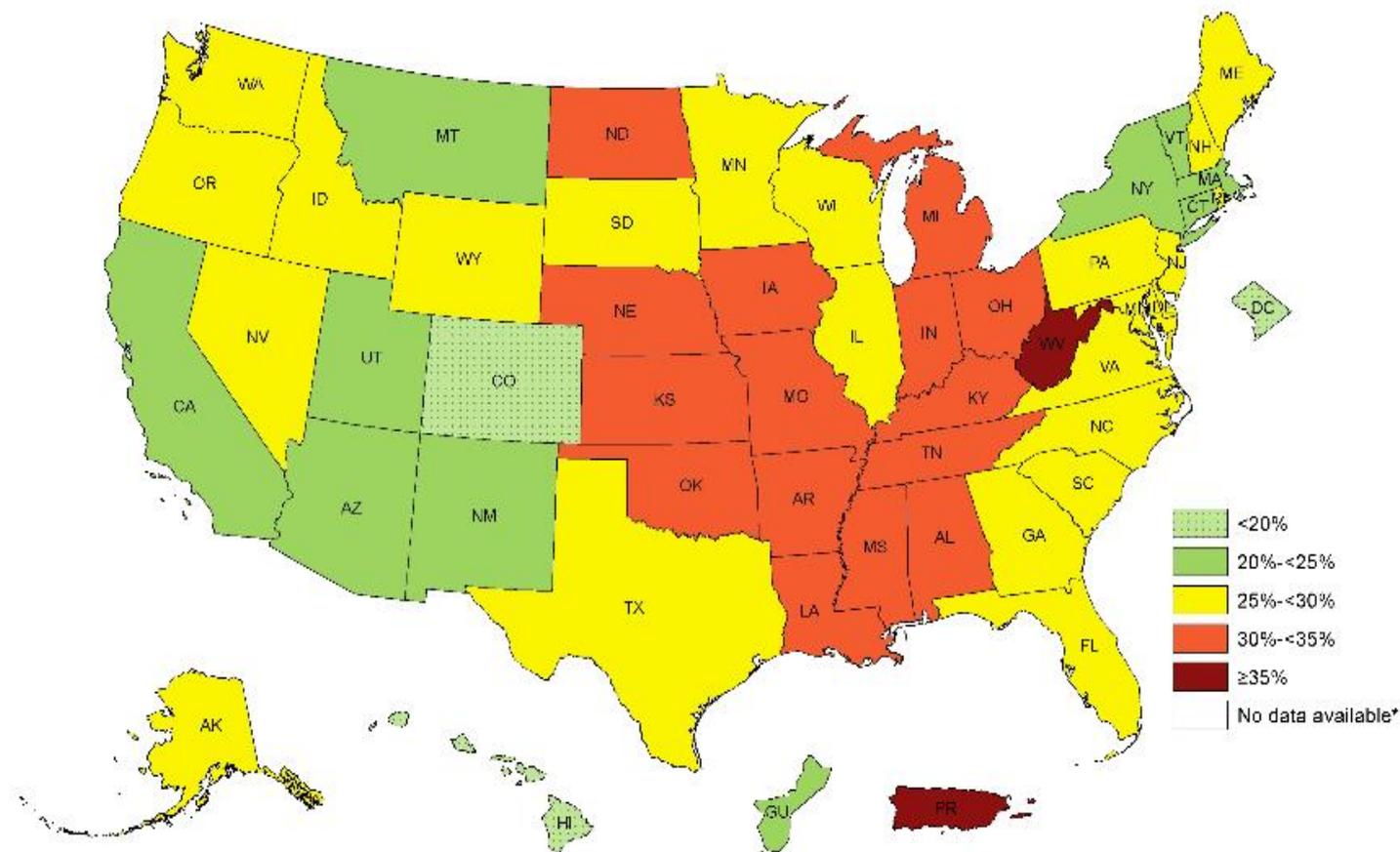
**Highest**

1. Mendocino
2. Kings
3. Monterey
4. Ventura
5. San Benito

Source: Obesity in California: The Weight of the State, 2000-2012.  
CDPH-NEOPB. 2014

**RACE Matters**

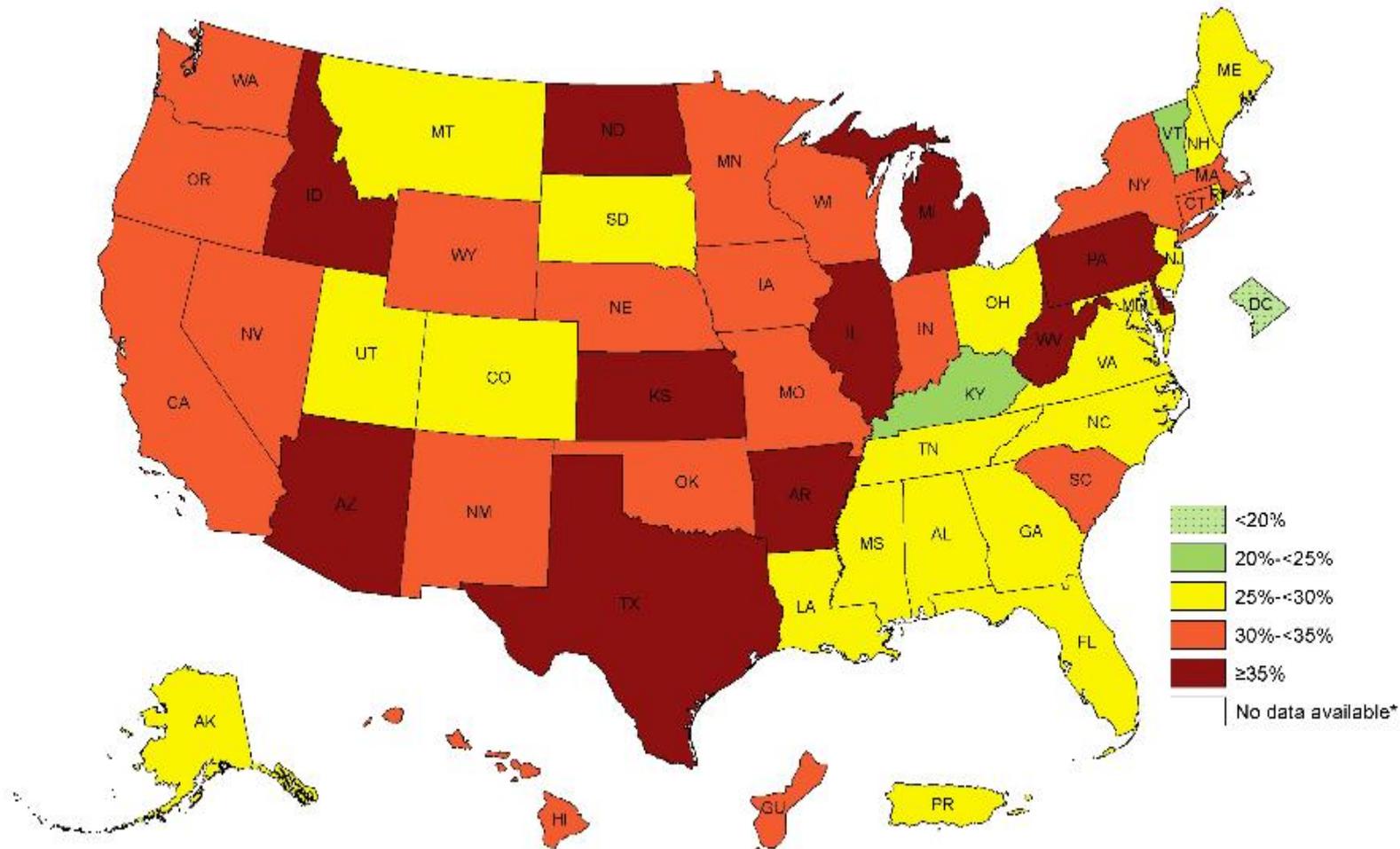
# Prevalence of Self-Reported Obesity Among Non-Hispanic White Adults, by State and Territory, BRFSS, 2013-2015



\*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.



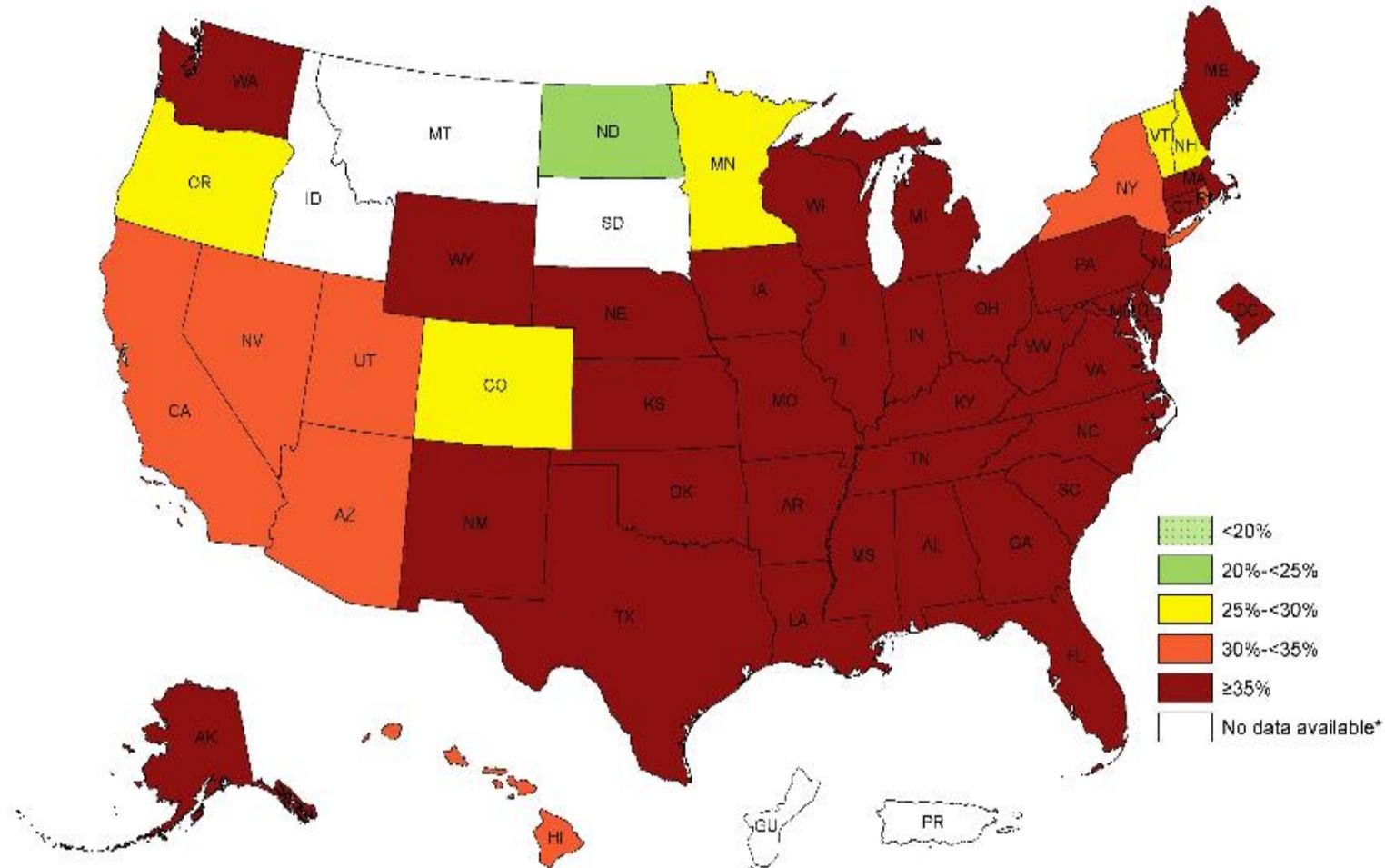
# Prevalence of Self-Reported Obesity Among Hispanic Adults, by State and Territory, BRFSS, 2013-2015



\*Sample size <50 or the relative standard error (dividing the standard error by the prevalence)  $\geq 30\%$ .



# Prevalence of Self-Reported Obesity Among Non-Hispanic Black Adults, by State and Territory, BRFSS, 2013-2015

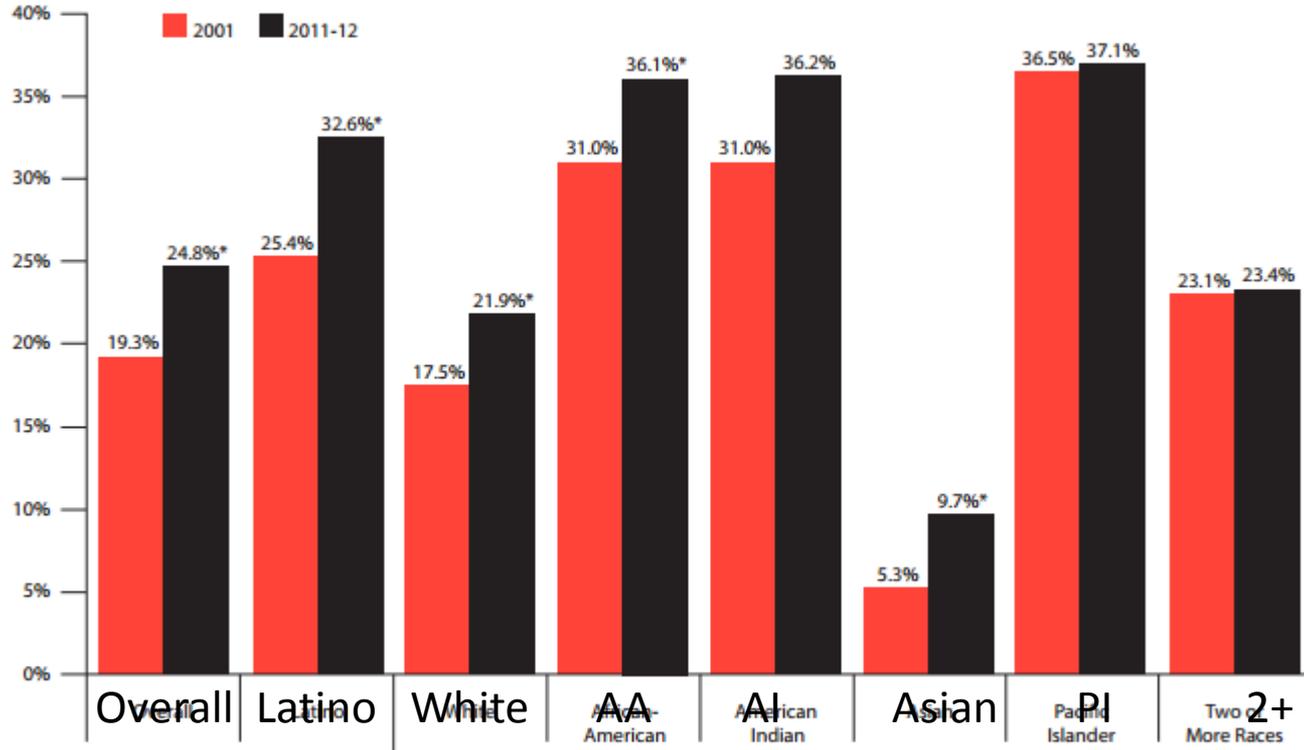


\*Sample size <50 or the relative standard error (dividing the standard error by the prevalence)  $\geq 30\%$ .



**Exhibit 6.**

**Obesity Prevalence by Race/Ethnicity, Adults 18 Years and Over, California, 2001 and 2011-12**



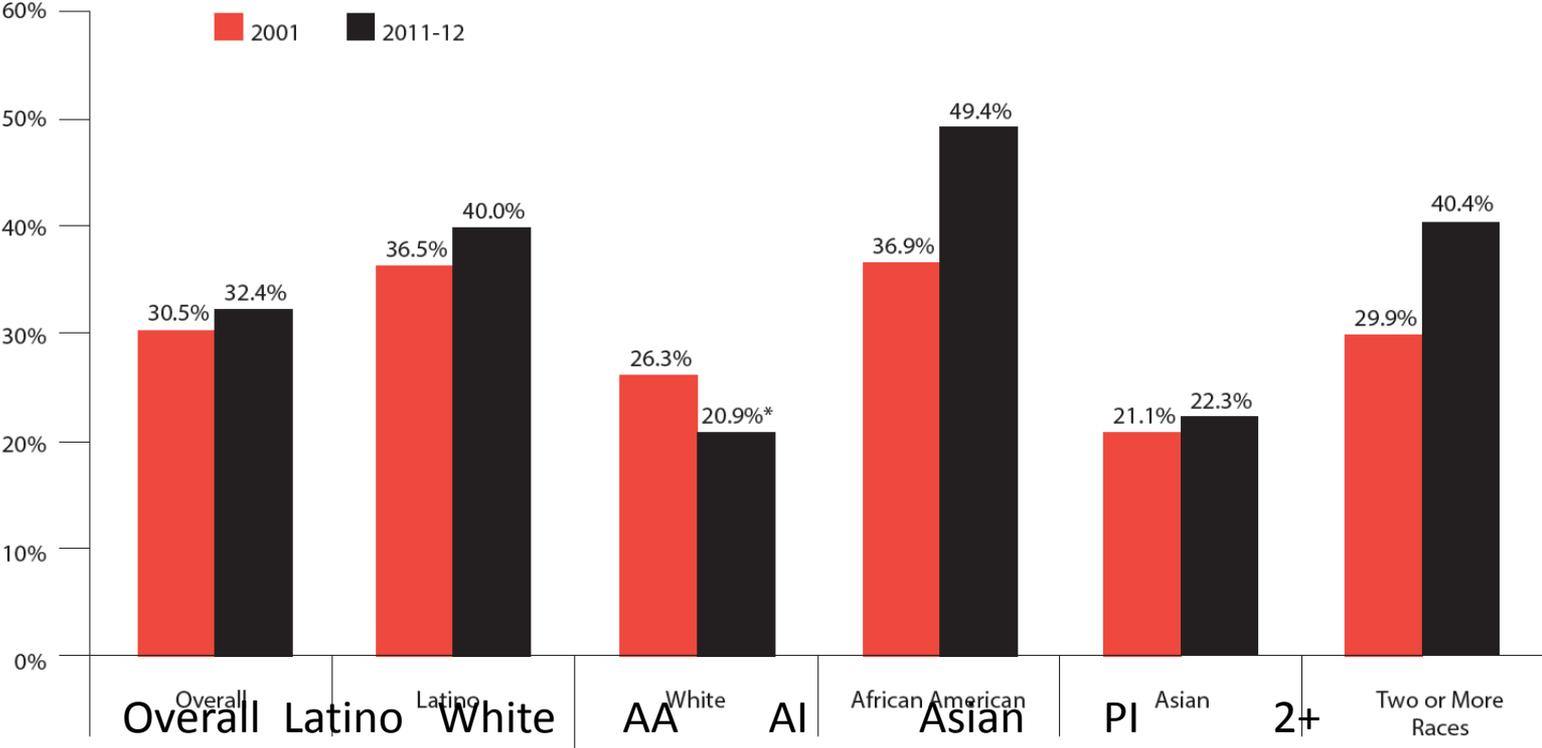
Source: 2001 and 2011-12 California Health Interview Surveys

\* Indicates significant difference from 2001;  $p < 0.05$ .

Changes from 2001 to 2011-12 may not be statistically significant in some groups due to small sample size.

Wolstein, Bavey and Diamant. Obesity in California, Los Angeles, CA. UCLA Center for Health Policy Research, 2015.

**Exhibit 10.**  
**Overweight/Obesity Prevalence by Race/Ethnicity, Adolescents Ages 12 -17, California, 2001 and 2011-12**



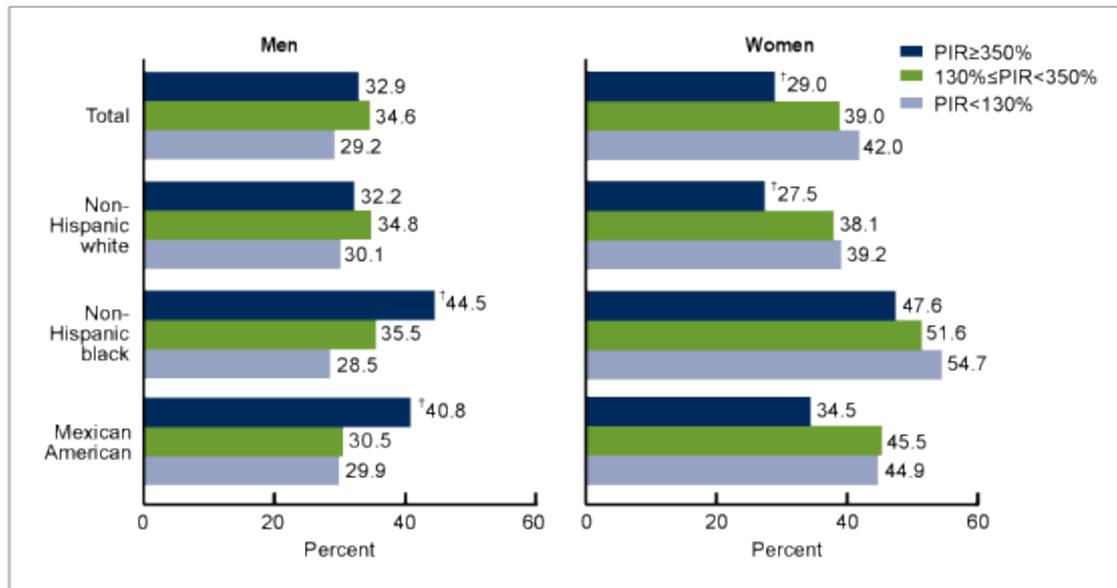
Source: 2001 and 2011-12 California Health Interview Surveys

\* Indicates significant difference from 2001; p < 0.05.

# **WEALTH Matters**

# Obesity by Poverty Income Ratio

Figure 1. Prevalence of obesity among adults aged 20 years and over, by poverty income ratio, sex, and race and ethnicity: United States 2005–2008



†Significant trend.

NOTES: PIR is poverty income ratio. Persons of other race and ethnicity included in total.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2005–2008.

Ogden CL, Lamb MM, Carroll MD, Flegal KM. Obesity and socioeconomic status in adults: United States 1988–1994 and 2005–2008. NCHS data brief no 50. Hyattsville, MD: National Center for Health Statistics. 2010.

# Health Consequences in California

55%

(15.5 million Californians)

Of all adults have  
pre-diabetes or  
diabetes

Babey, Wolstein, Diamant, Goldstein. Prediabetes in California: Nearly Half of California Adults on Path to Diabetes. Los Angeles, CA: UCLA Center for Health Policy Research and California Center for Public Health Advocacy, 2016.

# Health Consequences in California

33%

Of all young adults  
(18 – 39) have  
pre-diabetes

Babey, Wolstein, Diamant, Goldstein. Prediabetes in California: Nearly Half of California Adults on Path to Diabetes. Los Angeles, CA: UCLA Center for Health Policy Research and California Center for Public Health Advocacy, 2016.

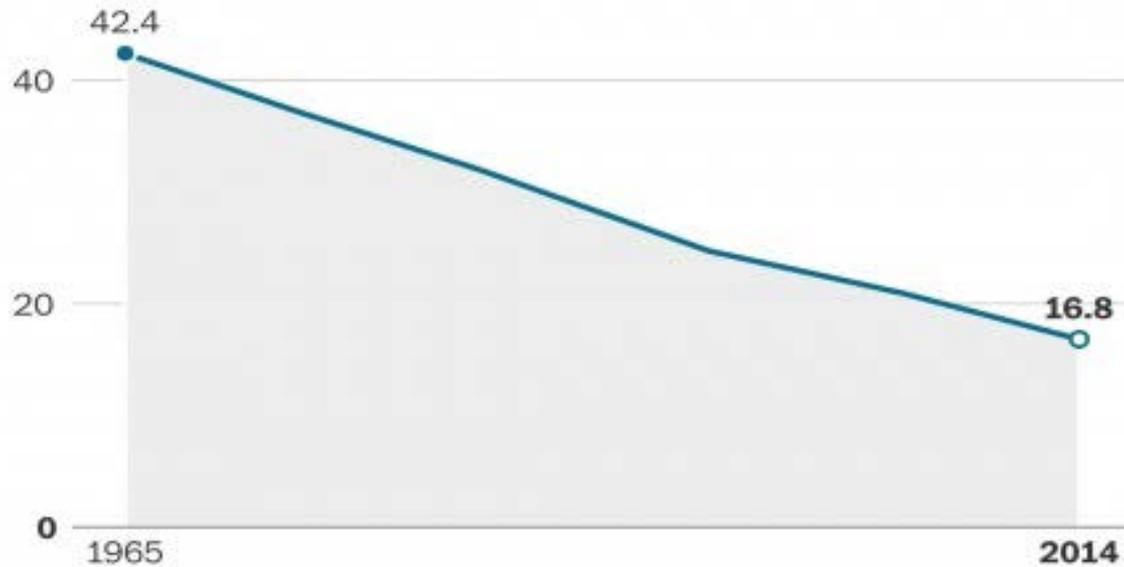
# Overall Impact of Diabetes in the Healthcare System

- The total estimated cost of diagnosed diabetes in 2012 was **\$245 billion**. The breakdown of this cost includes: **\$176 billion** in direct medical costs, which included hospital inpatient care (43% of the total medical cost). Prescription medications to treat the complications of diabetes (18%).

**What is to be Done?**

# Progress Happens

Smoking rate of U.S. adults

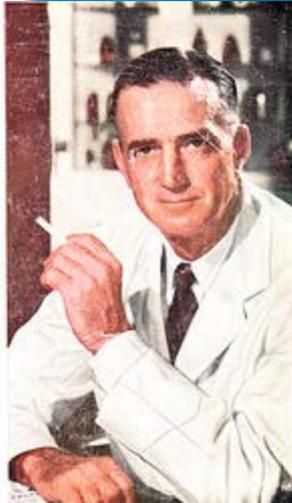


Source: CDC  
THE WASHINGTON POST

# Norms Change...

*According to repeated nationwide surveys,*

**More Doctors  
Smoke CAMELS  
than any other  
cigarette!**

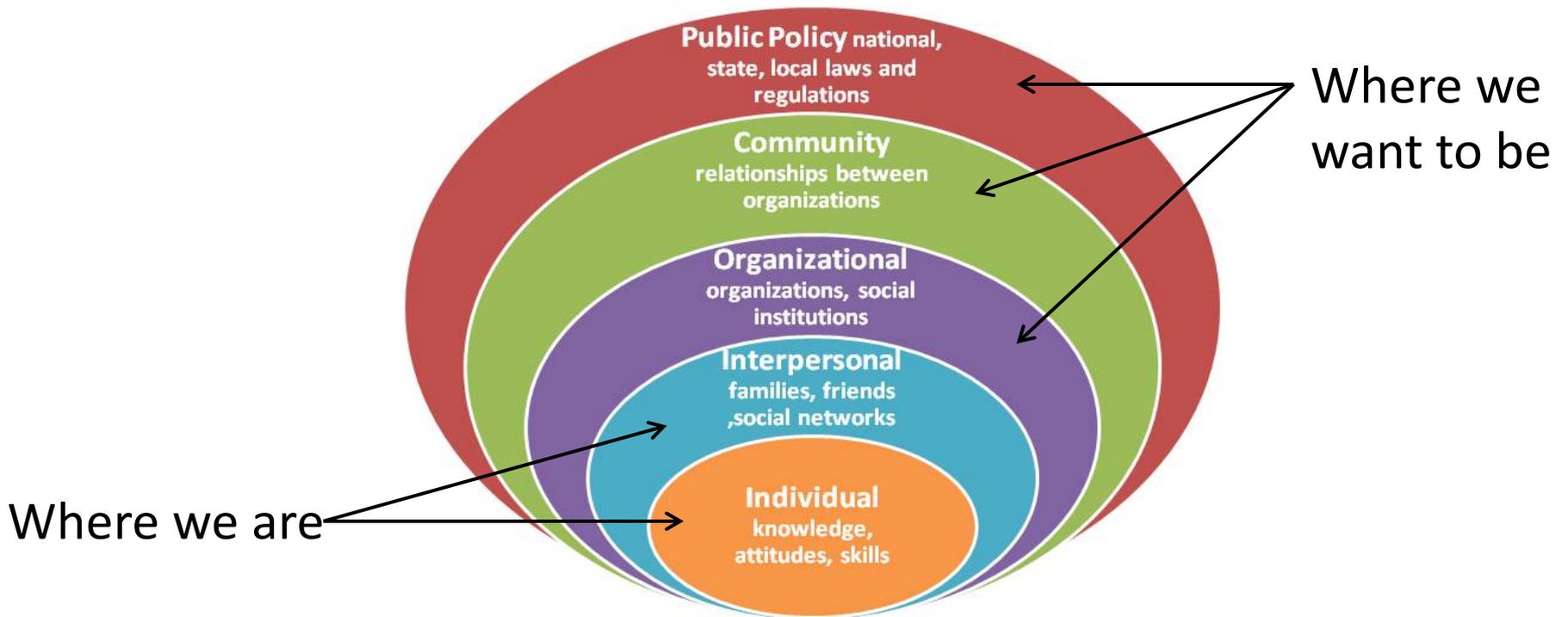


# Norms keep changing...

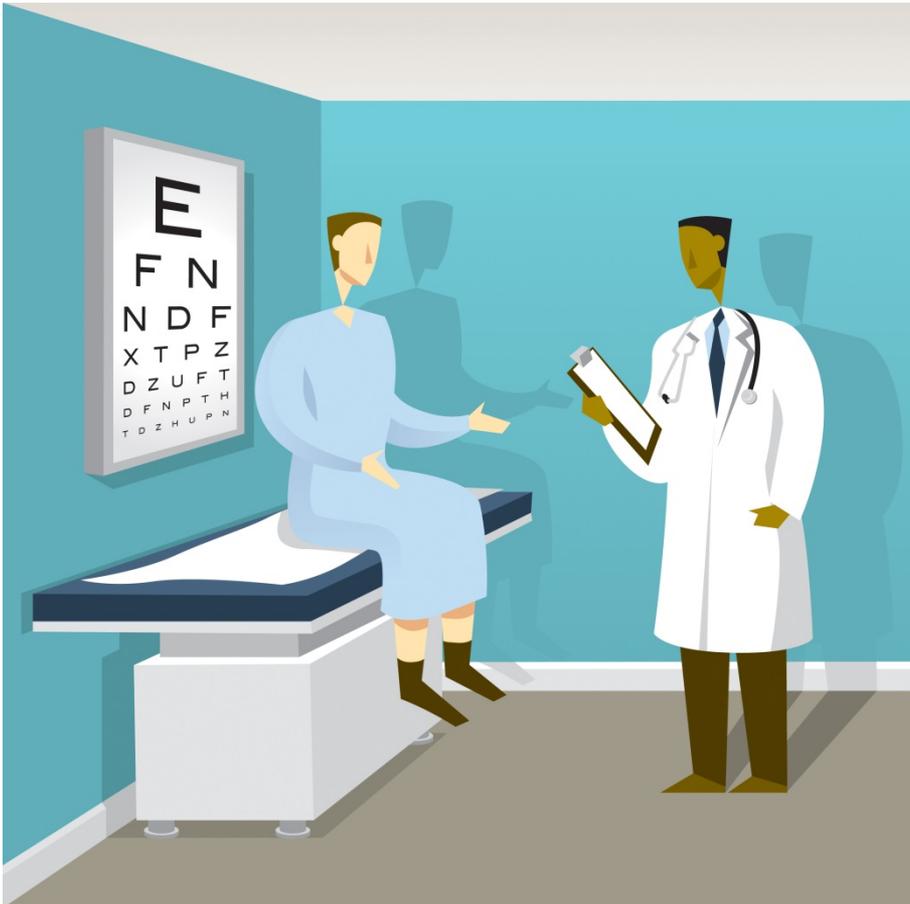


# The Parable of the River

# Social Ecological Model

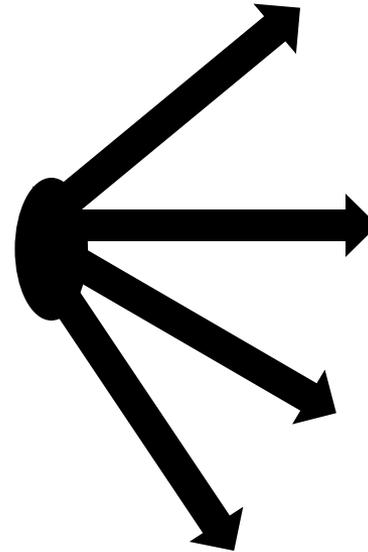


# Old Model



- Patient Care
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism
- Practice-Based Learning and Improvement
- Systems-Based Practice

# New Model = Old Model *Plus*



# New Roles, New (ish) Skills

- Working in partnerships
- Public writing, speaking
- Legislative advocacy
- Leading broad based groups
- Creating a policy strategic plan
- Persuasion across interest groups
- Resilience to setbacks, delays, attacks

# Many Strategies...

## WHO Framework Convention on Tobacco Control: Demand Reduction Measures

Taxation (article 6)	Smoke-free policies (article 8)	Warning labels (article 11)	Bans on advertising, promotion, and sponsorship (article 13)	Cessation programmes (article 14)
<p>Taxes comprise at least 75% of retail price of the most popular brands of cigarettes</p>	<p>All public places completely smoke-free:</p> <ul style="list-style-type: none"> <li>• Health-care facilities</li> <li>• Educational facilities</li> <li>• Universities</li> <li>• Government facilities</li> <li>• Indoor offices</li> <li>• Hospitality venues (restaurants, bars, pubs, etc)</li> <li>• Public transportation</li> </ul>	<p>Large warnings covering an average of at least 50% of the front and back of the package* with all appropriate characteristics:</p> <ul style="list-style-type: none"> <li>• Specific warnings are mandated and rotated</li> <li>• Describing the harmful effects of tobacco use on health</li> <li>• Located on individual packs and any outside packaging used in retail sale</li> <li>• Large, clear, visible, and legible</li> <li>• Written in (all) principal language(s) of the country</li> <li>• Including pictures or pictograms (photographic or graphic)</li> </ul>	<p>A ban on all forms of direct and indirect advertising:</p> <ul style="list-style-type: none"> <li>• National television and radio</li> <li>• Local magazines and newspaper</li> <li>• Billboards (and all other outdoor advertising)</li> <li>• Point-of-sale advertising</li> <li>• Free distribution by mail or other means</li> <li>• Promotional discounts</li> <li>• Non-tobacco goods and services identified with brand names</li> <li>• Brand name of non-tobacco goods and services used for tobacco products</li> <li>• Appearance of tobacco brands or products in television and films</li> <li>• Sponsored events</li> </ul>	<p>A national toll-free quit line, and both nicotine replacement treatment and some or all cessation services partially or fully cost-covered</p>

Gravely, et al. Implementation of key demand-reduction measures of the WHO Framework Convention on Tobacco Control and change in smoking prevalence in 126 countries: an association study. *The Lancet Public Health*. March 2017

# Many Strategies...

## WHO Framework Convention on **Obesity/Added Sugar Control**: Demand Reduction Measures

Taxation (article 6)	Smoke-free policies (article 8)	Warning labels (article 11)	Bans on advertising, promotion, and sponsorship (article 13)	Cessation programmes (article 14)
<p>Taxes comprise at least 75% of retail price of the most popular brands of cigarettes</p> 	<p>All public places completely smoke-free:</p> <ul style="list-style-type: none"> <li>• Health-care facilities</li> <li>• Educational facilities</li> <li>• Universities</li> <li>• Government facilities</li> <li>• Indoor offices</li> <li>• Hospitality venues (restaurants, bars, pubs, etc)</li> <li>• Public transportation</li> </ul> 	<p>Large warnings covering an average of at least 50% of the front and back of the package* with all appropriate characteristics:</p> <ul style="list-style-type: none"> <li>• Specific warnings are mandated and rotated</li> <li>• Describing the harmful effects of tobacco use on health</li> <li>• Located on individual packs</li> </ul>  <p>language(s) of the country</p> <ul style="list-style-type: none"> <li>• Including pictures or pictograms (photographic or graphic)</li> </ul>	<p>A ban on all forms of direct and indirect advertising:</p> <ul style="list-style-type: none"> <li>• National television and radio</li> <li>• Local magazines and newspaper</li> <li>• Billboards (and all other outdoor advertising)</li> <li>• Point-of-sale advertising</li> <li>• Free distribution by mail or other means</li> <li>• Promotional discounts</li> <li>• Non-tobacco goods and services identified with brand names</li> </ul>  <ul style="list-style-type: none"> <li>• Sponsored events</li> </ul>	<p>A national toll-free quit line, and both nicotine replacement and some or all cessation services partially or fully cost-covered</p> 

Gravely, et al. Implementation of key demand-reduction measures of the WHO Framework Convention on Tobacco Control and change in smoking prevalence in 126 countries: an association study. *The Lancet Public Health*. March 2017



caglecartoons.com current.com/blog

# Tobacco and Obesity

## Similarities and Differences, 2007

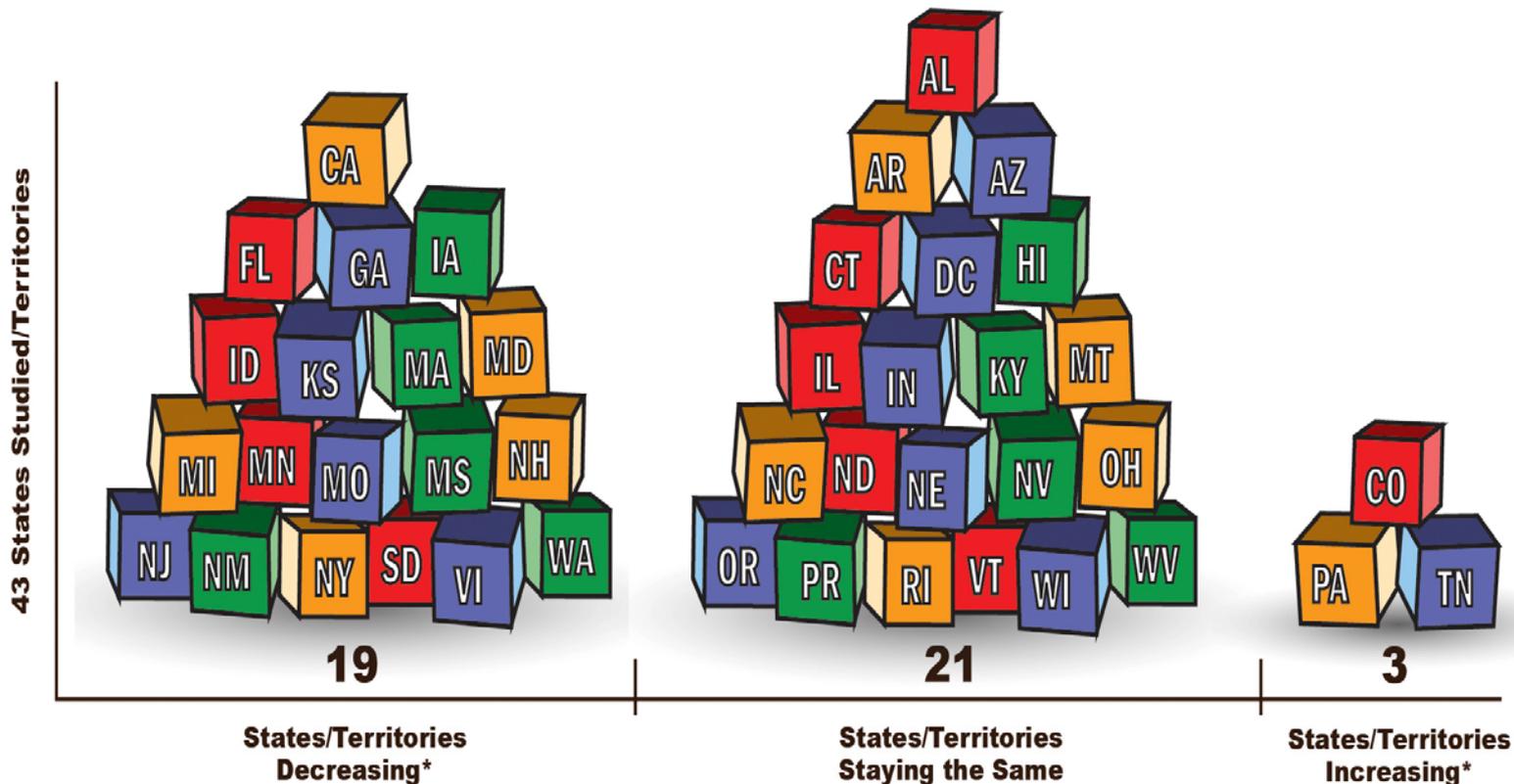
**Table 2. Similarities and Differences between Tobacco Use and Obesity.**

Characteristic	Tobacco	Obesity
High prevalence	Yes	Yes
Begins in youth	Yes	Yes
20th-century phenomenon	Yes	Yes
Major health implications	Yes	Yes
Heavy and influential industry promotion	Yes	Yes
Inverse relationship to socioeconomic class	Yes	Yes
Major regional variations	Yes	Yes
Stigma	Yes	Yes
Difficult to treat	Yes	Yes
Clinician antipathy	Yes	Yes
Relative and debatable definition	No	Yes
Cessation not an option	No	Yes
Chemical addictive component	Yes	No
Harmful at low doses	Yes	No
Harmful to others	Yes	No
Extensively documented industry duplicity	Yes	No
History of successful litigation	Yes	No
Large cash settlements by industry	Yes	No
Strong evidence base for treatment	Yes	No
Economic incentives available	Yes	Yes
Economic incentives in place	Yes	No
Successful counter-marketing campaigns	Yes	No

### Are Differences Changing?

- Chemical Addictive Component
- Extensively documented industry complicity
- Strong evidence base for treatment
- Economic incentives in place
- Successful counter-marketing campaigns

# Obesity rates among low-income preschoolers decreased in many states



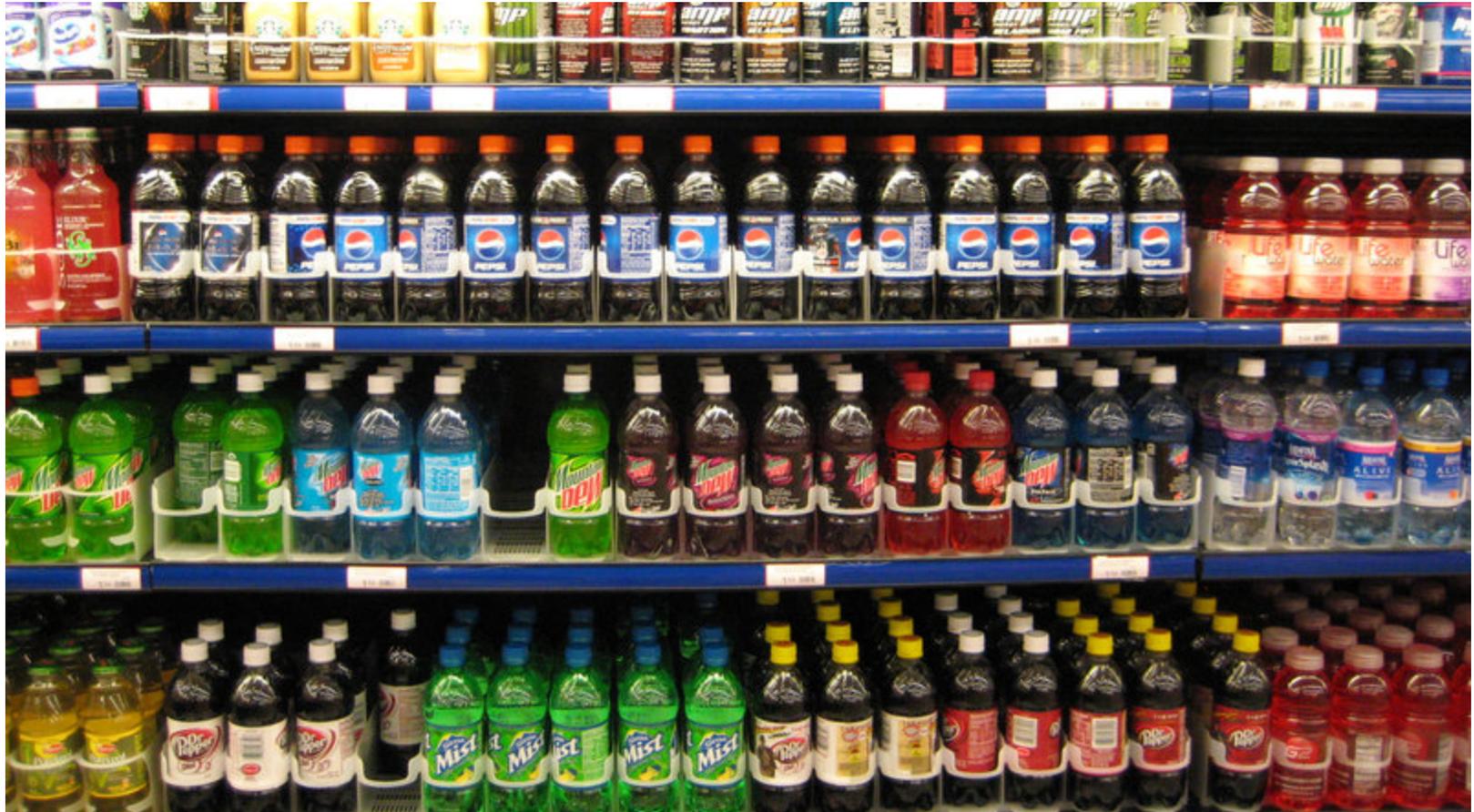
SOURCE: CDC Vital Signs, August, 2013. [www.cdc.gov/vitalsigns](http://www.cdc.gov/vitalsigns). Pediatric Nutrition Surveillance System, 2008-2011. \*Represents statistically significant annual decrease or increase in obesity. To learn more about how childhood obesity is measured, see <http://www.cdc.gov/obesity/childhood/basics.html>.

# Theory of Change

- Key role of civil society
  - Schools, community agencies, businesses, civic groups, unions, sports teams, etc. etc.
- Reflect norms; change norms
- Reflect structures; change structures
- Reflect laws; change norms

# Policy, Systems and Environmental Changes

# Policy: Soda Taxation



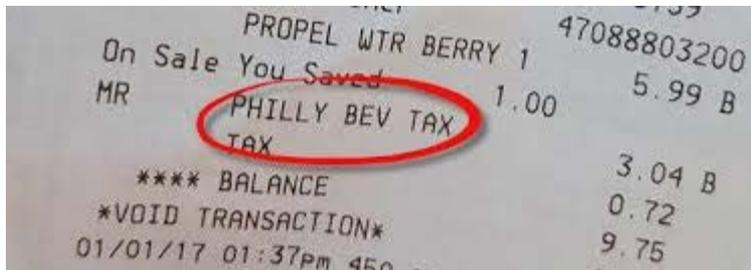
# Soda Taxes Proliferating



- Mexico
- France
- Hungary
- Ireland
- United Kingdom
- Spain



- California x4
- Illinois x 1
- Pennsylvania x1
- Colorado x 1



# SSB Taxation Evidence Base

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## Research

### Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study

BMJ 2016 ; 352 doi: <https://doi.org/10.1136/bmj.h6704> (Published 06 January 2016)

Cite this as: BMJ 2016;352:h6704

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M Arantxa Colchero, researcher<sup>1</sup>, Barry M Popkin, professor<sup>2</sup>, Juan A Rivera, director<sup>3</sup>, Shu Wen Ng, associate research professor<sup>2</sup>

Author affiliations ▾

SCALING BACK

## Sales Fall Again in Mexico's Second Year of Taxing Soda

[Leer en español](#)



**Margot Sanger-Katz** @sangerkatz FEB. 22. 2017

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### In Mexico, Evidence Of Sustained Consumer Response Two Years After Implementing A Sugar-Sweetened Beverage Tax

Expand

M. Arantxa Cochero<sup>1</sup>, Juan Rivera-Dommarco<sup>2</sup>, Barry M. Popkin<sup>3</sup> and Shu Wen Ng<sup>4,\*</sup>

#### This Article

Published online before print  
February 2017, doi:  
10.1377/hlthaff.2016.1231

Health Aff February 2017  
10.1377/hlthaff.2016.1231

» Abstract

Figures Only

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Appendix

Classifications

# Opinion Soda taxes work. We should have more of them.

**T**o the editor: It's a shame The Times reports only some of the data from the recently published American Journal of Public Health article entitled, "Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption." (["Ensuring access to safe drinking water ought to come before a push for soda taxes,"](#) Oct. 21)

The Times correctly notes that consumption of sugar-sweetened beverages did substantially drop in Berkeley after the passage of the excise tax. After that, however, The Times promulgates the Big Soda myth that people will drive to neighboring communities to avoid paying the tax, while in fact, the article showed that sugar-sweetened beverage consumption did not significantly change in the neighboring comparison cities.

The Times also speculates that the decreased consumption of sugar-sweetened beverages might lead to increase consumption of other sweets, while neglecting to note that the article found that water consumption increased after the passage of the excise tax. Reporting the complete data will lead the reader to conclude that taxing sugar-sweetened beverages is an effective way to reduce their consumption and lead to improved health.

*Theodore C. Friedman, MD, Los Angeles*

# Systems Change: Healthy Beverage Initiative

University of California San Francisco

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## UCSF Launches Healthy Beverage Initiative

Health Sciences Campus Will Focus Sales on Zero-Calorie and Nutritious Drinks

By Kristen Bole on May 29, 2015

UCSF Healthy Beverage Initiative



### Most Popular



Surprising New Role for Lungs: Making Blood



New Multiple Sclerosis Drug, Backed by 40 Years of Research, Could Halt Disease



Inspired by Work with Dalai Lama, Eve Ekman Creates App to Map Emotions

# Systems Change: Enrollment in state/national nutrition programs

Qualifying schools sign up for *Let's Move! Salad Bars to School* or *Let's Move! Active Schools* program



The banner features the Salad Bars to Schools logo on the left. The main text reads "Salad Bars + Schools = More Fruits & Vegetables For Children". Below this, statistics are displayed: "\$12,962,429 RAISED SO FAR", "388 SCHOOLS WAITING FOR A SALAD BAR", "2,491,500 KIDS SERVED", and "4,983 SALAD BARS GRANTED". A green bar at the bottom contains the text "We donate salad bars to schools so that every child across our nation has daily access to fresh fruits and vegetables." and a button that says "GET A SALAD BAR IN YOUR SCHOOL".

Let's Move. Active Schools

THE MOVEMENT

SCHOOL CHAMPIONS

PARENTS

RESOURCES & GRANTS

LATEST STORIES

LOG IN

SIGN UP



The banner shows a group of children in a starting crouch on a track. The text reads "Go from #0to60 with Active Schools" and "Join the movement to increase physical education and physical activity in our nation's schools." Below the text is a blue button that says "JOIN THE MOVEMENT".

CHAMPION PROVIDER FELLOWSHIP

# Environment: Complete Streets



- \$2 million allocated to the Bicycle Transportation Plan
- Wider bike lanes
  - Physical separations between bike lanes and cars
  - Citywide bicycling corridor

# Concluding thoughts

- Champion providers will be agents of change at the level of civil society by championing policy, system and environmental actions to prevent obesity
- Si se puede!



# DISCUSSION



# CHAMPION PROVIDER FELLOWSHIP



A close-up photograph of a silver stethoscope resting on a white surface, likely a doctor's coat.

# THANK YOU GRACIAS

