CARDI·OH

Ohio Cardiovascular and Diabetes Health Collaborative

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

In partnership with:

THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

COLLEGE OF MEDICINE AND LIFE SCIENCES THE UNIVERSITY OF TOLEDO

OHIO UNIVERSITY Heritage College of Osteopathic Medicine

Northeast Ohio MEDICAL UNIVERSITY

University of CINCINNATI FAMILY AND COMMUNITY MEDICINE

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OHIO COLLEGES OF MEDICINE GOVERNMENT RESOURCE CENTER

Ohio Department of Medicaid

Project ECHO®

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Cardi-OH ECHO

Weight Management and Behavior Change: Cases and Discussions

March 3, 2022

Cardi-OH ECHO Team and Presenters

FACILITATOR

Goutham Rao, MD
Case Western Reserve University

LEAD DISCUSSANT

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Ohio University

Liz Beverly, PhD
Ohio University

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The Ohio State University

DIDACTIC PRESENTERS

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Case Western Reserve University

CASE PRESENTERS

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University of Toledo Comprehensive Medical Practice

Sherrie Thompson, CNP
University Hospitals MacDonald Women's Hospital

Structure of ECHO Clinics

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Duration	Item
5 minutes	Introductions and announcements
10 minutes	Didactic presentation, followed by Q&A
40 minutes (20 minutes per case)	Patient case study presentations and discussions
5 minutes	Reminders and Post-Clinic Survey

Disclosure Statements

- The following planners, speakers, and/or content experts of the CME activity have financial relationships with commercial interests to disclose:
  - Marilee Clemons reports advising at Novo Nordisk.
  - Kathleen Dungan, MD, MPH reports receiving consulting fees from Eli Lilly, Boehringer Ingelheim, and Dexcom, research support from Sanofi, Dexcom, Abbott and Viacyte and presentation honoraria from Medscape, UpToDate, and Elsevier.
  - Adam T. Perzynski, PhD reports being co-founder of Global Health Metrics LLC, a Cleveland-based software company and royalty agreements for book authorship with Springer Nature publishing and Taylor Francis publishing.
  - Goutham Rao, MD serves on the Scientific Advisory Board of Dannon-WhiteWave (White Plains, NY), a division of Groupe Danone, S.A., Paris, France.
  - Christopher A. Taylor, PhD, RDN, LD, FAND reports funding for his role as a researcher and presenter for Abbott Nutrition and funding for research studies with the National Cattleman's Beef Association and the American Dairy Association Mideast.
  - These financial relationships are outside the presented work.
- All other planners, speakers, and/or content experts of the CME activity have no financial relationships with commercial interests to disclose.

Person-Centered Language Recommendations

The ADA and the APA recommend language that emphasizes inclusivity and respect:

- **Gender**: Gender is a social construct and social identity; use term “gender” when referring to people as a social group. Sex refers to biological sex assignment; use term “sex” when referring to the biological distinction.
- **Race**: Race is a social construct that is broadly used to categorize people based on physical characteristics, behavioral patterns, and geographic location. Race is not a proxy for biology or genetics. Examining health access, quality, and outcome data by race and ethnicity allows the healthcare system to assist in addressing the factors contributing to inequity and ensure that the health system serves the needs of all individuals.
- **Sexual Orientation**: Use the term “sexual orientation” rather than “sexual preference” or “sexual identity.” People choose partners regardless of their sexual orientation; however, sexual orientation is not a choice.
- **Disability**: The nature of a disability should be indicated when it is relevant. Disability language should maintain the integrity of the individual. Language should convey the expressed preference of the person with the disability.
- **Socioeconomic Status**: When reporting SES, provide detailed information about a person’s income, education, and occupation/employment. Avoid using pejorative and generalizing terms, such as “the homeless” or “inner-city.”

Food Choices

Goutham Rao, MD, FAHA

Chief Clinician Experience and Well-Being Officer, University Hospitals Health System

Jack H. Medalie Endowed Professor and Chairman

Department of Family Medicine and Community Health

Division Chief, Family Medicine, Rainbow Babies and Children's Hospital

Case Western Reserve University School of Medicine & University Hospitals Cleveland Medical Center

Learning Objectives

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1. List and describe key influences upon the foods people choose to eat.
2. Describe when and how preferences for specific foods develop from a life course perspective.
3. Describe the impact of the COVID-19 pandemic upon food choices and body weight.

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Chapter 10 - Taste, cost, convenience, and food choices

Adam Drewnowski PhD [1], Pablo Monsivais PhD, MPH [2]

The principal drivers of consumer food choice are taste, cost, and convenience. Each of these domains has its own interdisciplinary research tools, metrics, and

Are there group differences in taste preference?

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› Nutrition. 2019 Mar;59:103-107. doi: 10.1016/j.nut.2018.08.003. Epub 2018 Aug 23.

Sweet taste perception is greater in non-Hispanic black than in non-Hispanic white adults

Suzanne Bowser [1], Nicole Farnsworth [1], Kate Russell [1], Haley Schlechter [1], Shanna Bernstein [1], Amber B Courville [1], Kirsten Zambell [2], Monica Skarulis [3], Ranganath Muniyappa [3]

Affiliations + expand

PMID: 30468933 PMCID: PMC6347533 DOI: 10.1016/j.nut.2018.08.003

Free PMC article

Dietary fat intake among urban, African American adolescents

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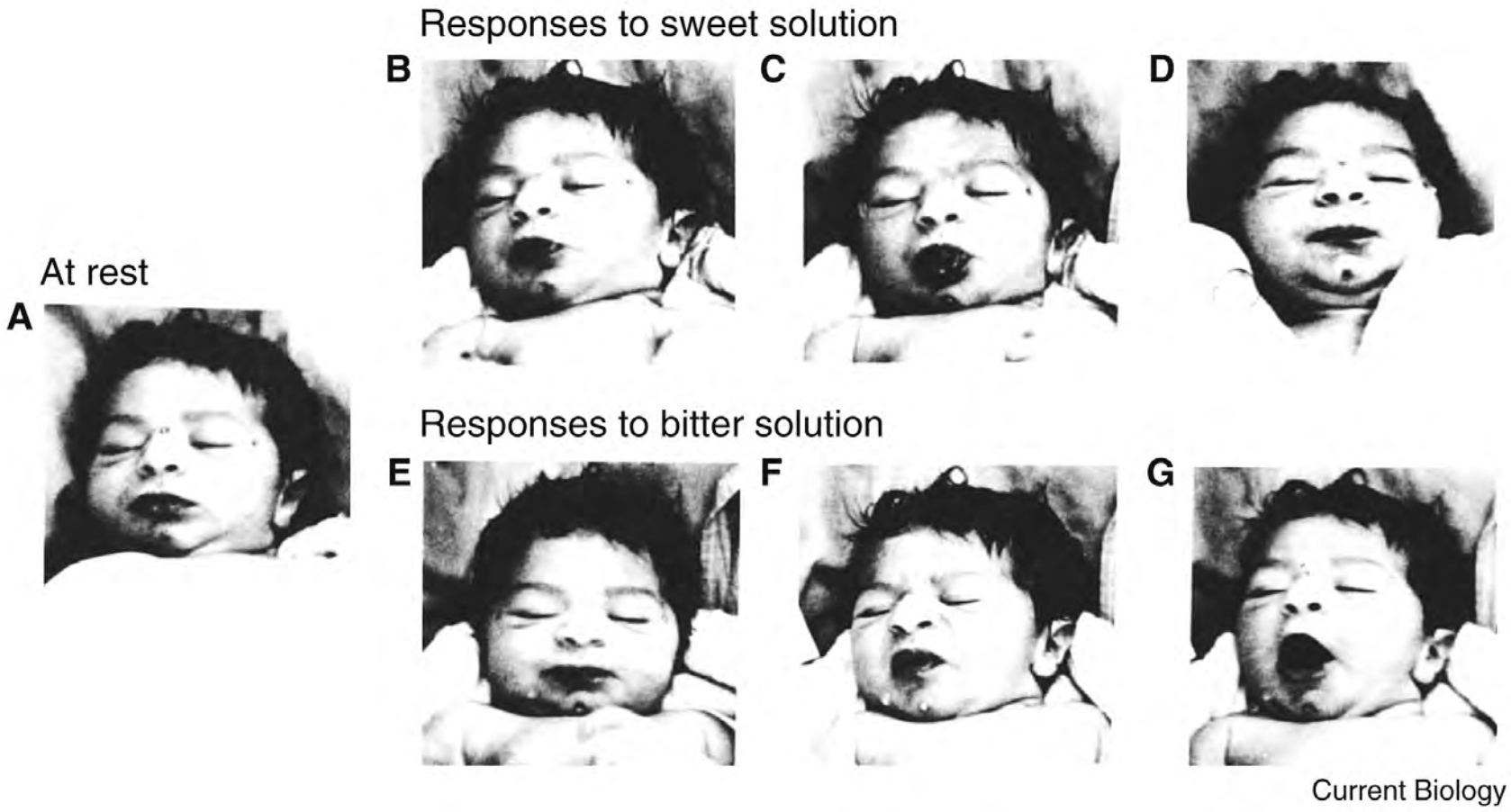
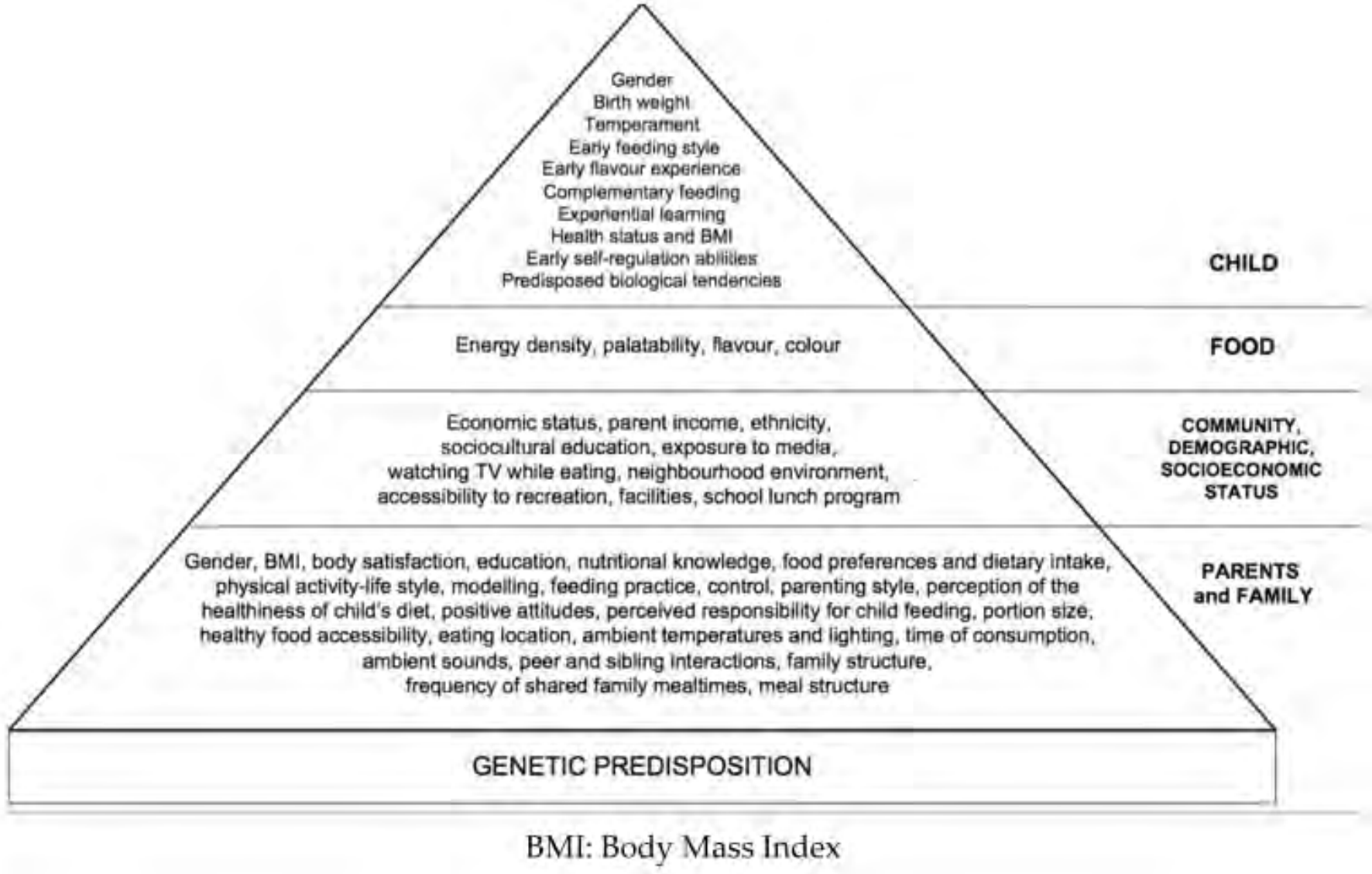
Abstract

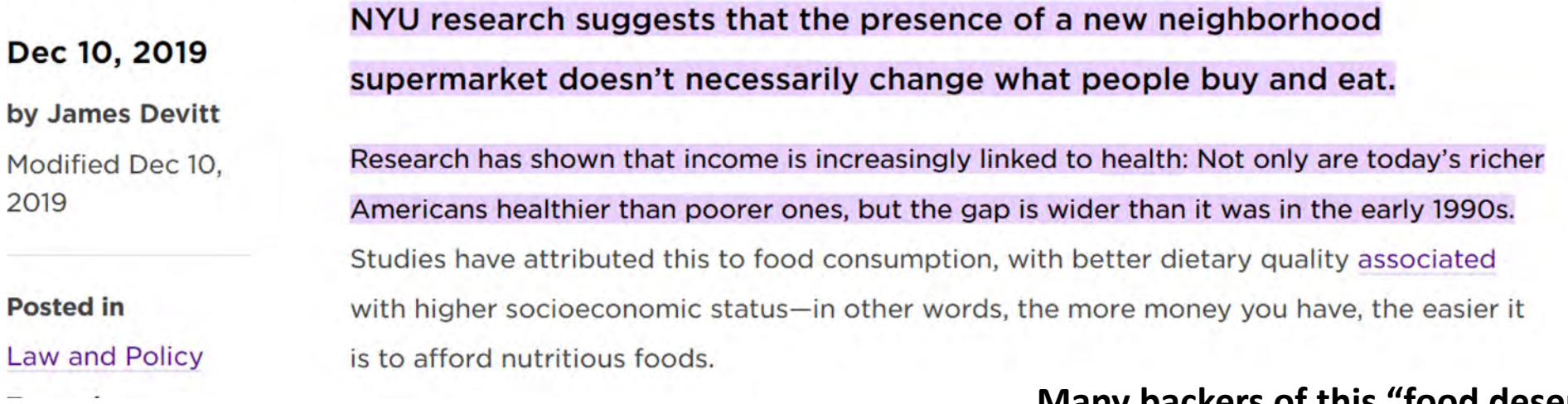
This study examined commonly consumed high-fat food sources to estimate dietary fat intake among 314 urban, African American adolescents (mean age (SD)=12.57 (.98) years; 66% female; 91% African American non-Hispanic; and 9% African American Hispanic). Youths' fat intake was measured using the Block Fat Screener. Most (77%) participants had diets very high in fat (i.e., 40% to 50% of energy). Mean frequencies of consumption revealed youths' preferences for the following high-fat food items: corn chips, potato chips, popcorn, and crackers; fried chicken; and doughnuts, pastries, cake, and cookies. Total fat intake differed based on youths' age. Urban, African American adolescents can benefit from intervention to lower their fat intake. Programs that target and address the food preferences and eating habits of this population are clearly needed.

When are food preferences established?





BMI: Body Mass Index



Dec 10, 2019

by James Devitt

Modified Dec 10, 2019

Posted in

Law and Policy

NYU research suggests that the presence of a new neighborhood supermarket doesn't necessarily change what people buy and eat.

Research has shown that income is increasingly linked to health: Not only are today's richer Americans healthier than poorer ones, but the gap is wider than it was in the early 1990s. Studies have attributed this to food consumption, with better dietary quality associated with higher socioeconomic status—in other words, the more money you have, the easier it is to afford nutritious foods.

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While it's true that these households buy less healthy groceries than people in wealthier neighborhoods, they do not start buying healthier groceries *after* a new supermarket opened. Instead, we find that people shop at the new supermarket, but they buy the same kinds of groceries they had been buying before.

Many backers of this "food desert story" point to distances many must travel to find healthier food options, making geography a barrier to better nutrition. Is there any validity to this claim?

There isn't much support for this explanation. The average American travels 5.2 miles to shop, and 90 percent of shopping trips are made by car. In fact, low-income households are not much different—they travel an average of 4.8 miles. Since we're traveling that far, we tend to shop in supermarkets even if there isn't one down the street. Even people who live in zip codes with no supermarket still buy 85 percent of their groceries from supermarkets.

COVID-19

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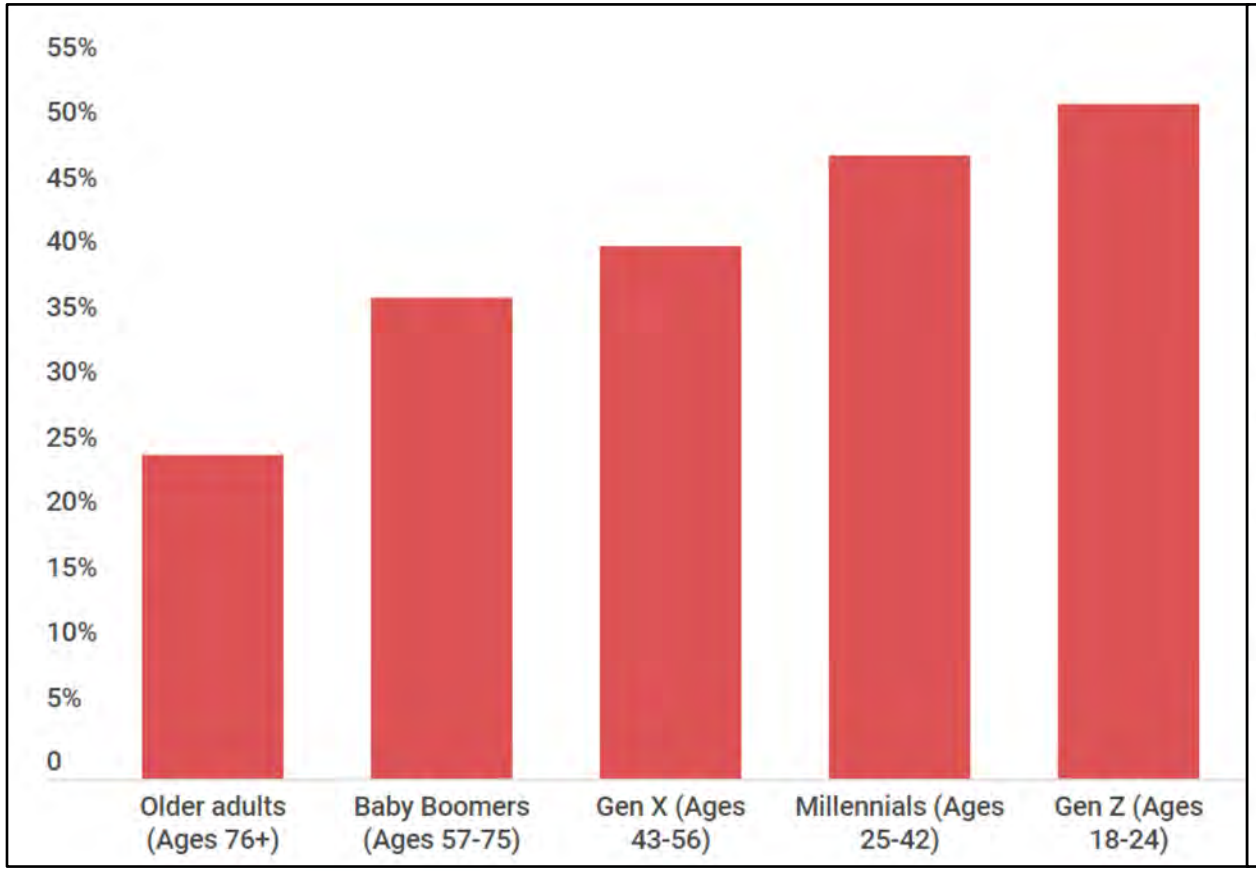
- 42% of Americans reported undesired weight gain during pandemic.
- Among those who gained weight, the gain was 29 lbs. on average.

Undesirable Weight Gain by Group



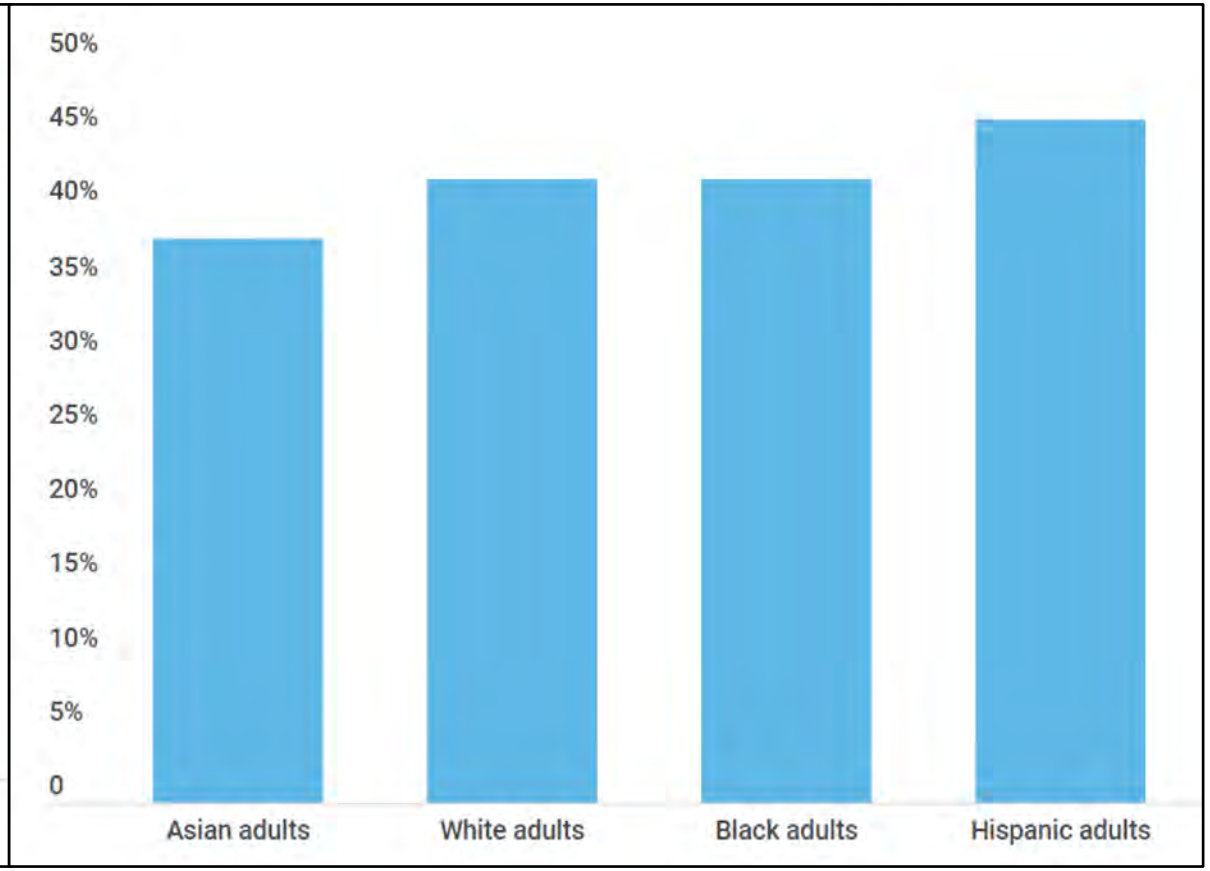


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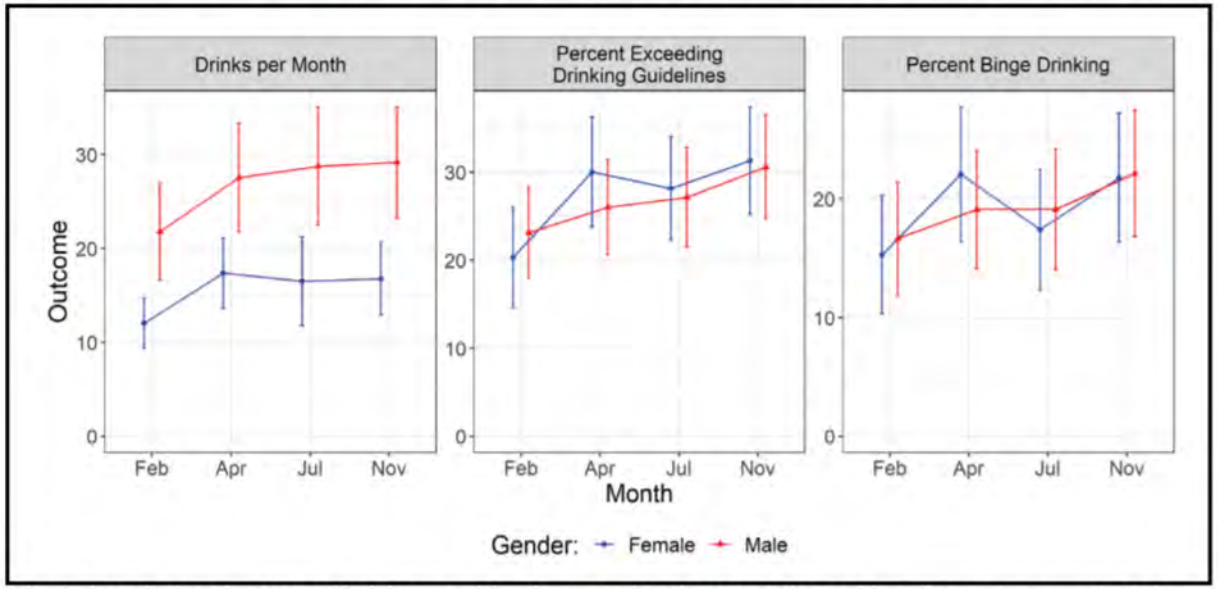
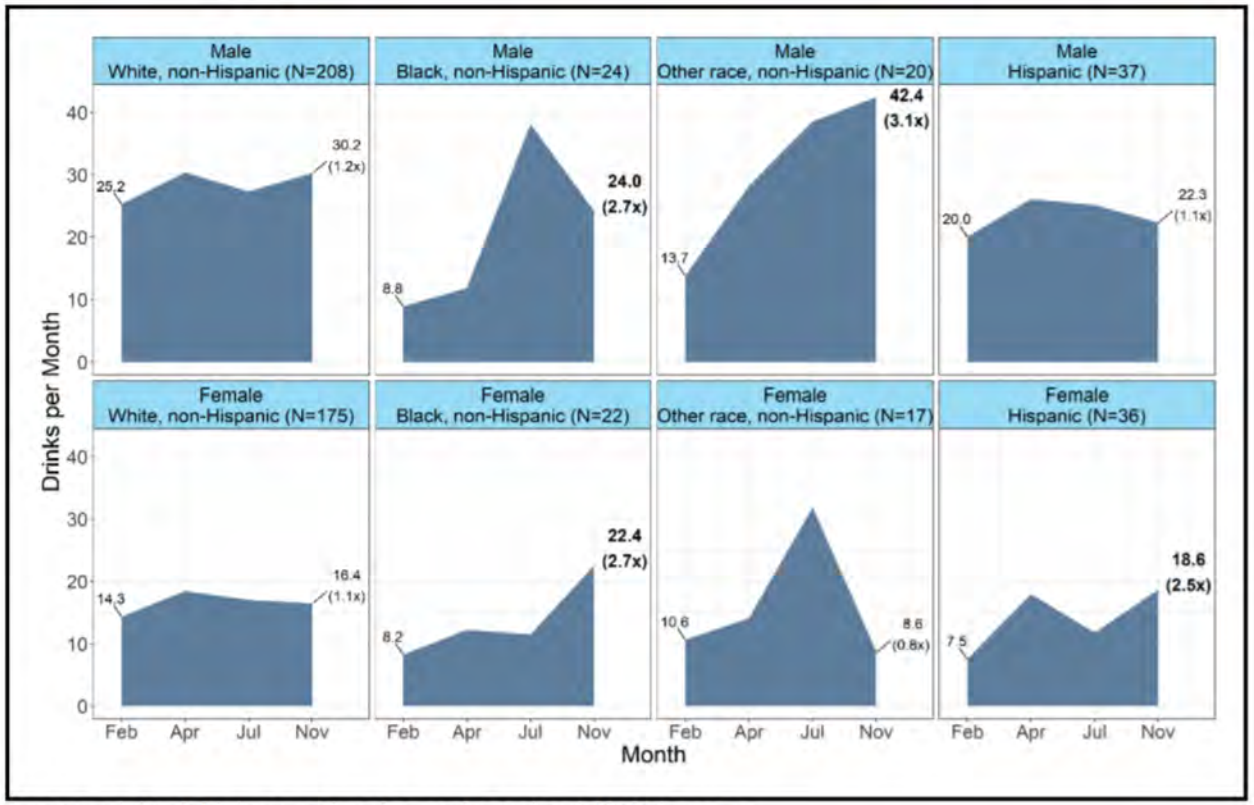
Figure 3.2 Changes in Alcohol Consumption Outcomes: Feb–Nov 2020, by Gender



Adjusted predictions by group. Models control for demographic characteristics and baseline socioeconomic status. The change in exceeding drinking guidelines from February to April is significantly different between groups (p=0.048)

Figure 3.5 Average Drinks per Month Consumed, by Gender and Racial/Ethnic Group



Survey-weighted drinks over time for gender and racial/ethnic groups.

Thank you!

Questions/Discussion