California Medical Leadership Forum for Public Health and Preventive Medicine
49th Meeting
December 9th, 2025, 8:00-9:30 am PST
MINUTES

This meeting used a Zoom account from CAPM with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes,) were attached to the email notice. All attendees except those participating by phone could enter information in "Chat." Web references for agenda topics were embedded in the agenda.

Dr. Hattis began the meeting at 8:00 and announced that **we would focus on "What's New in Nutrition," including current developments in the field and changes in medical training requirements.** Our introductions of participants would be split into two parts, allowing guests and new attendees the ability to introduce themselves. He noted that he had invited the local health department nutritionists through their organization, CCLHDN, and quite a few were on the call today. Ron explained that the Forum is mostly related to physicians, and includes teaching institutions and organizations that interact with or train physicians, departments of state government with physicians in lead roles overseeing our healthcare system, the Surgeon General's Office, and the health officers' association of California. We deal with general public health topics, and he felt it was worth inviting nutritionists so that we can share new information and have a dialogue with different perspectives. The presentation today will be by Jo Marie, Reilly of USC and Traci Stevenson from Touro University.

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1) Approval of Minutes:

Ron said that minutes from the quarterly meeting in September 9th had been distributed and asked if there were any requests for corrections or additions. There were none expressed. Sumedh Mankar, Vice-Chair, called for approval and there were no objections.

2) Roll Call:

There were 23 representatives from entities that are officially part of the Forum, 17 local public health nutritionists, and one other guest, for a total of 41. Sumedh led the roll call, in which typically we would 'popcorn' around the entire group, introducing ourselves and providing updates. Today, it was split into two parts, the first for attendees who might need to leave early. Attendees announced themselves and what organization or school was represented, and some added brief biographical information or announcements or added information in the chat. Attendance and updates from both portions of the roll call are combined below:

<u>California Academy of Preventive Medicine</u>

1) Dr. Hattis, Chair, led the meeting.
2) Dr. Mankar, Vice-Chair, facilitated the roll call.

State of California Surgeon General

Lauren Groves: Office of the California Surgeon General.

California Department of Public Health

1) Jessica Nunez de Ybarra, with the Office of Policy and Planning. Jessica shared work they are doing on a report to address heart disease and stroke, referenced in the Q&A session below.
2) Lisa Bandong is in the same office and serves as Academic Partnership Coordinator.

Department of Health Care Services

Karen Mark

California Medical Association

Alecia Sanchez

Public Health Institute

Marta Induni: Associate Vice President with the Public Health Institute. Has a background in nutrition, lifestyle medicine programs.

Public Health Officers Association of California

Kat DeBerg

Medical Schools

Touro University

Traci Stevenson: Forum Secretary; Co-presenter today.

UC Davis

Jeffrey Hoch

California Northstate University COM

Richard Isaacs, MD: Dean and SVP; Richard.Isaacs@CNSU.edu. He is a head and neck oncologic and skull-based surgeon who worked at Kaiser Permanente for almost 3 decades. This was his first meeting, and he was welcomed.

UC Irvine

Ariana Nelson: They are increasingly integrating nutrition into their curriculum. Ariana also shared that's Southern California is now a hotbed of the commercial space flight industry, and that has started a new conversation about what is nutrition, how is it important for people on Earth, and if we become an extraplanetary species. It sounds like sci-fi, but it's a reality that NASA and commercial spaceflight partners are looking at.

Stanford

1) Eleanor Levin: Preventive Cardiologist with 3 guests, cardiology nutritionists (see below)
2) Amy Reisenberg: MS, RDN, CDCES**:** works at Stanford with the cardiology team. Her focus is on cardiometabolic health noting they see a lot of patients with kidney disease, hypertension, and also diabetes.
3) Jessica Kung: Works as a cardiac dietitian at Stanford. Throughout career, has worked in inpatient settings as well, focusing on cardiac surgery. Jessica loves the prevention side of it and now focuses on preventative cardiology with Amy.
4) Serena Starr: Also with the Stanford Healthcare Clinic, doing dietetic internship, and currently working with Jessica

Loma Linda University

Karen Studer: Chair of the Department of Preventive Medicine and Program Director of the Preventive Medicine Residency Program. Karen shared that she is on the ACGME Review Committee for Preventive Medicine Residencies. She cannot talk on behalf of them but can say they announced in a press release that they are integrating more nutrition into the GME requirements. She added their annual conference in Baltimore this year for ACPM will also have a talk about nutrition and what new developments are happening.

a) Ron asked if Loma Linda had a teaching kitchen and Karen reported yes, adding that the American College of Lifestyle Medicine (ACLM) has different tiers of how much lifestyle medicine they incorporate into the medical school curriculum and Loma Linda is in the top tier. She thinks they call that level Platinum and there are only two in the country right now. It includes culinary medicine experiences. Also, they do culinary medicine in the residency program quite regularly. They are also trying to get their culinary medicine curriculum published on the AMA education site so that it can be free and used for everybody. She also shared that the ACLM also has a lot of free resources including a food is medicine course and things like that they're really trying to push out some things now that nutrition's becoming more popular and mandated to be popular. Theyare trying to help out and she thinks probably, besides Greenville, South Carolina, that they have the most nutrition training among medical schools.
b) Ron then asked Traci if there is culinary medicine at Touro and Traci stated yes, they have quite a bit. They're focused on the undergraduate medical portion, but they have mandatory culinary medicine through all four all four semesters including specific lessons on social determinants of health (SDOH) and cultural competency. She referred to Sumedh's point in the chat about thinking about cultural competency and SDOH.

UCLA

Priyanka Fernandes: Priyanka leads the lifestyle medicine clinic at UCLA, and they incorporate, nutrition into curriculum and med student elective. She also thinks there's also a course available for med students outside of electives.

Charles Drew

Roberto Vargas: Associate Dean for Clinical Partnerships and Health Policy at Charles Drew. They have a newly accredited MD four-year program. At the university, in their third cohort right now, and relevant to this conversation, they're working on the additions to the Standard 7 for nutrition and it was encouraging to hear the presentations. He will be be reaching out to connect some of us with their subcommittee that's working on that.

University Southern California (USC)

Jo Marie Reilly: Co-representative from the Department of Population and Public Health at the University of Southern California, USC. Co-presenter.

UC San Diego

Matthew Allison: A Preventive Medicine physician in the Department of Family Medicine

Public Health Schools

UC San Diego School of Public Health

Margaret Ryan

Local Public Health Nutritionist Guests

Santa Barbara Health Department

Adrienne Starr: Nutrition supervisor, dietitian, and diabetes educator.

Contra Costa County

Ana Flores: Registered dietitian starting a position in Contra Costa County. And was previously working as an inpatient dietitian at Contra Costa Hospital. She is interested in public health and prevention.

Orange County Health Care Agency

1) Gina Osborne, RDN: Supervising public health nutritionist at the Orange County Health Care Agency. gosborne@ochca.com
2) Lindsey Evelyn RD, MPH: With Orange County Healthcare Agency and a public health nutritionist, registered dietitian and has a master's in public health with a track in health promotion and disease prevention. She also works with Gina in the CalFresh Healthy Living Program. levelyn@ochca.com
3) Maridet Ibanez: Retired public health nutritionist but actively involved with CCLHCN. She just retired from Orange County.

County of Monterey

Niaomi Hrepich: Registered dietitian also representing the California Conference of Local Health Department Nutritionists as the local president. Niaomi is with

the County of Monterey, a public health program manager, and oversees all the nutrition programs. She has been there for over two decades and has done WIC and is currently doing the CalFresh Healthy Living (which is not going to be funded after a few more months). There is also a senior meals program**.**

Lassen

Barbara Longo: Currently a board member of the CCLHDN, Barbara is a registered dietitian who also worked for the California State Department of Public Health for about 23 years. Then, she moved on to Lassen County as the Health and Social Services Director for the past 8 years, and got through the pandemic and fires but is retiring.

County of San Luis Obispo

Shannon Massey: Services Program Manager for the WIC program in the County of San Luis Obispo.

Riverside County Public Health

1) Natalie Whaples: Director of Nutrition and Health Promotion. Natalie is a dietitian and a diabetes educator. She is also with the CCLHDN.
2) Christina Rivalcaba: From Riverside University Health System Public Health Department. She is a public health nutritionist for a cardiovascular health innovation program.

Alameda County

1) Annette Laverty, CHS: Annette is part of the nutrition services program, which was funded from CalFresh Healthy Living. Annette.laverty@acgov.org
2) Jackie Russum: Instructor with the Diabetes Program with Alameda County Public Health Department. Jacquelyn.russum@acgov.org

Shasta County

Kristi Ritchie, RD, IBCLC: dietician and lactation consultant in Shasta County with Shasta Public Health. krichey@shastacounty.gov

County of San Mateo

1) Tami Whelen: Dietician; twhelen@smcgov.org
2) Ana Castellon, RDN: San Mateo County. acastellon@smcgov.org

County of Yolo:

Laurie Walker, MS, RD County of Yolo and CCLHDN
Laurie.Walker@yolocounty.gov

Tuolumne County Public Health:

Lisa Hieb-Stock, RD, IBCLC, MPA,. lhieb@co.tuolumne.ca.us

Climate Health, Civic Health

Cynthia Mahoney

3) **Ron introduced the special topic, "What's New in Nutrition," led by Jo Marie Reilly and Traci Stevenson.**
    1) Jo Marie explained that the presentation is likened it to a 'sandwich' with the scaffolding of the bread on either side and the peanut butter and jelly in the middle with her and Traci dividing it accordingly. They are delighted to be invited as it is a really important public health topic as we think of the obesity epidemic and the challenges that so many of us across health professions have, with prevention and chronic disease management in nutrition.
    2) Introduction: Joe Marie Reilly is a public health- trained physician and a family physician and represents the Keck School of Medicine of USC. Traci Stevenson is a professor at Touro University, and is an osteopathic-trained family physician and a certified culinary medicine specialist.
    3) Traci stated the lecture is a 'smorgasbord' of topic commenting that by listening to the introductions felt like they will be 'preaching to the choir,' noting that it's fantastic to have such a nice group of experts with us, and especially RDs, recognizing that partnerships with physicians and dietitians are more important than ever.
    4) The objectives include a brief review of the history of nutrition and medical education, discuss new congressional and AAMC mandates to address GME nutrition, discuss new curricular nutrition competencies for medical students and residents that are coming out, to discuss current evidence-based diets to prevent chronic disease and then take a look at information on toxic food additives, ultra-processed foods, and microplastics. We will finish by looking at some of the federal and state nutrition legislation that's currently going on.
    5) Brief overview of nutrition education: As far back as 1902, physicians at Cornell began expressing concerns about lack of nutrition in medical training. The early 1900s brought the discovery of the energy value of proteins, fats, and carbohydrates, and the relationship between deficiencies in minerals and vitamins and various diseases. This inspired increased interest in nutrition and medicine and this was really the golden age for nutrition education in medicine.
        a. In 1940, the American Council on Medical Education actually studied the role of nutrition in medicine but by 1949, the medical profession somewhat arrogantly thought we knew everything about vitamins. And with the advancement of food technology and fortification, nutrition-related illnesses significantly declined, and nutrition interest diminished as medical training became more fragmented, driven by the increase in subspecialties and increased efforts towards therapeutics and technology.
        b. By the 1960s, there was a renewed interest in formal calls for medical nutrition education. In 1961, the AMA reported that nutrition training in United States medical schools was inadequate, urging schools to develop nutrition programs, stating that residencies should include defined nutritional experiences and that industry and government should allocate funds.

c. In 1969, the White House held its first conference on food, nutrition, and health. Despite these efforts, ongoing reports showed that nutrition knowledge of trainees was inadequate and that recommendations were not usually adopted. Throughout the 1970s, 80s, 90s, and into the 2000s, there were numerous of reports and calls for increased nutrition in medical training.
d. During this time, the Surgeon General's report on healthy people came out and cited the role of diet and health and recommended deficiencies in nutrition education be fixed. At the same time, the U.S. General Accounting Office recommended increased federal funding for medical nutrition education, and there were Senate subcommittee reviews indicating the low quantity and poor quality of nutrition questions on board exams.
e. A 1985 National Research Council Committee on Nutrition and Medical Education recommended a minimum of 25 to 30 hours in the pre-clinical years. Nonetheless, a 2019 report indicated that less than 25% of medical schools were meeting even that minimum recommended amount, renewing calls for improved nutrition.
f. Meanwhile. on the public health side of things, chronic disease related to nutrition, diet, and lifestyle were becoming increasingly responsible for escalating healthcare costs, morbidity, and mortality. The current CDC website states that 90% of the nation's $4.9 trillion in annual healthcare costs are for people with chronic and mental health conditions. Of these, heart disease and stroke account for 1 in 4 deaths. Over 38 million Americans have been diagnosed with type 2 diabetes, and another 98 million with prediabetes. Obesity affects 21% of American children and up to 40% of adults.
g. In 2019, Harvard Law released Doctoring Our Diet, sharing policy tools for medical nutrition training as requirements. In 2022, House resolution 1118, sponsored by Rep. James McGovern, called on medical schools, graduate medical education programs, and other health professional training programs to provide meaningful physician and health professional education.
h. In September of 2022, the Biden-Harris White House sponsored the National Strategy on Hunger, Nutrition, and Health, the first since 1969. In March of 2023, the ACGME followed this up with a summit on Nutrition and Medical Education and published the proceedings.
i. Following this, the American Association of College of Osteopathic Medicine held a “Food as Medicine” Special Summit, calling for all osteopathic medical schools to increase nutrition education across all aspects of medical training, including CME.
j. In September 2024, JAMA published an expert consensus statement on proposed nutrition competencies that should be required in medical

school. Contributing authors included members of this forum, including Jo Marie and Karen.

k. In August of 2025, the current Department of Health and Human Services called for comprehensive medical training on nutrition across all facets of medical education, and the HHS directed medical schools to submit written plans that detailed the scope, timeline, standards alignment, measurable milestones, and their accountability measures of nutrition education commitment.
l. The Department of Education also weighed in on that mandate, and in September of this year, the AAMC published their response to the government, outlining a commitment to advance nutrition with three specific areas of effort, including a position statement and call to action to address nutrition and chronic disease, integration of nutrition education at annual meetings, and convening a best practices in medicine education, which will be in April of 2026.
m. The LCME is in the process of proposing changes to Standard 7, which would add Element 7.3 to include the role of prevention and management of chronic disease related to nutrition. This is currently open for public comment, and they will review it at their February 2026 meeting.
n. For over 125 years, we've been struggling to improve nutrition education and amazingly, there is some bipartisan effort spurring this current momentum.
o. Ron asked if this effort includes continuing education for the majority of physicians who are already out in practice, rather than just training the new students? Traci responded that yes, the call to action does include that. Ron added that as a reassurance to our public health nutritionists on the call, this, this forum is especially interested in medical education and we have representatives of the schools of medicine and of public health, throughout the state but we will be also, considering the general public health recommendations, that health departments are bound to promote throughout the communities.

6) Jo Marie added that the education of medical students and residents has been one of our big challenges. There have been been some ‘carrots’, but no ‘sticks’ to make sure this really happens. She noted that we have a whole team that educates people in health professions about nutrition, including our dietitians on this call. Often, however, physicians who are not prepared in this area drive the directions of medical training, and do not have conversations with the dietitians to advance this.
7) Jo Marie shared that one of the great things that happened this last year is we've now published competencies. We can tell medical schools that they have to have at least 20 to 25 hours over the course of 4 years but, we need tell schools what they need to train, so that there's consistency and standardization across schools.
8) This was a national effort to put together these competencies and what came out of that are 36 sub-competencies, which were subdivided into 6 competencies.

a. 34 of those sub-competencies are across medical schools, and 2 were only, specific to residency education.
b. The 6 main competencies include foundational nutritional knowledge, assessment and diagnosis, communication skills. One of the key features of the new communication skills is that physicians in training must have the ability and the knowledge of what a registered dietitian is, who our colleagues are that also train in nutrition, and how do we make those referrals.
c. There is also a sub-competency on public health and public health nutrition and social determinants of health which is very relevant to this call, and collaborative support and treatment across other health professions, and indications for how to make referrals.
d. These competencies are very comprehensive and were done over almost a year and a half process with a national group of experts in nutrition.
e. As schools and residencies are trying to find curriculum to put these competencies into my education, they are using evidence-based tools to find that curriculum. Jo Marie shared links to the following national bodies that many are using.
    i. Teaching Kitchen Collaborative
    ii. American College of Lifestyle Medicine, ACLM.
    iii. Health Meets Food, which is out of Tulane
    iv. Culinary Medicine.
f. This is just the beginning, as many things still are in the works and need to be addressed. This includes that there are no standards in the MCAT to give any person starting medical school any standards and any foundation as they enter medical school of any nutritional content noting that the medical schools still have a lot of work to do in curriculum integration.
    i. The medical licenses exams still have very few, questions that reinforce that medical educators need to put into their training nutrition content.
    ii. Jo Marie pointed out that if you don't have to be tested on something, you're not going to read it, and it’s not going to be emphasized. She stated we still have a way to go to catch up and make sure that our licensing exams reinforce nutrition content.
    iii. There are really no standardization requirements in residency education, and the goal of these standards that we talked about are really across all disciplines. We find tremendous deficiencies in the literature on our cardiologists, on our GI physicians, on our vascular surgeons, many of whom are treating our patients who have long-term outcomes of poor nutrition and chronic disease and diabetes. We need to make sure that we are getting our residents appropriately trained as well.

iv. Board certification also does not have any kind of "stick" to reinforce that our physicians who are already practicing are required to have additional training. There are two exceptions in that, and one is the state of Louisiana and the other state of Texas, that require that physicians have a certain number of hours in nutritional continuing medical education for licensure. No other states have so far done that. We're hoping that that might happen. Some of you in this state who are physicians might remember that we have had required licensure requirements on pain and end-of-life care, so our hope is that nutrition might also be added.

9) Next Jo Marie transitioned to discussion about evidence-based diets, noting this is not comprehensive, and each of these diets is a lecture in and of itself. The hope is to give you the highlights of the diets that are mostly being used now that are evidence-based that are meeting the macronutrient needs, the micronutrient needs, and their energy needs of people.
    a. Most of the national organizations that look at chronic disease management and prevention recommend five evidence-based diets. They include the Mediterranean diet, the DASH diet, the MIND diet, plant-based diets (which are particularly endorsed by the ACLM), and the vegetarian or vegan diet. Jo Marie provided links for anyone interested in a deeper dive.
10) The Mediterranean diet is probably the one that most are aware of and is most published. She noted, however it has not been standardly taught in medical schools and residencies.
    a. When we do studies of practicing physicians, national studies tell us that fewer than 20% of physicians in practice feel comfortable talking about these diets. They know what they are, but ability to educate patients where you can actually make a difference is remarkably low.
    b. The Mediterranean diet has a foundation of plant-based foods. It includes fish, poultry, eggs, cheese, yogurt a few times a week, with meats and sweets less often. When you look at the pyramid you see that red meats are few and meats and proteins are just a few times a week.
    c. The foundational standard is exercise, and social eating together in a community, with the foods the lowest on the pyramid (making up most of the diet) being fruits and vegetables, and whole grains, olive oil, and alcohol at a minimum.
    d. This diet actually has evidence and is probably the most studied of all the diets presented today. It has shown in both large population studies and randomized clinical trials that it reduces the risk of heart disease, metabolic syndrome, diabetes, certain cancers, particularly colon, breast, and prostate cancer. It also impacts depression in older adults, reduces the risk of frailty, and improves mental and physical function in people who partake in this diet on a regular basis.

11) The second diet we want to talk about is the DASH diet. This is the Dietary Approaches to Stopping Hypertension diet, and it has a lot of similar features to the Mediterranean diet. This one emphasizes fresh whole fruits and vegetables and whole grains.
    a. Jo Morie noted that the DASH diet also emphasizes decreasing foods and saturated and trans fats and focuses on lowering sodium.
    b. The DASH diet has two components to it. The regular DASH diet recommends limiting sodium content to no more than 2,300 milligrams of sodium a day. The really restricted DASH diet recommends reducing the amount of sodium to 1,500 milligrams a day.
    c. 2,300 milligrams of sodium a day is a teaspoon of table salt, your old Morton table salt. Sodium of 1500 milligrams a day is reducing your sodium intake to only about 3 quarters of a teaspoon. If you put that in a baggie and show it to students, or look at it yourself, it's really not much sodium when you think of all the hidden sodium and the food contents that we eat.
    d. The research has shown that the DASH diet lowers blood pressure. This diet also has been shown to improve cardiac health, probably particularly because it's looking at saturated fats and sodium by lowering cholesterol and blood pressure. It also helps in weight management. We also know that this diet will help with blood glucose with diabetes, it's been shown to lower triglyceride levels, and and also certain cancers.
    e. This diet also, in substituting out sodium for other minerals, is rich in other nutrients, particularly potassium, magnesium, and calcium which also helps overall health.
12) Our third diet is the MIND diet (Mediterranean-DASH Intervention for Neurodegenerative Delay). The MIND diet is an integration of the Mediterranean and DASH diet and has a focus on integration to promote brain health and to prevent cognitive decline and reduce the risk of dementia.
    a. It includes a lot of leafy greens and berries, nuts and whole grains, and also limit the amount of butter and cheeses and red meats.
    b. The health benefits of this diet, particularly, again, are looking at brain health, is preserving brain function and slowing cognitive decline, reducing dementia risk, improving heart health. It focuses also on anti-inflammatories and antioxidants, working on weight management and this diet has also had some evidence that it has a lower risk of diabetes and things.
13) The fourth diet that we wanted to mention is the ACLM, the American College of Lifestyle Medicine, emphasized diet, which is a plant-based diet.
    a. It particularly is looking at whole foods and whole plants, such as fruits and vegetables, whole grains, legumes, nuts, and seeds. It doesn't completely exclude animal proteins but really wants to focus on whole foods.

b. Evidence looking at plant-based diets show a lower heart disease, type 2 diabetes, a number of cancers and lowering saturated fats and high fiber. Plant-based diets have evidence showing benefits with improved blood pressure, reduced inflammation, helping with weight management, and a positive impact on gut health.

14) The fifth diet that we wanted to highlight that is evidence-based is actually a group of vegan and vegetarian diets across their permutations.
    a. Vegetarian diets focus exclusively on plant foods, fruits and vegetables, different types of beans and peas, grains and seeds. There's no single type of vegetarian diet. Lacto-ovo-vegetarian diets include eggs, and products from dairy area
    b. A vegan diet excludes all meat and animal products so there are no dairy or eggs, and some of the proteins in gelatins and things that people don't even think about are also excluded in the vegan diet. This diet is, showing protective effects against the development of obesity and diabetes, hypertension, CHD, and certain types of cancers, and cognitive decline.
15) These are the five main diets we wanted to introduce that have evidence bases to them. Jo Marie added that we didn't include the keto diet. The keto diet has some evidence for it; however, the keto diet is one that has some of the challenges. The evidence is growing that maybe it will lower calorie intake in general, but it's a challenging to maintain, and we see increased incidences also of kidney stones.
16) Ron asked us to touch on popular diets that contribute to obesity. Jo Marie stated that she thinks the general diet contributes to obesity, but the popular diet would include ultra-processed foods.
    a. She showed a number of slides looking at the higher intake of ultra-processed foods, sugary drinks, and foods that are high in refined grains and unhealthy fats. Compared to unprocessed diets, weight changes are significant if you go on an ultra-processed diet. (the diets that we just mentioned, the five evidence-based ones)
    b. Jo Marie referenced slides with sugared beverage noting that soda, particularly Coke, has 10 teaspoons of sugar. If you put that in a baggie and hold it up to people, it's quite impressive.
    c. Standard juice has 8 teaspoons of sugar.
    d. Sports drinks, like our Gatorades, have 5 or 6 teaspoons of sugar per serving.
    e. A lot of patients are drinking huge amounts of these, and the amount of refined sugar is enormous. These ultra-processed diets really are contributors to obesity and contributors to our 40% of Americans who are overweight, and our 20-plus percent of American children who are overweight and obese.
    f. Diets that are ultra-processed and sugary drinks are contributing to cardiovascular disease, diabetes, obesity, metabolic syndrome, cancers, dementia, decrease in brain function, multiple chronic diseases, including

chronic kidney disease, GI challenges, asthma and all cause cancer mortality.

17) The next slide looked at the types of unprocessed and processed food noting that unprocessed or minimally processed foods are what we're trying to encourage all our patients to go to, and how to learn how to counsel patients on this.
18) Jo Marie Reilly noted that many times what happens with physicians who have short time periods with patients in offices for 20 minutes or so, they'll tell patients that they need to lose weight and exercise, but patients already know that. Our goal is really to try to help.
    a. She asked how we can teach people and give them handouts and referrals in small ways to learn? How can we give people nuggets and pearls in even the exam room? And how can we as, physicians and dietitians live out and role model that for our patients?
19) Jo Marie referenced links to the diets before turning to talk about some of the latest toxic food additives and regulation to try to eliminate them from American food products. Thie is legislation targeting removing petroleum-based dyes.
    a. There's 6 that are out there including green dye number 3, red dye number 40, yellow dye number 5, number 6, blue dye number 1, blue dye number two that the FDA is working on phasing out.
    b. She noted that it's kind of scary that there are 40 different red dyes out there. Maybe we should eliminate all of them. The slide demonstrated the dyes that are currently on the docket. There were slides of some of the cereals, noting they're the things that look pretty in the food that we eat. Those ultra-shiny, bright, colorful things. And there's evidence now in these particular additives, that they have health effects, particularly in children, and they're part of a broader national initiative to reduce the consumption of petroleum-based chemicals.
    c. These have been linked to hyperactivity, ADHD, behavioral issues in kids, cancers in animals, hypersensitivity reactions in adults and animals, and genotoxicity. And they have no nutritional value. These "empty carbs" are high in sugar and have other potential significant, dietary impacts.
20) Other developments on toxic food additives targeted now in legislation are the brominated vegetable oils that is an emulsifier that's being phased out and will be in effect in 2027. Also, potassium bromates, red dye number 3, promoparabin, (preservative). Titanium dioxide, (whitener) is currently being scrutinized, it is in a lot of the teeth whiteners.
21) There are also other preservatives and sweeteners that are out there and Walmart has a plan, in 2027 to remove all products that it sells in its store that include potassium nitrate and artificial sweeteners.
    a. Other food dyes and examples referenced include Cheerios. In contrast to plain Cheerios, some of the flavored Cheerios, like, the Very Berry Cheerios, instead of using natural coloring, are using, some of the dyes

that we talked about that are toxic. Nationally, we're trying to make dye-free cereals.

22) Touching briefly on environmental food contamination, Jo Marie shared sources of non-infectious food contaminants. Environmental contamination can come from the heavy metals that are in polluted soil and water, which our animals also eat and then get into food or absorbed in the soil that our plants and vegetables grow in. There are residues of pesticides, but also substances that are naturally present in some foods, or that are formed during processing. Mycotoxins are found in moldy food production, and might persist even with cooking. She noted there is cross-contamination of microorganisms and contaminants on food surfaces that people don't always realize that have significant health effects. They can lead to acute illnesses, and there are long-term health problems that include chemical contaminants over time that might damage organs like the brain and kidneys.
23) Two things that are common in environmental food contamination include bisphenols and the phthalates and microplastics.
    a. The bisphenols, like BPA are endocrine disruptors. They mimic hormones and cause health issues, particularly reproductive health problems.
    b. We've seen increase in poly-cystic ovary syndrome (PCOS), infertility, and metabolic disorders in our patients, including obesity, heart disease, etc., and there's some evidence that these might be linked to some of the bisphenols that are increasingly in environmental contaminants in our food. They might interfere with cellular signaling and impact children as they're growing up.
    c. The phthalates are also endocrine disruptors and interfere with hormones, but in addition there is some evidence that also links them to reproductive problems, particularly male infertility, which is also on the rise.
    d. These are linked to disorders in neurocognitive development, which are also on the rise, including ADHD and learning issues in kids, asthma, obesity. Of course, these are multifactorial, but there's an increasing look at how these might be impacting these environmental food contaminants, might be impacting, our health and the overall health of children as they grow.
    e. Microplastics are found in everything. Jo Marie shared a picture of things that we store our food in and noting any standard food places, even places that we might be healthier, have foods stored in these plastics and plastic containers. They are also in personal care items, including cosmetics and fragrances, even the dust on our body, body fluids, blood, urine, breast milk, placenta organs, all have been found to have not only bisphosphols and phospholates but also microplastics. There’s the thought that maybe these are leaching in from plastic containers into the food that we consume, enter our bodies via ingestion, inhalation, and skin absorption, and contaminating nearly everything that we eat. And how does that then

impact our overall health? There is an emphasis on using glass containers and other containers to store our foods.

f. Jo Marie also shared a slide to look at the environmental food contaminants, and the distinction between the additives, which are the BPAs and phthalates, that build plastic properties, and the microplastics that are the broken-down plastics themselves and that act as carriers in our bodies. The interactions between the microplastics can absorb and transport the biphenyls and the phthalates making them a double threat to our health. They have been linked to micro-challenges, including oxidative stress in our body, DNA damage, leading to metabolic disorders and organ dysfunction, neurotoxicities, challenges with our immune responses, challenges to reproductive and developmental toxicities.

24) Jo Marie invited anybody with increased expertise in these areas for future discussion as an intersection of public health and medicine presentation to this group.
25) She noted that complications with ingestions lead to reproductive issues, metabolic and cardiac disease challenges, certain cancers, neurologic and developmental problems noting that there's been a particular look by this this administration on ADHD, neurogenerative health, and learning difficulties in children and older adults.
26) There are a number of studies in the literature linking the ingestion of these substances to potential challenges with cellular and genetic damage.
27) Jo Marie then turned it to Traci to highlight what laws we can get involved in, read more about, and advocate for that might help us with nutrition initiatives and advocacy.
28) Traci noted one thing on top of our mind right now with Congress and the so-called Big Beautiful Bill is cuts to SNAP. It's an ongoing discussion but she did note that the HHS actually did have some changes that included expanding Head Start and $61.9 million to nutrition services for children and families within that area although there's concern that with the budget cuts it might not actually happen. There is a little bit of effort going to nutrition services despite the cutting back of SNAP at the same exact time.
29) Traci shared a slide about the Food Research and Action Center (FRAC), a non-profit, nonpartisan group that watches different legislation around food. They're a great website for resources and includes some of the main bills on food access that are in Congress right now. There's also one on SNAP-related funding, early childhood funding, and then a specific legislation looking at how to maintain WIC-related funding.
30) Some of the general initiatives that MAHA particularly speaks to is looking at ultra-processed foods, and in July of 2025 the HHS with FDA and USDA stated that they plan to gather information and data on ultra-processed foods to establish uniform definitions. This is important because we can't make regulations, recommendations or do research without a uniform definition. In September they also advocated for a shift from those highly processed foods to whole food-based foods for populations in need. And in fact, the USDA did approve certain state waivers that would restrict the ability

to buy ultra-processed foods with SNAP benefits. However, there still is a lack of a clear policy, and loss of funding may affect these goals, so we just need to keep an eye on it and be advocates.

31) She stated the government is also requesting manufacturers to voluntarily remove synthetic dyes from food. Unfortunately, it does not seem to reflect public health hazard-based analysis and prioritization, but more of a general voluntary removal.
32) Likewise, there is a mandate for manufacturers to notify FDA of self-affirmed, generally regarded as safe ingredients but there are no specifics, only asking for voluntary cooperation with the White House.
33) Traci stated they also are trying to phase out petroleum-based synthetic dyes and have established a standard timeline to do that. These include many of those same colors Joe Marie already spoke about and they authorized new coloring with natural colors into the cereals. They have said they're going to partner with the NIH to actually fund research on how additives affect children and have requested companies to voluntarily remove at least red number 3 sooner than the current 2027-2028 guideline. That's what's coming out of the federal government.
34) Switching to California, there has been the Real Food Healthy Kids Act that passed in October of this year and it's the first in the nation to phase out harmful ultra-processed foods from our school system.
35) California also established the first-ever statutory definition of ultra-processed foods, so maybe that will guide the federal government as well. It's listed generally as any food or beverage containing one or more specified functional ingredient, and either high amounts of fat, sodium, or sugars, non-nutritive sweeteners or other substances. With this bill, the Department of Public Health is tasked to identify the most harmful ultra-processed foods that will be taken out of the school lunch system.
36) In October, the California Food Safety Act that would prohibit manufacturing, selling, and so forth of foods that have the brominated vegetable oils and red dye 3 was passed. Brominated vegetable oil is used in a lot of the sodas, anything that has a citrus base to keep it from spilling out, so all those kids' sodas have the brominated oils in them.
37) They've also passed the California School Food Safety Act, and as effective of December 31st of 2027, those 6 dyes will be banned from our school system’s food in the state of California. California has been trying to lead the way on this.
38) In 2024, there was a legislative package to increase enrollment in our state food programs, reduce youth consumption of processed foods, and look to support our farmers and environment, increase access to locally grown food.
39) In April 2025, Sunbucks was passed, which gave children and families funding to buy fruits and vegetables on an EBT type card. We are also the first state in the country to provide universal school meals, K-12, regardless of income and that includes two meals a day and is in collaboration with Farm to School programs.
40) California is also the first state to codify President Biden's federal guidelines on nutrition standards for reduced sugar and salt in the school meals. The bill included a

process to maintain standards even if the federal standards change or get lowered. And we've had a long ban on sodas in public schools.

41) Traci shared, ‘straight off the press,’ just a few weeks ago the city of San Francisco filed a lawsuit against top food manufacturers arguing that ultra-processed foods are responsible for a public health crisis. It seeks a court order preventing companies from deceptive marketing and requiring them to take actions such as consumer education on the health risk of those ultra-processed foods and limits the advertising and marketing to kids. It also asks for financial penalties to help offset the healthcare costs caused by the consumption of these ultra-processed foods.
42) Finally, Traci said they wanted to end with a consideration or call to action.
    a. As Jo Marie mentioned, only two states, Louisiana and Texas, have mandates for medical nutrition in CME and they're actually pretty low. The Louisiana law requires 1 hour of medical nutrition or metabolic CME every four years, where the Texas bill is worded towards mandating physicians, nurses, and dietitians to complete CME but the exact number of hours is unclear.
    b. Traci noted that in California in 2011 there was a state bill 380 that would have required 7 hours of CME nutrition education to maintain California license. The bill was ultimately amended to omit any specified hours of a requirement, and instead it gave the California Medical Board authorization to develop standards for CME and nutrition. They were required to include a website that included at least two articles a year in their board's newsletter. They also encouraged primary care providers to obtain ongoing medical nutrition education but there was no actual requirement. That amended version was signed by Governor Jerry Brown in 2011.
43) She concluded with the question that as a forum and in our individual roles, should we advocate for and consider a mandatory CME requirement as part of licensing in California?
44) Questions and Answers:
    a. A question in chat asked if slides would be shared. Jo Marie replied yes, the slides would be shared.
    b. There was also a comment that food, even if labeled organic, if it touches plastic becomes contaminated.
    c. Alecia Sanchez from CMA shared that with respect to the question about requiring nutrition CME for licensure thta colleagues have had long-standing concerns about adding mandatory CMEs adding that if that's something that you think is important to consider having that conversation within organized medicine.
    d. Ron added an alternative proposal that CME on any disease should include the epidemiology and the nutritional and lifestyle components related to the disease that is being discussed in the CME rather than

carving out chunks of topics that are mandatory. Alecia noted, either way this should be a conversation with CMA to avoid raising concerns.

e. Sumedh asked when thinking about nutrition education and wanting to be scientific that we kind of take things down to elemental levels of vitamins and different minerals, etc. He noted that some of the basis for the different types of diets we talked about today, have the common theme of legumes, whole grains, whole food. He shared an example when considering Mediterranean diet and have chickpeas that you can convert that into a hummus. That's one dish that's considered to be very Mediterranean in nature whereas if you just boil it and put it in a salad that could be the DASH diet, and you can cook it with spices into Indian gravy. The question then becomes, 'is the nutritional value of any of these better than others?' And is there synergistic effect with spices and the way it's cooked, that really does make a difference? And, he wondered, do we have any studies or understanding into cooking style, culture, and other aspects of diets also impact the nutritional value and the overall benefit to mortality and morbidity as we think about diets, not just as diets, but as part of the cultural fabric of somebody growing up and doing what they do.
f. Traci replied that the science would show the best diet is something someone can stick to, so that's the first starting point. The second point, we could have 12 different classes today on the different diets. But there's a group, called the Old Ways Diet, where they build food pyramids that are basically based on the Mediterranean diet, but they take into consideration what foods might be in a certain person's culture. It's not necessary to have a specific food such as Mediterranean olives, but that you need a wide variety of vegetables, fruits, grains, and low amounts of sugar, and you can see that theme across every one of those diets. She added that to his point about social determinants of health, even the food pyramid shows on the bottom, eating together in community and she thinks that is a huge component noting that if we think about food as medicine, it's super hard to quantify. Nutrition studies are very difficult to do and really take long-term outcomes, but then to put in that aspect of culture and people coming together in community, it's an intangible that's hard to capture in data, but it's an intangible that really is the base of all of nutrition and includes bringing people together in community. She added, Chef Jose Andres has a saying 'longer tables, shorter walls' and thinks it kind of sums it up really well.
g. Ron and Priyanka added that raw foods are nott always the healthiest, and that tomatoes cooked, actually release more antioxidants. This is something that ought to be taught more.
h. Lindsey Evely stated in the chat that there are many things to consider when we talk about healthy eating/diets. We need to respect cultures and

lifestyles and meet people where they are at. It is also really important to know when to refer patients to Registered Dietitian, your food and nutrition experts! Traci added it is important to partner and consult with our RDs, because we don't necessarily have all the time or the bandwidth to know that in detail, but we can order consults. The same way we might consult a cardiologist when I don't know how to manage heart disease at a higher level than primary care, we should be absolutely talking to our RDs, who have more expertise in that. Jo Marie also added that insurances cover it, so that's the one thing that physicians don't always realize, that even our managed Medi-Cal in California, covers nutrition consults, and they cover multiple sessions and this is something we can do in partnership with our colleagues.

i. Barbara stated in the chat that nutrition is complex and ever changing as research, food production, and individual food preferences, cultures, and eating habits are taken into consideration...also the nutrient/drug interactions (GLP1s for example) are critical to patients who take a variety of medications.

j. Jessica shared that in regard to the CME question she is working on a heart disease and stroke prevention treatment action plan, a framework that incorporates a lot of the nutrition. They are finalizing it now, but it was felt that not enough physicians know about the ways that heart disease and stroke, which are the number one and three killer of people in California and across the globe, affect people. She noted that they also want to put in some requirements for every physician to know about heart disease and stroke. She is wondering if we could join forces and will circle back with Joe, Marie and Traci. She shares this because what she is most interested in, if we are promoting CME, learning if there is a ready-made CME for providers in California that's no cost, online, that they could direct people to take, and to show, it's very simple especially if we have folks who may be kind of opposed to the notion of it.

    i. Jessica invited anyone else who's interested to feel free to reach out to her or Lisa Bandong, who was on the call. It is an important opportunity with this report coming out and she would love to highlight the work just outlined today, maybe in some of the resources. It will be used by local health jurisdictions, health plans, and providers, as they put together community health assessments and improvement plans and strategic plans, for how to protect population health in California.

4) **Topics For Next Meeting, and Conclusion**: Ron asked for feedback on the next meeting's topic. Ron stated that if nothing were changing, if we were not under siege in public health, he would want to get into epidemiology and how to include it, as well as the nutrition and lifestyle, as diseases are discussed in both medical school and continuing medical education.

But, he added, there are crises everywhere because a lot of the funding that schools and local health departments get, has been filtered through from the federal government through the state or directly in grants, and is no longer assured.

Ron asked if there is a way of approaching this in a meeting that would be valuable to help us collaborate in a closer network? He also asked if it might be helpful to get a sense from someone in the California government or state government to present the opportunities with the current government and also what funding cuts are coming. Priyanka suggested looking at both sides of the coin, noting that while we are losing something maybe there are opportunities to work in our space. Ron suggested we try to put something together on how we're coping because everybody's been working individually, separately from other entities. He stated one school develops a program but doesn't communicate with or share with another school there is duplicated work. Although we really need more money, we could increase our impact on public policy and legislation if we work together to mitigate the disastrous funding cuts that we are experiencing.

a. Jessica added that one thing she wants to invite us to talk about next meeting would be the decision made recently that students in public health are limited in the amount they can borrow from the federal government in terms of loan support, as well as nurses and other allied health professionals. She stated that doctors aren't impacted by it, but it's going to undermine the cross-representation of students across the country if young people can't afford education. As an academic minded group, we need to be mindful of that. She suggested that she and Ron could research a little bit and (write) letters that the Academy could speak to or send letters of our concern about those decisions. She wondered if we could bring it back to the group to do a little bit of campaigning on that matter because it affects a lot of students and our academic partners if their students can't get loans to afford the school. Ron added that we are going to need feedback from everybody about what the limitations and new restrictions are. Jessica stated the board of CAPM could speak to it and come back to hear from everybody and together we could come up with a strategy and communication from the Academy about the concerns.

Ron stated the next meeting will be in March on the second Tuesday morning and concluded the meeting.

Minutes submitted by Traci Stevenson with edits by Ron Hattis
Approved at the meeting of March 26, 2026