



**TASK FORCE ON EARLY CHILDHOOD OBESITY PREVENTION  
CLINICAL TOPIC MEETING  
NOVEMBER 18, 2011  
NCIOM**

*Members Present:* Abena Asante, Randall Best, Don Bradley, Deborah Cassidy, Diana Dolinsky, Anthony Emekalam, Stephanie Fanjul, David Gardner, Greg Griggs, Gibbie Harris, Kathy Higgins, Brenda Jones, Jonathan Kotch, Miriam Labbok, Alice Lenihan, Jenni Owen, Eliana Perrin, Rich Rairigh, Melissa Roupe, Willona Stallings, Betsey Tilson, Helen Zehnder

*Steering Committee and NCIOM Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Pat Hansen, Emily McClure, Pam Silberman

**WELCOME AND INTRODUCTIONS**

**Olson Huff, MD**

Dr. Huff welcomed the group and asked everyone to introduce themselves.

**REVIEW OF CHARGE, RECOMMENDATIONS, AND PROGRESS FOR CLINICAL WORK GROUP**

**Kimberly Alexander-Bratcher, MPH**

Project Director

North Carolina Institute of Medicine

Ms. Alexander-Bratcher first gave an overview of previous task force meetings and the clinical group process. Afterwards, she briefly discussed the clinical recommendations made by the Institute of Medicine of the National Academies (IOM), North Carolina Division of Public Health (DPH), North Carolina Health and Wellness Trust Fund (HWTF), North Carolina Institute of Medicine (NCIOM), the White House Task Force on Childhood Obesity (WHTF), and Dr. Tilson's presentation on clinical guidelines.

A copy of Ms. Alexander-Bratcher's presentation can be found [here](#).

**Pam Silberman, JD, DrPH**

CEO and President

North Carolina Institute of Medicine

Dr. Pam Silberman led a discussion with task force members on the barriers in implementing clinical recommendations. She reviewed Dr. Tilson's previous presentation on clinical guidelines and practice tools, which included guidelines on how to help pregnant women with weight gain, motivational interviewing, group visits, provider advocacy efforts that influence policies. When preparing recommendations and/or strategies, Dr. Silberman discussed the need to look at all factors comprehensively. The following six strategies were discussed: education of pregnant women, research, education and support for breastfeeding, assessment, treatment and advocacy.

**Selected Discussion:**

**1) Education of Pregnant Women**

- a) How do we help pregnant women with weight gain?
  - i) Treatment: motivational interviewing, group visits, and other ways to work with more people at one time.
  - ii) Advocacy: how do we get clinicians involved outside of practice to influence policies?
    - (1) First, must address the barriers to educating pregnant women and mothers.
- b) Barriers
  - i) Waiting until people become pregnant.
  - ii) The lack of cohesive system for women's primary care. The clinic is where education of women of childbearing age should happen, but currently this is happening at family planning centers.
  - iii) Once the woman is pregnant: a common cultural misunderstanding is that pregnant women should gain a lot of weight during pregnancy.
  - iv) Reimbursement barriers to provide incentives to health care teams for counseling.
  - v) Not fully utilizing WIC program, which does provide nutritional care.
  - vi) Helping providers know about how to use community resources to reinforce messages
  - vii) Preconception and postpartum is a great opportunity for medical intervention at an early stage. An unusual doctor-focused time because the woman and sometimes the partner are coming more frequently for family/health care intervention.

**2) Research**

- a) What leads to health weight gain during pregnancy?
- b) What is a good practice that will result in appropriate weight gain?
  - i) Pay for performance
  - ii) In the primary care settings, there is not any simple pay for performance methods.
  - iii) PCMH (payment for risk assessment and follow-up)
- c) Do not extrapolate results for normal adults for pregnant women because weight gain for pregnant women is not the same as normal non-pregnant adults

**3) Education and Support of Breastfeeding**

- a) Preconception training for pregnant women on breastfeeding
- b) Providers are not offering education for pregnant women during pregnancy about breast feeding
- c) Role of pediatrician in support breast-feeding in a group setting prior to individual care with moms and partners.
- d) Before pregnancy (or inter-conception), most moms have made the decision to breast-feeding before delivering and maybe before even becoming pregnant.
- e) After baby is born:
  - i) Counseling (skilled training) and support for realities of breast feeding, about continuing breast feeding while going back to work
  - ii) Hospital practices that do not interfere with breastfeeding (PQCNC) – 10 steps
  - iii) Clinical and hospital practices typically provide family planning methods, which can interfere with breastfeeding.
  - iv) NC Plan for Breastfeeding (blueprint) is a good research tool to use.
  - v) Hospital referral to “Zip Milk”
- f) Social Media
  - (1) IT, Healthy Start, education for moms through tools such as Text for Baby (free mobile text messaging service)
- g) Educating and support for moms/parents about not always having to finish the bottle

- h) Need for exclusivity in breastfeeding. See real impacts on decrease in obesity with exclusive breastfeeding.
- i) Lack of availability of human milk (especially for twins)
- j) Screening for postpartum depression and its impact on breastfeeding

**4) Clinical Practice: Assessment**

- a) Universal assessment for weight and height (both parameters)
- b) Delivery of persistent messages that change with the age of the child
- c) Communication style that is patient centered with motivational interviewing
- d) Dr. Tilson's slide, page 9 on the BMI scale. At age 5, there is a dip and parents are concerned about this; thus typically force their child to overeat at this age, which can lead to later obesity problems. If see an uptake in weight gain at age 5, greater risk of early onset of diabetes and other chronic diseases.
- e) Electronic health records not built for children/infants
  - i) CHIPRA D – gives input into what is pediatric friendly EHR (Marian Earls, MD work)
  - ii) Maintenance of certification Part 4 is quality improvement in the practice. Nothing currently for adolescents.
- f) Providing counseling for parents
- g) What tools do pediatricians need?
- h) When discover a child is overweight/obese, then what's next?

**5) Clinical Practice: Treatment (triangle)**

- a) Treatment guidelines (page 11 from Dr. Tilson's presentation) to encourage healthy behaviors in diet, physical activity, readiness to change, motivational interviewing, implemented stage approach
  - i) Do not over medicalize, much broader societal issue
  - ii) Endorse nonmedical treatment, community referrals
  - iii) Families are more likely to follow-through on recommendations if they realize health consequences (important to start with this framework)
  - iv) Hard to do staged approach for very young children (0-5)
    - (1) Staging does not happen (monthly visit for 3-6 months)
    - (2) fits better with group process.
    - (3) Bringing patient back in for a visit is dependent on a provider...problem here is how do we view obesity in light of the health of that child AND the volume of the provider's patients.
    - (4) Does obesity cause stress on the family (in relation to asthma, or other health problems) does it predisposes children to high blood pressure, glucose control, inflammation. Is it an immediate problem (0-5)...hard to tell, but if it continues, it is a problem from (5-12).
    - (5) Reimbursement of obesity prevention is good to do because it is a cost controlling issue.
    - (6) Obese children less expensive (for BCBSNC population) than non-obese children (b/c not moving, fewer accidents).
  - v) Need to do more research on if it is necessary to bring child back to the office.
    - (1) Race to the top requirement for a kindergarten assessment using a standardized assessment tool.
  - vi) Training throughout all of this for providers

**6) Clinical Practice: Advocacy**

- a) Not an integrated, standardized method for advocating for breastfeeding
  - i) Fragmented messages across different providers
  - ii) Need a joint message, need providers to get involved more with these advocacy groups (La Leche)
  - iii) Getting providers/clinicians on board with understanding their role in helping improved "population health" not just role with individual patients.
  - iv) Payment structure—move from FFS to population health is not easy to do for a practice. Health reform—ACO is paying for outcomes instead of widgets.

- v) Assumption that someone else is already doing it.
- vi) Education about advocacy, learning about the needs of the community.
- b) NCPS providing training on advocacy at annual meeting
  - i) Need to do more in clinical training programs
  - ii) When do we do obesity prevention/education?
  - iii) In medical school discuss population health and during residency, more clinical focus.
    - (a) Specialists are the least engaged with obesity. Pediatricians and family care providers are the biggest advocates.

The Task Force decided to continue the discussion electronically. Members were asked to submit responses two weeks before the next meeting. The responses will be compiled to further the discussion at the next meeting. The next meeting will be held Friday December 16 at the NCIOM offices in Morrisville.