



## **TASK FORCE ON EARLY CHILDHOOD OBESITY PREVENTION**

**DECEMBER 16, 2011**

**NCIOM OFFICE**

**10:00-3:00**

*Members Present:* March Archambault, Randall Best, Don Bradley, Diana Dolinsky, Stephanie Fanjul, David Gardner, Greg Griggs, Gibbie Harris, Olson Huff, Jonathan Kotch, Miriam Labbok, Alice Lenhian, Eliana Perrin, Andrea Phillips, Jenni Owens, Lisa Oxendine, Melissa Roupe, Robert Schwartz, Steve Shore, Edgar Villanueva, Dianne Ward, Helene Zehnder

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

*Interested Persons:* Anne Bryan, Brenda Jones, Andrea Phillips, Stacy Warren

### **WELCOME AND INTRODUCTIONS**

#### **Olson Huff, MD**

Chairman, Board of Directors  
North Carolina Partnership for Children, Inc.

Dr. Huff welcomed the group and asked everyone to introduce themselves. Afterwards, Dr. Huff asked Stephanie Fanjul to share some exciting news that relates to our Task Force work.

Stephanie Fanjul shared the news that North Carolina won one of the nine Race to the Top grants, which intend to jumpstart improvements in our early childhood programs. The press release for the grant is attached [here](#).

### **REVIEW OF TASK FORCE CHARGE AND WORK PRODUCT**

**Pam Silberman, JD, DrPH**, President & CEO, North Carolina Institute of Medicine

Dr. Silberman discussed other related updates such as the CHIPRA grant and their importance to implementing a strategic plan for preventing early childhood obesity in North Carolina. She reviewed the significance of the clinical workgroup and explained how this task force is different from previous NCIOM task forces. She addressed the main charge of the task force, which is to examine evidence-based and promising practices from prior North Carolina related task forces. Through this analysis, the task force will develop a strategic plan to prevent or reduce early childhood obesity in North Carolina that can serve as a blueprint for foundations, government, health professional associations, and other community groups interested in improving the health of young children, ages 0-5.

### **UPDATE ON OTHER ACTIVITIES RELATED TO CLINICAL RECOMMENDATIONS**

#### **CHIPRA GRANT**

**Stacy Warren, M.Ed**, CHIPRA Project Director, Office of Rural Health and Community Care

Ms. Warren discussed the update on the CHIPRA grant and how it relates to our current task force work. In category C, the CHIPRA grant established an obesity prevention workgroup. The workgroup's first task was to develop a training protocol that focuses on small test of changes, motivational interviewing, and dissemination of materials. The materials the workgroup aims to disseminate are color-coded food plate models and BMI charts to providers, who will in turn give to their patients and their families. The purpose of the materials given to patients is for them to start the conversation between providers and patients about obesity prevention, which should occur at every visit in an appropriate way. The category A work reinforces category C by making sure that providers measure and report BMI in a clear way on an insurance claim, which may lead to reimbursing providers for obesity prevention.

Moreover, Ms. Warren explained the significance of North Carolina's CHIPRA grant in more detail. The grant consists of 3 following categories:

- 1.) Category A: Deals with 24 measures that the 18 awardees are required to report on regularly. Currently, NC can report on 13 of the 24 measures and aims to report on all 24 measures by the end of 2012.
- 2.) Category C: Improves care for children with special health care needs. NC has chosen to implement this category through two learning collaborative models, which allow NC to implement certain benchmarks such as maternal depression screening, oral health, and obesity prevention.
- 3.) Category D: Develops a pediatric format for electronic health records (EHR). North Carolina and Pennsylvania are currently the only two states that chose to develop this pediatric EHR format. There are currently 700 measures, which pediatricians hope to include.

Questions/Comments:

- 1.) Could we get a list of the 24 data indicators?
  - a. Yes, Ms. Warren will send the 24 measures to NCIOM, who will then disseminate to task force members.
- 2.) Is this grant addressing the early childhood population or just the adolescent population?
  - a. Yes, the grant is addressing the early childhood through adolescent population by making sure that pediatricians discuss issues surrounding obesity and healthy eating at every office visit.

**PERINATAL QUALITY COLLABORATIVE OF NORTH CAROLINA: BCBSNC AND OFFICE OF RURAL HEALTH AND COMMUNITY CARE PARTNERSHIP**

**Don Bradley, MD, MHS-CL**, Senior Vice President of Healthcare, Chief Medical Officer, Blue Cross and Blue Shield of North Carolina

Dr. Bradley discussed the BCBSNC funding for the Perinatal Quality Collaborative of North Carolina (PQCNC) efforts to reduce elective cesarean delivery by 43%. This new focus aims to prevent premature C-section births in North Carolina and more importantly, improve maternal and child health. By reducing C-section births, unnecessary medical costs for NC will also decrease. Additionally, the grant promotes the exclusive use of breast milk at the hospital. This initiative was started and led by providers. BCBSNC decided to fund the PQCNC and has received matching federal funds through the Office of Rural Health. The initiative expanded original activity from 39 hospitals to 51 hospitals. The goal is to improve maternal and child

outcomes, but this also will have a large impact on preventing early childhood obesity through exclusive use of breast milk at hospitals.

Questions/Comments:

- Eliana Perrin, MD is currently working on research, which entails following children at age 2 and age 9 and seeing whether their weight gain is due to catch-up growth or post-natal care/exclusive breastfeeding.
- On May 2, Smart Start is hosting a meeting/luncheon in Greensboro, which is pertinent to this collaborative and all are invited to attend.

Pam Silberman also gave a brief update on the US Medicare program, which will now cover obesity screening and counseling. This could be window of opportunity for potentially covering obesity screening/counseling for early childhood. To read more, click [here](#).

## **DEVELOPMENT OF A WORK PLAN TO IMPLEMENT CLINICAL RECOMMENDATIONS**

### **Pam Silberman, JD, DrPH**

Dr. Silberman discussed the development of the grid and four category strategic breakdown for the clinical work plan. The initial clinical work plan consists of the following four main categories: (1) Health Professional Education; (2) Education for Practicing Health Professionals; (3) Coverage and Incentives for Prevention, Diagnosis and Treatment of Obesity; and (4) Community Resource Guide. She explained the background and rationale for the initial four categories and strategic plans.

- I. Health Professional Education
  - a. Discussion around main recommendations.
    - i. The 5-3-2-1-almost none is an action oriented tool for providers, students, and caregivers.
      1. 5 fruits and vegetables today, 3 healthy meals a day, 2 less than 2 hours of screen time a day, 1 hour of exercise a day, Almost none—sugar based foods and beverages.
    - ii. Add communication between providers and parents about results of BMI and encourage universal screening.
    - iii. Motivational Interviewing approaches:
      1. Ask patients (children and parents) to grade themselves on their current healthy eating and living efforts.
      2. Asking parents how confident parents are in addressing obesity (such as: dining out less, reducing sugar drinks).
    - iv. Skills to support new mothers to exclusively breastfeed.
    - v. Need to make sure that the intra-agency council is representative of diverse health professionals, geography, race/ethnicity, gender, etc.
    - vi. The curriculum development needs to be an evolving a plan.
  - b. What are other resources are needed to make this successful?
    - i. Analyze and incorporate the strengths of other organizations and programs.
    - ii. Make sure messages between the providers disseminating the material and the individuals developing the curriculum are the same.
    - iii. Encourage academic institutions to take ownership of developing and implementing the curriculum.

1. Need to involve a key champion like Exceptional Children's Assistance Center or other key policy leader.
- c. What other groups need to be involved?
  - i. Health professionals in addition to educators. Community practitioners in addition to academic providers and clinical preceptors.
- d. Who will take the lead?
  - i. AHEC and different schools (medical, PA, nursing, and public health schools) and ask them to lead the modules.
- e. How much funding would this require?
  - i. Research ways to send small incentive grants to universities, which will allow academics to work with other partners in obesity prevention.
  - ii. Tie educational innovation grants in academic health centers.
- f. What are the performance measures that we would need to evaluate the success of this initiative?
  - i. Schools/programs that have used this curriculum for 2 years after the development of these modules.
  - ii. Pre and post tests of performance measures and implementation of standardized patient programs.
- II. Education for Practicing Health Professionals
  - a. Primary care utilizes the following resources:
    - i. AHEC via Regional Extension Centers, CCNC with the CHIPRA grant
  - b. How can the current resources utilized by primary care be strengthened?
    - i. Be more hands on, systems changing training instead of pants in seats training.
  - c. What resources are needed to make this successful?
    - i. Implement the 10 steps guide for breastfeeding for every hospital
    - ii. Decision support for EHRs so that providers are notified when items are not checked off.
    - iii. Broadly disseminate Eat Smart Move More obesity prevention tools
  - d. What other groups will be involved?
    - i. Health professional associations, Breast feeding trainers, Payers, EHR vendors (EPIC, Allscripts), Local medical societies, NCHA, PQCNC, NCHQA.
    - ii. NC Dietetic Assoc., NC Pediatrics and NC Academy of Family Physicians should work together to develop a module MOC on early childhood obesity/prevention treatment.
  - e. Who will take the lead on this?
    - i. AHEC, CCNC
  - f. How much funding would this require?
    - i. Stacey Warren will provide us with figures on potentially implementing the focus of obesity prevention via part-time employees at CCNC's 14 networks.
    - ii. How can we build on the community transformation grant?
  - g. How can we effect change?
    - i. From the patient perspective, how do you get the patient from getting appropriate care?
    - ii. Could we use the waiting room as an opportunity to do obesity prevention?
  - h. What performance measure should we include to evaluate the success of the initiative?

- i. Figure out how many Maintenance of Certification (MOC) projects are focused on obesity?
- ii. Build obesity measures into MOC requirements for pediatricians/family medicine/endocrinologists.
- iii. Add question to CHAMPS about whether doctors advise about physical education and nutrition
- iv. Look at trends in early childhood obesity (may not want to hold providers accountable for this)

### III. Coverage and Incentives for Prevention, Diagnosis and Treatment of Obesity

- 1) Insurers should evaluate benefit design and work with employers and others to incentivize health plan members to take advantage of healthy lifestyles.
- 2) Who is taking the lead on this?
  - a) Alliance for a Healthier Generation? (BCBSNC, DMA, and State Health Plan (SHP))
- 3) What other groups need to be involved?
  - a) NCAHP, DMA, SHP, and CCNC
- 4) What other resources are needed to make this successful?
  - a) Health economists, actuaries or SPH faculty to think about how this could work.
  - b) Utilize the well-child visit as a means to connect with patient more frequently.
  - c) Need more one stop, comprehensive shopping for health insurance
  - d) Need to offer patients family and community based programs for nutrition, physical activity, which involve both children and their parents.
  - e) Dissemination vehicles
  - f) Social media: use of twitter.
- 5) What are the performance measures should we include to evaluate the success of this initiative?
  - a) Increase in # of physicians who are doing BMI screen.
  - b) Increase in # of people getting diagnosed or treated.
  - c) Increase in # of people who change coverage policies to support obesity prevention/treatment.

### IV. Community Guide

- 1) Utilize current existing resources: (CHIPRA grant, CCNC)
- 2) What other groups need to be involved?
  - a) BCBSNC, CCNC, NC Pediatric Society, Eat Smart Move More, DPH, WIC, YMCA, YWCA, Ag. Extension, NC Brest feeding Coalition, zip milk (type in zip code to get sources available in zip code), Child Care Research Referral Network, childcare resource guide, park systems, hospitals
- 3) Who will take the lead on this?
  - a) NC Partnership for Children as part of the Shape NC.
  - b) Could Shape NC contact help build and work with the CCNC practices?
  - c) Health visitors in the home can provide these resources as well.
- 4) What are performance measures should we include to evaluate the success of the initiative
  - a) EHR will be able to measure whether patients referred to community resources and whether there was follow up.

Next meeting will be held on Friday January 20<sup>th</sup> for community group. The core group is required, but clinical group will not meet again until a later date in 2012.