

**TASK FORCE ON EARLY CHILDHOOD OBESITY PREVENTION  
OCTOBER 21<sup>ST</sup>, 2011  
NCIOM  
10:00-3:00**

*Task Force and Steering Committee Members Present:* Mark Archambault, Randall Best, Don Bradley, Deborah Cassidy, Alice Dean, Stephanie Fanjul, David Gardner, Pat Hansen, Gibbie Harris, Jonathan Kotch, Beth Lovette, Alice Lenihan, Jennifer MacDougall, Mary Etta Moorachian, Jenni Owen, Lisa Oxendine, Richard Rairigh, James Rhodes, Melissa Roupe, Susan Riordan, Robert Schwartz, Steve Shore, Janet Singerman, Willona Stallings, Betsey Tilson, Dianne Ward, Helen Zehnder

*NCIOM Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Emily McClure, Sharon Schiro, Pam Silberman

**WELCOME AND INTRODUCTIONS**

**Jennifer MacDougall**

Healthy Active Communities Senior Program Officer  
Blue Cross and Blue Shield of North Carolina Foundation

Ms. MacDougall welcomed the group and asked everyone to introduce themselves.

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

**Kimberly Alexander-Bratcher, MPH**

Project Director  
North Carolina Institute of Medicine

Ms. Alexander-Bratcher gave an overview of the task force process. She then 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), and the White House Task Force on Childhood Obesity (WHTF). A copy of Ms. Alexander-Bratcher's presentation can be found [here](#).

**Selected Questions and Comments:**

- Q: How can we make sure that this task force is talking about the same thing regarding children at risk of being overweight and obesity? Are our recommendations targeting children at the 85 percentile of BMI to prevent overweight or are we also going to make recommendations to prevent children from being obese?
  - Our approach should be a population-based perspective. If you are a human, you are at risk of being overweight or obese.
  - We should also not forget the women who decide not to breastfeed. These moms also need to know when they should feed their babies and how to respond to their baby's cries.
- Q: Are we are going to look at measures of success? If so, what metrics are we going to use in our recommendations? Important to see how our recommendations are performing.
- Q: How are recommendations being structured in terms of clinical outcomes/behavioral change? How can we make behavioral changes as the main outcome instead of increasing the number of programs?
- C: Everything we do in this task force should revolve around the family and not just about overweight kids. The primary behavioral change needs to be addressed by the family. Our recommendations should provide that supportive environment to encourage behavioral changes.

## REVIEW OF CLINICAL GUIDELINES AND PRACTICE TOOLS

### Elizabeth Cuervo Tilson, MD, MPH

Pediatrician, Wake County Human Services Child Health Clinic  
Medical Director, Community Care of Wake and Johnston Counties

Dr. Tilson presented a system-level approach for providers on clinical guidelines and practice tools for early childhood obesity prevention. She discussed the family/parenting dynamics that are essential to understand when addressing the health needs of children ages 0-5. When conducting motivational interviewing with parents and/or caregivers, providers should assess the risk of parents and/or caregivers and their influence on children. Dr. Tilson highlighted concise assessment tools provided through Eat Smart Move More. These tools offer salient information on specific needs of the child and their family. Clinicians have the opportunity to change the culture of eating and treating children at risk of being overweight or obese. Several color-coded BMI charts based on ages 2-5 provide clinicians with a tool to inform parents and caregivers of their children's health needs. In response to conflicting societal messages on healthy eating, providers can encourage parents to be healthy role models and make conscious decisions' for their children's health. Dr. Tilson's full presentation can be viewed [here](#).

### Selected Questions and Comments:

- Do prenatal counseling prevention recommendations start at birth?
  - Having a healthy mom normally allows you to have a healthy birth outcome. Important to start prevention early for the mother and the child.
- Parenting styles are typically fixed as authoritarian or authoritative.
  - Authoritative is a positive parenting approach, which blends compassion with control and praise.
  - Authoritarian is not coupled with praise and if you disobey, sense of punishment.
- What is CCNC using as a tool to assess overweight and obese children?
  - CCNC is using the WHO growth chart for ages 0-2 and to use the BMI chart for children ages 2+.
  - Many practices have switched to the WHO growth chart for ages 0-2.
  - Important to not treat relapse of a high BMI as a failure, but build on these failures and learn from them.
- How do we address these barriers and create change?
  - Our clinical group will not be addressing community/cultural barriers in this topic group. Our other topic groups we will focus on these.
  - Important to connect our clinical recommendations with the community/education/and cultural realms in later discussions.
  - Education for providers of these topics should go beyond academic and be more experiential so that providers are not out of touch with the needs of their patients.
- Many parents do not know what the BMI scale represents because it is difficult for parents to “see it.” Several studies have shown that it is helpful for parents/caregivers to see photos of children with appropriate weight. Eliana Perrin, MD is the pediatrician at UNC who is a pioneer in this research.
- Culture of accommodating to overweight/obesity:
  - Clothing sizes have increasingly grown.
  - Perspective of a skinny child as an outlier: Forces parents to feel that they are not doing their job and feeding their child enough.
  - Comparing all children to children with an appropriate weight could be a positive approach, but could also potentially lead to body disorders and stigma issues.
- What is the percentage of usage of BMI as a tool in the clinical setting?

- 95% of CCNC practices currently use BMI charts during their well-child visits.
- Cultural differences exist with understanding BMI. What may be considered the norm of a healthy weight gain/loss in one group differs in comparing to another group.
- C: Important to understand disease prevention, especially preventing diabetes.
- Are there similar lab tests for children ages 0-5?
  - No, children ages 0-5 have not been overweight/obese long enough to have the result in their lab that could show physical comorbidities.
- Are there any key interventions that you could highlight?
  - No, there is no one magic bullet intervention. A mix of tools necessary for the family to move towards improving children at risk for overweight and obesity.
- Motivational interviewing cannot be the only tool, need the environment to be conducive to change. They will not the behavioral change until they are ready.
  - Most physicians are poorly trained around nutrition counseling. More difficult to work with a kid who has gotten to a higher BMI percentile than a healthy one. Keeping a kid at a healthy weight and reinforcing these behaviors is the best prevention.
- BCBSNC and Medicaid in NC will reimburse for nutritional counseling/dietician.
  - The reimbursement of a nutritionist is a key source in NC that we could build on to prevent overweight/obese children. Many states do not have this option.
- The Children's Health Insurance Program Reauthorization Act (CHIP-RA) grant is working towards quality improvement for pediatricians and capturing the correct measurements.
  - Quality standards: documenting BMI as an outcome measure
  - Pediatricians' meaningful use approaches need to be more intertwined. If meaningful use is left out of the discussion, the approaches should change.
- What are the barriers to the Medical Nutritional Therapy (MNT) and why is it not working?
  - Barriers: patient show rates, space, practice buy-in to pay the nutritionist a salary or have a contractual relationship and bill on his/her behalf.
- Family history of obesity: a combination of genetics, culture, and family dynamics.
  - In NEJM article, states that the people you associate with can make a huge change in your behavior. Our genes have not changed in the past 30 years, but our environment has changed.
  - Need to start preventing obesity at prenatal care and look to the family to create behavioral changes.
  - Currently, there is not a ton of data on the dads and their influence on the family.
  - Portion size is a concern in eating. Once a child is off the breast, then what is the appropriate portion size for children?
    - Key to use visuals. Often there are distortions in our portions. When a person eats out, they almost always receive the maximum portions.

## **BARRIERS TO IMPLEMENTING RECOMMENDATIONS**

**PAM SILBERMAN, JD, MPH**

### **Education of Providers--Barriers for training in school:**

*What are the barriers to implementation?*

- If nutrition training is not tested on the national boards, it is often not taught, even if it is important.
  - Need to get specific nutrition related questions on the national boards.
- Lack of an evidence-base for teaching about obesity. Currently, we know about the epidemiology, but we need more evidence-base for teaching about overweight/obesity.
- Since there is a lack of an evidence-base, current medical students cannot sink teeth into issues without

seeing intervention and behavior change.

- Student perspective is: If I cannot do anything about it, why should I change.
- Core competencies for pediatricians and other physicians should be developed around behavioral change via motivational interviewing. Internal vs. external motivation.
- Requirement for providers (MD, PA, NP, RD, Social worker, dentist) to show that they have been exposed to 0-5 year old children through pediatric rotation.
- Respect and understanding of team members' expertise. Nutritionist is far better trained, better tied to community resources, and more affordable.
- Parental and caregiver training is also essential to improve.
- In addition, providers have a lack of knowledge about family dynamics.

*What are the changes in the future that might help?*

- The American Academy of Pediatrics (AAP): has provisions for childhood obesity and recommends that they should be built into boards.
  - Has this same effort been made with dietitians, NPs, PAs (board exam) discusses obesity, but not necessarily in the context of pediatrics?
  - PAs are considering: Specialty/Certificate of Added Qualification (CAQ) to have a specialization in pediatrics.
  - RNs: tested on nutritional accounts and do a lot of education with patients, families, and children related to nutrition to prevent obesity. State exam test nutrition and obesity as issues
  - Family practices are ahead (see expert: Greg Griggs)
  - Ob-gyn: (weight gain in pregnancy)
- Content to add to curriculum: obesity prevention, nutritional counseling, motivational interviewing, family dynamics, breastfeeding, exercise.

*How can we overcome these barriers?*

- Develop a curriculum: Wake Forest School of Medicine's model develops a case on how to address obesity.
- Accreditation is driving curriculum; thus, necessary to work with accreditation agencies to revise the general education and standards in order to meet the need for overweight/obesity children.
- Need to find out what is happening on the national level for 0-5 year olds and national boards.
- Looking into national boards: can we get these questions onto national board of medical examiners and FLEX?

### **Education of Providers-Barriers for Post-School/Graduation:**

*What are the barriers to implementation?*

- Lack time, skills in motivational interviewing, support (from dietitians), reimbursements (legitimate),
- Even though dietitians are covered under insurance, the reimbursement process is very cumbersome to receive.
- Costs of hiring/training RDs and do not have RDs in all of our counties.
- CMEs are hard to do due to the expense (do through AHEC), time requirement, and health literacy with motivational interviewing (hard to effectively train PAs).
- RDs services may be on the cutting block

*What are the changes in the future that might help?*

- The William Clinton Foundation and Blue Cross and Blue Shield of North Carolina are reimbursing for nutritional counseling.
- Need to cut back time a provider or coder spends on trying to figure out how to bill via standardization.
- Moving towards: Capitation/ Global Payment/Bundle payment (no more widgets).

*How can we overcome these barriers?*

- Moving more towards a community based multidisciplinary approach to best reach the needs of a population with the per member per month payment. Funnel it through the network dieticians who need to be working with obese children.
- Children will benefit from a full-time dietician because MDs(Pediatricians), PAs, and NPs cannot enact change over a one-time visit. Need to work with child and family consistently in order to see change.
  - WIC: children aged 0-5 (50% of children participate in the program).
    - Step 1: partner with Cooperative Extension Agencies
    - Step 2: two nutrition education sessions held over 6 months
    - Step 3: High-risk category receive intense counseling with step 3 (do not have the resources to do this)
- MNT (Medical nutritional therapy) have 6 visits, but average number used per patient is 2 visits. The patients (and families) also have to want to participate.
- RDs can get additional certification in adult or pediatric populations (extra training) and are required to have a certain number of practice hours.

**Clinical Practice Prevention:**

*What are the barriers to implementation?*

- In African American and Latina populations, children who breast and bottle feed, gain as much weight as the children who bottle feed alone.
- The bad food stuff tastes so good.
- NC, however, does not have the workforce capacity to see a large number of kids.
- The physician is not the most qualified (does take his endorsement) to see/provide the care for obesity prevention.
- Screen time prevents physical activity, interactions with people, and includes advertising unhealthy foods.
- Sleep: Feeding a baby to fall asleep gets an additional 120 calories before going to bed.

*What are the changes in the future that might help?*

- Universal screening and counseling for everyone.
- Every physician should have skill set in obesity prevention.
- Bright Futures forum: provides a counseling sheet.

*How can we overcome these barriers?*

- Focus messages on behavior than on obesity/overweight.
- Messages should go to everyone- about healthy eating and physical activity.
- Important for the mother/family/caregiver to control the home environment, especially food/drinks purchased and where the family goes out to eat.
- Use interviewing skills of *importance* and *confidence*. How important is it to you to change your baby's eating habits and how confident are you to handle this problem?
- As part of well-child check: should address BMI and weight counseling.
- Appropriate portion size starting from birth 0-2 and conversations need to start early.
- Enlisting the help of the grandmother-aunt network and provide nutritional aides.

The next meeting of the Task Force on Early Child Obesity Prevention Clinical Workgroup will be Friday November 18 at the NCIOM offices in Morrisville.

