



Virginia Youth Overweight Collaborative

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Virginia and Childhood Overweight

- 16% of children ages 6-19 are overweight
 - 9 million children
- 30% of adults over 20 are overweight
 - 60 million adults
- Incidence has tripled since 1980



Virginians and Health Habits

- 74% do not exercise 30 minutes three days per week
- 73% do not eat 5 fruits or vegetables per day
- 70% spend more than 2 hours per day in front of a screen (computer, TV)



Virginia's Health Care Costs

- Related to Obesity
 - \$1.6 billion in 2003
 - 5.7% of Virginia's total medical expenses (CHAMPION, 2005)
 - \$222 per Virginian spent on obesity related conditions



So, whose job is it anyway.....

- From a parent –
 - “My whole family is big boned, the kids are just the same way.”
 - “You don’t understand how hard it is; I try to put the right things on the table.”
- From a Primary Care Clinician –
 - “This isn’t my problem, it’s the patient and family’s choice on how they eat and what they do.”
 - “I don’t know what to do – except order tests.”
 - “I’m not a social worker – I don’t have the time (nor knowledge) on how to talk to patients about behavior change”



So, whose job is this anyway...

- From a School – “Our role is to teach, we don’t have the time nor the resources to do get kids up an moving more, the school lunch program is fine. We make money off the bake sales and vending machines so, don’t touch them etc.”
- From the Local Rec Department – “How are we involved????”
- From City Hall - “What role to we have? – Isn’t this a personal issue?”



So, whose job is this anyway...

- We all have a role to play. And it needs to be a coordinated role.



IOM September 2006 Report

- Progress in Preventing Childhood Obesity: How Do We Measure Up?
 - Institute of Medicine September 2006
- Addressing the childhood obesity epidemic is a collective responsibility involving multiple stakeholders and different sectors—including:
 - Federal Government
 - State and local government
 - Communities
 - Schools
 - Industry
 - Media
 - Families



Virginia Youth Overweight Collaborative (VYOC)

- Primary Care Prevention and Treatment of Childhood Overweight
- Connection and Interaction with Community Programs and School
- Referral to Specialty Centers to prevent secondary morbidity
- Community Social Marketing pilot (Northern Virginia)
- Connection to CHAMPION

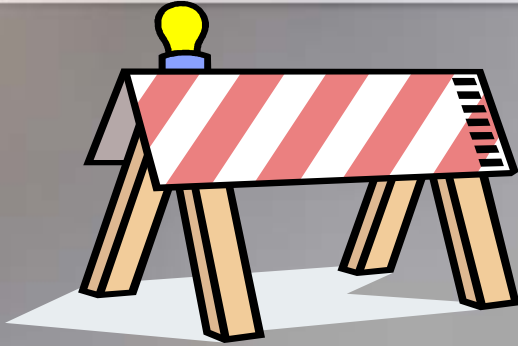


Primary Care Prevention and Treatment

- Collaborative model to address childhood overweight
- Model used successfully in Maine and Arkansas, halted the increase in Childhood Obesity



Barriers to Addressing Overweight in the Office



Pediatric primary care system is designed

- For the 80% of children who have no issues
- To provide preventive care services and acute illness management
- To support single service encounter



Peds 21

- Mental Health
- School Problems
- Obesity
- Language Barriers
- Chronic Illness



Virginia Youth Overweight Collaborative (VYOC)

- 24 Practices in Virginia using Learning Collaborative model to improve care
- Complexities of Childhood Obesity divided into smaller, discrete components
- Success in:
 - Improvement in Care delivered in Patients and Families
 - Improvement Knowledge, Attitudes, and Beliefs of PCPs
 - Improvement in Patient changes
 - Improvement in Linkages to Communities



Virginia Youth Overweight Collaborative

- Practices in six different regions of the state (Northern Virginia, Richmond, Tidewater, Charlottesville, Roanoke, Southwest)
- On-site curriculum and technical assistance with chronic care model



Chronic Care Model

- Community
- Health Systems
- Self Management support
- Delivery System Design
- Decision Support
- Clinical Information Systems/Registry



Primary Care Provider's Role Prevention

- Breastfeeding Promotion
- Pregnancy and Postnatal weight gain counseling
- Healthy Lifestyle Behavior Screening -
Fruits and Vegetables, Screen Time,
Physical Activity, Sugar Sweetened
Beverages
(5-2-1-0 Survey)



Primary Care Provider's Role Assessment

- Weight for Length – birth to 23 months
- BMI - age 2 years and up
- Screening for co-morbidities
- Use of terminology for our charts
 - Overweight
 - Obesity
- Use of terminology when we talk to patients and families
 - "Excess weight"
 - "Weight growing faster than height"
 - Quickly shifting the conversation to lifestyle behaviors



Primary Care Role

- Family History Screening
 - Diabetes
 - Hypertension
 - Chronic Morbidity
- Laboratory Assessment
 - Lipids/Cholesterol
 - Kidney function
 - Hemoglobin A1c
- Follow up



Primary Care Provider's Role Treatment

- Family Center Care
 - Individual
 - Group Setting
- Behavior Change Counseling –
Motivational Interviewing, Brief
Focused Negotiation
- Medical Therapies
- Surgery



Primary Care Role

- Connection and Interaction with Community Programs
 - Attendance
 - Successes
 - Challenges



Team Approach is Critical

- Healthcare Providers
- Nurses
- Medical Assistants
- Office Staff Support
- Community Partners



Community Linkages

- Start where you are in your community
 - Local gym
 - School - PTO, School Board, Parent
 - Faith Based Organization
 - Community Sports team
- What's going on at the local level?
- What's going on at the state level?



Our Goals

Engage practices, not just providers, to:

1. Classify & track BMI%ile for age/gender at all annual well child visits for patients age 5—18 (BMI as a vital sign)
2. Promote healthy eating, nutritional education & increased physical activity using our 5-2-1-0 toolkit
3. Appropriate medical evaluation & goal setting



Our Goals

Engage practices, not just providers, to:

4. Choose and/or tailor interventions appropriate to patient's age & readiness to change
5. Use motivational interviewing with brief negotiation and brief focused advice ASK—Don't Tell
6. Facilitate sub-specialist referrals when co-morbidities persist



**5 or more
fruits or
vegetables
per day**

**1 hour or
more of
physical
activity daily**

**2 hours or
less of total
“screen
time”**

**0—Limit
soda &
sugared
drinks**





VYOC “Key Changes” Self-management Support

Self-management support: *Recognize patient & family is at center of team, and support the patient’s ability to manage their disease!*

- Deliver consistent, focused message about healthy lifestyles (5-2-1-0)
- Assess readiness to change & self-efficacy, and provide advice for behavior change consistent with patient / family’s readiness to change
- Use collaborative approach to setting goals
- Promote self-management skills





Goal Setting



DRAFT Goal Setting Worksheet

It is important for your medical team to know how ready you are to make changes to improve your health. The following information can help you and your provider talk about steps you can take to move toward a healthier lifestyle for you and your family.

Ideas for Change	
5	Eat at least 5 servings of fruits and vegetables on most days. Try one new vegetable or fruit Add fruit to my cereal
2	Reduce screen time to 2 hours or less every day Plan my TV time Take the TV out of my bedroom
1	Participate in at least 1 hour or more of physical activity every day Take a walk Play my favorite sport or physical activity Wear a pedometer Walk 10,000 steps
0	Limit soda and sugar sweetened drinks No soda
Other: Familiarize myself with portion sizes Eat two family meals together each week Eat breakfast Eat no fast / junk food Drink skim/non-fat milk rather than whole milk	

On a scale of 0 (not ready) to 10 (very ready) how ready are you (please circle appropriate number) to consider making a change? 0---1---2---3---4---5---6---7---8---9---10

My personal health goal is to:

If I reach my goal I will reward myself by: (ideas might be a special privilege, attend an event, do a special activity)

Patient Signature _____

Clinician Signature _____

Parent Signature _____

BMI _____

Visit # _____

It may be helpful for someone from our office to call you to check in on your progress.



The best time to call me (Monday to Friday) is: _____



The best phone number to reach me at (Monday to Friday) is: _____

I prefer not to be called for follow-up: ☐

(please check if this choice applies)



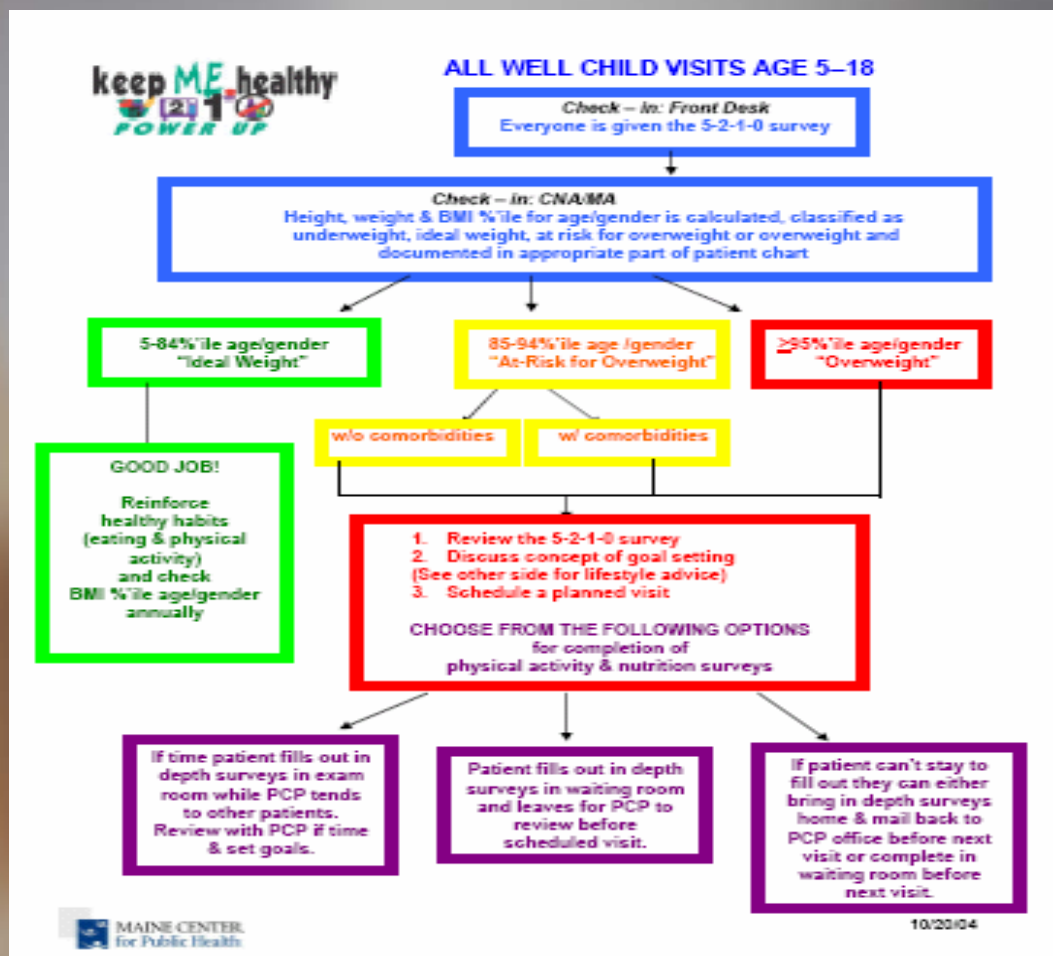
VYOC “Key Changes” Office System Redesign

Office system redesign: *Use your team to deliver planned care for overweight!*

- Identify expectations and explore opportunities to enhance team functioning & communication
- Provide care through planned care visits for follow up of overweight
- Consider alternative models of care (e.g. group visits, telephone follow up calls, brief stop at office)



Office Flow





MYOC "Key Changes" Clinical Decision Support

Clinical decision support: *Find ways to translate guidelines into practice!*

- Use Medical Assessment of Overweight Patient algorithm to consistently evaluate appropriate patients
- Use available clinical tools (algorithms/flipchart) and incorporate them into routine care
- Incorporate specialty expertise routinely into care
- See patients at recommended intervals for routine follow up

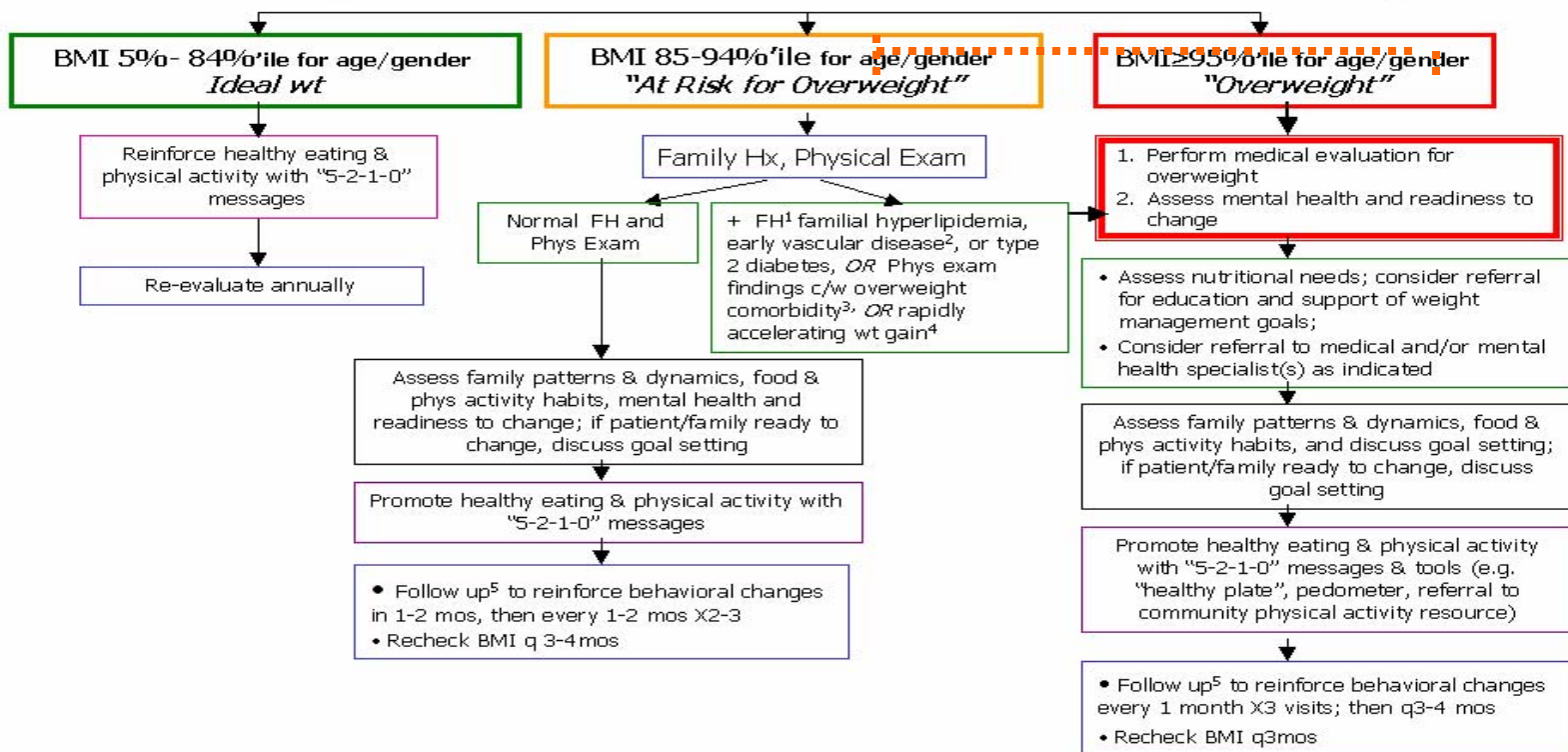
Guidelines for Prevention & Management of Overweight Youth

Guidelines for Prevention & Management of Overweight in Children 5-18 yrs



ALL PATIENTS at ANNUAL Preventive Well-Child Check

1. Measure and plot Ht & Wt
2. Calculate BMI and plot BMI% for age/gender → classify weight
3. Ask patient / family to complete "Keep ME Healthy 5-2-1-0" Survey





VYOC “Key Changes” Clinical Information Systems

Clinical information systems: *Use data to manage not just patients, but also populations!*

- Identify population of patients overweight / at-risk for overweight and track outcomes data on BMI & key clinical metrics
- Use registry to identify patients who would benefit from proactive care (e.g. specific follow up, referral, labs)
- Identify patients with BMI%’ile for age /gender ≥ 95 and create specific plan to support behavior change (e.g. referral to nutritionist, exercise program)



An Example of a registry

Practice name Physician name											
		Patient Information									
ID #	Visit Date	Name	DOB	Age	M/F	BMI	Class	BP	Labs	Goals	F/U
001	3/2/06	Max Jones	9/8/94	10	M	20	At Risk	100/56	No	set	4/2/06
002	3/8/06	Katie Smith	8/6/92	12	F	26	Overweight	110/72	Lipids ALT AST FBS	Not set	4/8/06



VYOC “Key Changes” Healthcare System Support

Healthcare system support: *Provide leadership with health system leaders, including payers*

- Contacted major payers in Virginia – confirmed claims payment for PCP and specialist OV’s, follow up visits, & lab services using dx code for obesity (ICD 278)
- Identified potential barriers with some out-of-state Identified and educated providers on alternative codes for obesity co-morbidities
- Advocated for standard quality measures (NCQA/HEDIS) for dx, management of obesity



VYOC “Key Changes” Link to the Community

Community: Practices *can't do it alone - identify resources in your community, and use them!*

- Identify, connect, and become familiar with local resources in your community
- Explore available community resources that promote physical activity and or healthy eating and actively refer patients for participation
- Connect with the local school (nurse, CSHP, PTO, School Board) to address issues of physical activity and / or healthy eating in the school.



Northern Virginia Community Pilot

- Social Marketing Campaign
- Parent Survey
- Connection with Directory of Resources for CHAMPION
- Shared Data with CHAMPION



Cultural Competencies

- What cultures exist in your practice, in your community?
- Who are the leaders, decision makers in these cultures?
- Do your messages make sense to your patients?



CHAMPION

- Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity, and Nutrition



Thank You



Questions

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