

NWX-BPHC

**Moderator: Stephanie Crist
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1:00 pm CT**

Coordinator: Welcome and thank you for standing by. All participants will be in a listen only mode until the question and answer session of today's conference call. At that time please press star 1 on your touchtone phone to ask your question.

Please unmute your line and state your name clearly so that I may announce you. Today's call is being recorded. If anyone has any objections you may disconnect at this time. I'd like to introduce your host for today's call, Dr. Sarah Linde-Feucht. You may begin.

Dr. Sarah Linde-Feucht: Good afternoon everyone and thanks for joining us.

Today's session, Stepping Up to Healthy Weight, reducing and preventing overweight and obesity in health center populations, is another in a series of monthly TA enrichment sessions presented to BPHC grantees through the Office of Training and Technical Assistance Coordination at BPHC.

As the Chief Public Health Officer of HRSA it is a pleasure and honor to open up today's session for you. I do want to mention that there's a current slide set that was uploaded to the BPHC TA page at 12:30 eastern time today.

So if you want to be sure you have that current slide set please go to the page and get that while I'm talking. As you all know, obesity is a high priority health issue across the country. The most recent statistics show that 10% of all medical spending goes to obesity related conditions.

Two-thirds of US adults are overweight or obese. And we know that percentage is higher in the health center population. Additionally, approximately 1/3 of children in our country are overweight or obese.

Obesity is a disease with broad roots which requires interventions across all facets of society to address risk factors. Health and Human Services initiatives aimed at improving healthy weight outcomes include targeting schools, targeting child care settings and workplaces as well as marketplaces.

And most importantly, to those of you on the phone, healthcare settings. Within HRSA we are focused primarily on improving outcomes in the healthcare setting and the communities in which that healthcare is provided.

These initiatives are particularly important for health centers whose patients as we will learn, and really as you already know, are on the front lines of battling an increasingly obeseogenic environment.

HRSA initiatives to improve weight outcomes include funding maternal and child health programs in nutrition education, partnering with the National Institutes of Health or NIH for the We Can Program to prevent overweight among youth and working with outside groups like the National Initiative for Children's Healthcare Quality on the Healthy Weight Collaborative.

This is a national quality improvement initiative in which primary care providers, public health professionals and leaders of community based organizations worked together on teams to discover, test and disseminate evidence based and promising interventions to prevent and treat obesity in children and families.

In fact one of today's featured speakers will be sharing their experience as a health center grantee participating in the Healthy Weight Collaborative.

The purpose of today's BPHC Grantee TA Enrichment Session is to provide you with a clinical review of obesity in the United States, identify the importance of achieving a healthy weight in health center populations, describe some of the challenges health center patient populations face in maintaining a healthy weight.

And to provide presentations from two current BPHC health center grantees who will discuss their approach to achieving healthy weight in patient populations. I hope you find this call informative and enlightening.

And I encourage you to contact us at the Web site shown on your screen for any additional questions. With that I give you Dr. Robert Sigh, Senior Clinical Advisor for the North Central Division in the Bureau of Primary Health Care.

Dr. Robert Sigh: Thank you Dr. Linde-Feucht. Before beginning this overview I just want to once again remind you that we have an updated slide presentation on the BPHC TA Web site that was uploaded at 12:30. So just make sure that you have that and we can be on the same page.

I will begin this presentation with a short overview which will include the obesity trends in America and in the health center population. We will also

review the Bureau of Primary Health Care's efforts that promote directly and indirectly healthy weight.

And remind you of the resources available to grantees to pursue quality improvement initiatives. Next slide. As we look at the obesity nationally we see a significant change in the last 20 years.

Data from the Centers of Disease Control and Prevention shows that 20 years ago no state had an obesity rate higher than 20%. However, in 2010 no state had a rate lower than 20%. In fact the US average is roughly 33%. Next slide.

Obesity is defined by a person's Body Mass Index which takes into account the weight and the height according to the formula on this slide. As we look at normal weight, BMI is 18.5 to 24.9, overweight has a BMI of 25 to 29.9 and obesity, a BMI of 30 and greater.

How has this affected the health center population? Nearly 1/2 of health center patients are obese which means that nearly 1/2 of the health center patients have body mass indexes of greater than 30. And what is the impact of obesity?

Obesity accounts for 2/3 of Type II Diabetes as well as drives the hypertension, high cholesterol, heart disease, stroke and certain types of cancer. What about the cost in the United States? It has doubled since 1999 up to \$147 billion.

Surprisingly loss of life expectancy of eight to ten years is the same as smoking. Of course heart disease, cancer, stroke, diabetes are among the ten leading causes of death in the United States.

However, the good news is the top leading causes of death are responsive to lifestyle interventions including achieving healthy weight. Next slide.

Now this slide gives us an idea of the number of patients served through the community health program, the number of patient visits and the number of dedicated staff providing quality healthcare.

The takeaway message from this slide is nearly 10 million patients served as community health centers are affected by obesity. Providers have an average of four visits or opportunities per year to assess weight, advise, intervene and provide follow ups or referral care or in a team based setting. Next slide.

Now let's consider the healthy weight initiative, how it fits into the broader national quality strategy. The national quality strategy seeks to promote quality healthcare that is focused on the needs of patients, families and communities with three aims for the healthcare system.

Better care by improving the overall quality by making healthcare more patient centered, reliable, accessible and safe.

Promote healthy people in community by improving the health of the US population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering high quality care.

And finally, providing affordable care by reducing the cost of quality healthcare for individuals, families, employees and governments. Promoting healthy weight is a part of the aims of the National Quality Strategy.

However, for it to be successful all health weight strategies must align at all levels. Next slide. From the bureau and agency level here are a few efforts around obesity initiatives. And I just want to highlight two on this slide.

The patients in the medical home initiative, although it focuses on the infrastructure and health IT it will help foster such initiatives as the healthy weight initiative.

And of course the healthy weight collaborative we will have two health centers report on their experiences with the HRSA Healthy Weight Collaborative. Next slide. As we look at clinical quality measures from the calendar year 2011 four new UDS clinical measures have been proposed.

These measures support current Health and Human Services priorities. Two of the new clinical measures are related to healthy weight management - child and adolescent weight assessment and counseling, adult weight screening and follow up.

In order to adequately intervene in both the childhood and adult obesity problem there must be a concerted effort to assess, document and follow over time and include these two measures as part of the clinical quality improvement plan. Next slide.

In conclusion, I want to remind you of resources for obesity at the following Web sites, the accreditation Web site, the patient center medical home health initiative and also the Healthy Weight Collaborative. Next slide.

Please refer to my contact information on this slide for future questions that may arise after this webinar. Now let's move into the really interesting and practical part of this presentation.

Our next presenter is Dr. Shikha Anand, Director of Obesity Programs for the National Initiative for Children's Healthcare Quality and a pediatrician at the Codman Square Health Center in Dorchester, Massachusetts. Dr. Anand?

Dr. Shikha Anand: Thank you Dr. Sigh. So for this part of the presentation we will be focusing on a little bit of the evidence base and how obesity impacts your community health center. And then focus more in depth on practical strategies to address obesity within your population. Next slide please.

So as Dr. Sigh reviewed there are numerous statistics about the concern of obesity. To focus a little bit on the pediatric data, more than 1/3 of children ages 10 to 17 are obese or overweight. And state specific rates range from a low of 9.6% in Oregon to a high of 29.9% in Mississippi.

And as you all know, poor minority children are disproportionately overweight and obese so they're more affected by this epidemic than other populations making it a more - a larger challenge within our health center population. Next slide please.

On slide 16 this is the action model to achieve Health People 2020 overarching goals. And the reason why I draw attention to this model is because it really outlines nicely the different factors that impact obesity.

So in the innermost circle it draws attention to the genetic factors that influence obesity. You know, even within families there may be different members who eat similarly but have very different body mass indices. And so the genetic factors play in, in that way.

And then the individual behaviors that are selected as well as the social family and community networks, so the support that exists within the community, and then the second to last ring is the living and working conditions. So the choices that are available readily to patients and families.

And then in the outermost circle really thinking about the policy and the system and the environment that either support or don't support a healthy eating and active living for the families that we serve. Next slide please.

So there are numerous factors that impact obesity in underserved communities many of which you're all too familiar with but I thought I would highlight a few. The first is limited access to healthy, affordable foods. I think this is a problem in many underserved communities.

Many of our families live in food deserts where there are limited numbers of full scale grocery stores or there is limited access to fresh produce through farmers' markets and other outlets. There - in contrast there is easy access to unhealthy foods.

Portion sizes are increasing both in fast food outlets and in other restaurant outlets and other venues within the communities that we serve. Unhealthy foods continue to be prevalent in schools and workplaces although we're making a lot of headway with this.

I think that still it is very prevalent to have unhealthy cafeteria meals or unhealthy foods in vending machines.

And then there is an abundance of unhealthy foods in drug stores, convenience stores and bodegas so all of the smaller retail outlets where a lot of our families do the majority of their food shopping.

In addition to that there's targeted marketing of high energy dense foods and sugar drinks across the country but in particular to some of the populations that we serve. Next slide please. On slide 18 there are a few more factors that impact obesity in underserved communities.

In many communities there are no safe and appealing places to play or be active. There are high rates of television and media use that limit the time available for physical activity. There is limited community support for breastfeeding as a strategy to prevent obesity.

Variance in parenting styles and skills - this often comes into play with younger parents. And this impacts feeding behaviors and the food choices that are available for children. And then there are cultural barriers to weight loss.

So there may be certain cultural preferences for body images that are in fact associated with unhealthy weights by the definitions that we use according to the centers for disease control.

And a history of food insecurity in some families may also make them reluctant to restrict caloric intake in either themselves or in their children. Next slide please.

So the impact on community health centers - I think you all know that this has a tremendous impact on our health center populations. The prevalence is overwhelming. And there's a lot of time that is needed to spend with families to bring them around.

And there's a lot of controversy over whether or not the clinic is the best place to have these conversations with families but it is certainly one great place to

have the conversation in the current structure. So this is a review of a study that was conducted in 2008 with over 1000 patients in 70 health centers.

And in this study fewer than - and this is conducted only with overweight and obese adults. And in this study fewer than one of five overweight patients were told they were overweight by their provider. And certainly over half of obese patients reported being told they were overweight by their provider.

And this is concerning. And this status is consistent with this is in adults. This is consistent with pediatric data and with other adult data. I think as providers we don't always do the best job of identifying obesity and then of bringing it up with families.

And it's indeed a challenging thing to raise. But if you look at the next bullet, the patients that were told they were overweight by a health provider were almost nine times as likely to believe their weight was damaging to their health as those who were not told this.

So to me this is really a missed opportunity. We are not doing a great job of starting that conversation and despite the challenges that we all face in having these conversations.

But the impact that we could have is very - is large and you're nine times more likely to really acknowledge the impact of weight on health.

To me that suggests that there's good evidence for us to do a better job with having these conversations and we'll go through a few strategies to have those conversations on subsequent slides.

After adjusting for provider advice regarding weight status, both non-Hispanic Black and Hispanic patients were half as likely as white patients to believe their weight was damaging to their health.

So for those of you that work with largely minority populations, you know, it can be even more challenging to have these conversations and more challenging to get your message across.

But to me the reason to have the conversation more respectfully and more often which we'll talk about in the next part of the talk. Next slide please. So briefly I've listed for you the obesity measures. I know Dr. Sigh went into those as well. These are the specifics of the measures.

And what's notable to me is that in the meaningful use and EDS measures for children it's not only asking us to measure BMI percentiles but to counsel for nutrition and counsel for physical activity.

And so we're not only going to have to document that we know that our families are overweight or obese but we're going to have to document that we started that conversation with them. And in adults it's the percentage of patients with the calculated BMI.

But also if there's - the most recent BMI is outside of parameters but there's a follow up plan documented. So again not only are we going to have to assess BMI but we are going to have to follow up with families and with patients and really work with them on their obesity. Next slide please.

The (HEDIS) measures are fairly similar to the EDS measures but the notable change - the notable difference in children is that it includes counseling for

screen time as well as nutrition and physical activity. And in adults it does not mandate the presence of a follow up plan. Next slide please.

So what you can do in your health center and I've listed some of the strategies. There are many, many strategies that we can take. These strategies represent a mix of the evidence base as well as my personal experience running obesity programs and health centers over the past few years.

The first is very simply to incorporate obesity prevention and management into preventive visits. So - and we'll go into each of these in greater detail on subsequent slides. To conduct plan visits consider using team based care to conduct these plan visits and we'll go into that in more detail as well.

Understand the resources in your community for healthy eating and active living including farmers' markets, community supported agricultural shares, parks, community walks and other organized programs for physical activity.

To partner with community programs to promote healthy eating and active living and that includes things that you can do in your own community health center. So community health center based physical activity programs are prevalent throughout the country.

But also looking at things like connecting to farmers' market through farmers' market prescriptions and other means.

And then the last thing is if you have the ability to do this, to advocate for policy systems and environmental changes within your community because as that shows you on that Healthy People 2020 slide the individual health behavior choices are one piece of the puzzle.

But really it's going to take a real change in the environment to allow our families to be more healthy. Next slide please. So the first strategy I mentioned is preventive visits.

And so for all patients regardless of their weight status, it's important to obtain a BMI and then consider waist circumference in adults. I know some clinics are able to do that and other clinics are not.

To assess the weight status, so it's not good enough just to write down the BMI but to really classify the patient. And Dr. Sigh gave you the criteria for the adult obesity BMIs but for the children it's a little bit more challenging. You have to use the CDC curves and they're based on age as well as gender.

So sometimes it becomes challenging to do that within a visit but it's very important to assess the weight status because especially in children, people who look normal weight may not be normal weight.

And then to provide information about recommended eating and activity and that includes brain time. And then also consider recommendations around breast feeding and sleep. I think the data around breast feeding is quite well established. And the data around sleep is emerging.

But these are both considered to be strategies to prevent obesity. For patients who already are overweight or obese assess patient and family readiness to make changes. Assess comorbidities and determine treatment based on algorithms.

And I'll be presenting the pediatric and adult algorithms in subsequent slides. And then create a healthy weight plan including lifestyle goes, treatment and a plan for follow up. Next slide please.

So here are some just very simple tips for assessing and classifying BMI as well as the link for finding the CDC curves for children. Next slide please. And for dietary recommendations I think it's wise to choose a few that you mention as part of your usual routine in preventive visits.

Here are some of the things that I focus on both within preventive and planned obesity visits. Make half of each plate fruits and vegetables. I think that's a really easy thing for families to understand. Try to get five servings of fruits and vegetables per day.

Remember that for families particularly on fixed incomes fresh is better than frozen which is the most expensive option. But frozen is better than canned and sometimes the price per serving is fairly equivalent between frozen and canned. For grains, making at least half of the grains you eat per day whole.

For beverages drinking water instead of sugary drinks and switching to fat free or low fat milk. Portion control - enjoy your food but eat less. I think that's a really important message.

Many of the families I see are eating quite healthfully but really eat so much that it would be difficult to lose weight at their current, you know, at their current portion size. And then consider reducing the plate size. This is something I go over with families.

So if you're using a ten inch plate you might want to go down to an eight inch or a six inch plate. And I tell them not to pile it high but to kind of make it flat across.

Again very simple visual messages that families can absorb well as strategies that they can take home with them and hopefully make changes on that same day or that same week. And then to avoid oversized portion so buffets and supersized meals, I think we all know that.

But maybe we don't all stress that within our clinic visits. Next slide please. For activity recommendations in children it's one hour or more physical activity daily and it's two hours or less of screen time daily.

There's a bit of controversy around whether - television is clearly the worst offender but whether video games or other modes should be included in that screen time versus TV alone. I think in general less screen time is better but certainly less than two hours of TV per day.

In adults the recommendations are here and to set a long term goal to accumulate at least 30 minutes or more of moderate intensity, physical activity on most and preferably all days of the week. And on - the next slide please.

There are some examples of moderate physical activity so I think it's very easy to think about physical activity for patients who are really active so who do things like bike or run or swim.

It's more challenging for the patients who are overweight often who don't engage in sports or other real forms of physical activity that are listed in the sporting activities on the right, who may need to incorporate more rigorous activity into their daily life.

And so for this reason I've given you this list of common chores that qualify as moderate physical activity. And you'll note that as the intensity goes up of the activities, the time needed goes down. Next slide please.

On slide 28 the next strategy is really evaluating readiness of the patient you're seeing and in setting goals for weight loss. So when you evaluate readiness there are a few things to keep in mind.

The first is to discuss the patient's reasons and motivation for weight loss if they have any, previous attempts that they might have engaged in that may have sort of colored their view of what works or what doesn't work, the support they expect from their family and friends.

So many of our families live in larger households and so it's very difficult for one family member to restrict their caloric intake when what's in the pantry is entirely junk food. So we're really thinking about how this fits into their broader living situation.

The understanding of the risks and benefits of weight loss - so, you know, I see children, I'm a pediatrician, and I really focus on health much more than weight.

So really understanding the consequences of obesity and then how weight loss can alter their trajectory towards consequences like diabetes or heart disease or other comorbidities. Understand their attitude towards physical activity, what they like and what they don't like is really important.

The time they have available to engage in these activities every day so food prep can be very time consuming and sometimes that drives families' food choices. And then potential barriers to the patients' adoption of change and that's covered in some of these other bullets.

But then just flatly asking, you know, whether they think they can make changes. And if they don't think they can make changes why not and how you can help them overcome those barriers. Motivational interviewing techniques - there is emerging literature on that.

It's becoming more and more mainstream within the obesity literature. I use these all the time within my clinic visits and I think that they're incredibly important. They are a topic unto themselves so I won't go into them in detail here.

But certainly if you have questions you're welcome to ask them at the end or contact me. Setting self management goals - so I think it's really important to have the family set the goals for you. So - and sometimes it's not the obvious goal.

So in the past I've had children who drink a liter or two liters of soda a day and clearly if they continue to drink that much soda there is no possibility that they can sort of grow into their weight if you will. But they may instead choose to start walking around the track once a day and I've had this situation.

And it's a challenge because you want them to just stop drinking the soda and you're dying to tell them that but if they set the goals, if they will adhere to the goals better and as they work their way down the list of goals they will eventually get to the things that are at the top of your priority list.

So do make sure that they are self management goals not provider driven goals.

And then for patients who you're having difficulty finding the gaps, you know, we - I see a lot of patients who feel like they're doing a great job and

they're eating really healthfully and they can't understand where the weight is coming from.

Consider a food and activity diary because often patients eat more than they think they do or they exercise less and that can help you develop discrepancies between the goals of obtaining a healthy weight and then the practices that the patient is currently engaged in that are preventing them from getting there.

Next slide please. Weight loss briefly, in children when they are still growing, the goal is to maintain weight and then decrease BMI as height increases. For adolescents who are growing slowly or not at all defer to the adult recommendations.

The adult recommendations are listed here. I won't read them to you but these are the kinds of baseline recommendations for weight loss. And the key point here is reducing a weight at a rate of about one to two pounds per week for six months.

Next slide please. So this slide and the slide to follow are algorithms for managing obesity. This is the pediatric obesity algorithm that was developed in 2007. Again I won't read it to you. This is for your reference after you leave this talk today but I am happy to take questions on it. Next slide.

And this is for managing obesity in adults. Again these are the very basic recommendations. You know, you can easily set up a whole day conference on pharmacotherapy or surgery alone. But these are kind of the basic recommendations for managing obesity in adults. Next slide please.

Planned obesity visits - so both adult and pediatric guidelines emphasize frequent follow ups of planned obesity visits. And the goals of these are to

determine the treatment response, whatever your treatment is and then to reinforce the self management plan and set new goals.

So, you know, what works best for me in clinic is to set two to three new goals per month and again these are patient centered goals.

And when you're seeing (diads) - parent and child, I often actually have them each set goals and sometimes set goals for each other so that they can really work with each other and the goals are well aligned.

Because you can imagine if one - if the goal of the child is to reduce sweetened beverages and mom continues to buy juice it's not actually going to work that well. So you may need more than one set of goals if you have more than one family member in the room.

So and then at these monthly visits what we do is reinforce the self management plan. We look at the progress made on the goals set last month and then look at whether some of these goals have been met and can move to a maintenance phase and whether it's time to add new goals.

And the monthly frequency has worked best for me. I have tried less frequent and more frequent visits.

I think there are a lot of people who do monthly visits but I know that this can be very difficult to conduct in the usual clinic flow, particularly if you work in an area where there just isn't enough primary care access to begin with.

I have developed a team based obesity care model in part because the challenge of obesity visits is that they take a long time particularly if you're

going to do things like goal setting that can be relatively complex and engage in motivational interviewing.

And so what we did in my clinic and we spread to the clinic subsequently, is to reorganize care for the provider and nutritionist and a community health worker, all accessible to the family at the same time.

And the roles are listed below that but the real goal of this is to allow the provider a short time in the room but still reinforce that health messaging that allows people to really believe that there's a link between weight and health as I mentioned in one of the first slides while allowing the nutritionist and the community health worker to really provide more details on the diet and activity recommendations. Next slide please.

So going beyond the encounter - partnering with community and public health agencies to create innovative programs and consistent messages for families, I think the more that you can partner across your community the more effective you will be.

And that's certainly been a basic principle of the Collaborate for Healthy Weight initiative that Sarah mentioned at the beginning of this call. Create more opportunities for healthy eating and physical activity at your community health center.

So again if you have a pharmacy in your basement and the pharmacy serves unhealthy food at least working with the pharmacy to get better foods offered would be fantastic. Advocating for policy as a simple environmental change in your community and there are some examples listed below.

And then connect to a national movement. Next slide please. So on slide 34 there are some ways in which you can connect nationally. And there are so many obesity initiatives that are wonderful. This is just a sampling of a few that I've worked with in my own experience.

So, you know, the first way you can do this is by joining a learning community. The second is to use evidence based patient materials to reinforce your message with families and with patients. Next slide please. The third is to advocate for environmental change.

The fourth is to add your effort to a resource map and then the fifth is to host or attend an event in your area to sort of get the community engaged around healthy eating and active living. Next slide please. So that's all I have for today. I'm happy to take questions.

This was a very brief presentation so there is certainly much more content that we could cover and so I welcome questions from the group. Thank you.

Coordinator: Thank you. If you would like to ask a question please press star 1 on your touchtone phone. Please unmute your line and state your name only. To withdraw your question press star 2. Once again if you have a question please press star 1. One moment please for the first question.

We have one question - the party's name was not captured. Please state your name and ask your question.

(Julie Woodyard): (Julie Woodyard). Our community health center started a community garden last year and it is only two blocks away from the center but we've had trouble getting people to take advantage of the free seeds and plants and free advice and everything that they could possibly want.

I'm just wondering if you have any advice on how to get people excited about that.

Dr. Shikha Anand: Absolutely. Have you targeted the children specifically in your community?

(Julie Woodyard): Not yet but we are going to do that this year.

Dr. Shikha Anand: So I am a pediatrician, full disclosure, but I think that that's a great place to get families engaged. I certainly have seen in the programs that I've run, that engaging children is a great way to engage families. They come home really excited about what they learned and what they grew.

And that gets the parents excited because they're proud of the child's accomplishment. So while that won't capture your whole community that can give you that beginning critical mass to move forward.

(Julie Woodyard): Okay, thanks.

Dr. Shikha Anand: Sure.

Coordinator: Once again to ask a question please press star 1. One moment please. I'm showing no further questions at this time.

Dr. Shikha Anand: Great. Thank you. I'll turn it back over to Dr. Sigh to introduce the next speaker.

Coordinator: Excuse me. A question just came up. One moment please.

(Penny Crumpton): I was wondering if there's any...

Coordinator: (Penny Crumpton) your line is open.

(Penny Crumpton): Yes. I was wondering if you have any suggestions for funding or resources to fund these childhood obesity programs. We're a federally funded health center and finances are tight. So I just wanted to see if you had any suggestions on grants or things on how to fund these programs for kids.

Dr. Shikha Anand: Absolutely. Well I think that there are actually a lot of funders at this time interested in obesity. I think it depends on the type of program you're running. So do you have a specific program in mind?

(Penny Crumpton): No. I've just been on staff for a little over a year and so I'm just kind of getting my feet wet and trying to get my arms around this obesity epidemic in our county. So I'm really at the baseline here of what to do since it tends to be overwhelming when I really...

Dr. Shikha Anand: Great.

(Penny Crumpton): ...focus on it.

Dr. Shikha Anand: So my brief advice on how to approach this would be first, ask your families what they want as you design your pilot. They will tell you things that you could never guess or that's certainly been my experience again and again.

And then once you have an idea of a pilot I think there are a lot of local funders that are interested in funding community wellness at a low level. So you might be able to get, you know, five or ten or \$15,000 from local funders.

And the most likely suspects in those tend to be insurers or hospitals, the community benefits offices of hospitals sometimes can provide that type of support. Surrounding workplaces or small businesses also can be great resources.

And to me those are some of the best places to start with your seed funding. And then you use that to build up data.

Make sure that you collect metrics on your initial pilot so that you can then go to the next layers of funding which are larger foundations and then potentially down the road federal funding, government funding and things like that. Does that answer your question okay?

(Penny Crumpton): I think so. Yes. Thank you.

Dr. Shikha Anand: Sure.

Coordinator: We have another question from Dr. (Tolentino). You may ask your question. You may ask your question.

Dr. (Esther Tolentino): My question is in terms of fasting labs, some literature shows that with children it's not necessary to have them fasting which would actually help in terms of seeing them at the visit, if it's an afternoon, drawing the blood at that time. What's your recommendation on that?

Dr. Shikha Anand: Yes. I think increasingly people are going to non fasting labs. My personal experience in a health center population, I think probably I did - I ordered maybe 50 or 60 sets of fasting labs when I first came out of training. And I maybe got one or two back.

So I think that the rates of return are pretty abysmal depending on the adherence of your population. I do random labs first. And if random labs are abnormal then I discuss the results with the patients, random being non fasting, a random plasma glucose.

And it's - if the results are abnormal you now have sort of a teaching moment with the family because now they're as concerned as you are. And then actually the adherence to fasting labs is very good. So I do the randoms as screening.

Dr. (Esther Tolentino): Thank you very much.

Dr. Shikha Anand: Absolutely.

Coordinator: (Rini Basu) you may ask your question.

Dr. (Rini Basu): Hi. I'm a pediatrician as well and I was just wondering if you ever go over a specific meal plan with your patients or - because right now our clinic is set up so that they see the nutritionist separately and then they see me on separate visits.

And I go over the general guidelines like half of your plate should be fruits and vegetables. But do you ever go over a specific meal plan with them or do you leave that to the nutritionist?

Dr. Shikha Anand: I think it depends on the family. But I - so I think that the nutritionists do a good job with that.

I have done most of my recent work in a multidisciplinary setting where the nutritionists and I were part of the same visit so I had access to her records when I was seeing the patient so I could just kind of reap the benefit of the 24 hour food recall.

I think in terms of setting up meal plans it depends on the stage of readiness of the family. But for most families I see that's a really overwhelming idea that we're really going to structure the meal plans bit by bit.

So I think that what I choose to do is target a few behaviors so looking at the self management goals. And we use kind of a motivational interviewing type bubble sheet where there a whole bunch of different diet related options. So one may say, you know, increase fruits and vegetables.

Another one may say decrease sweetened beverages and we allow them to choose one of those behaviors to target as one of their goals for the month. And I've personally found that to be more effective than really spending the time on meal planning.

Dr. (Rini Basu): Okay. Thank you.

Dr. Shikha Anand: Sure.

Coordinator: I would now like to turn the call back over to Dr. Robert Sigh. Sir, you may continue.

Dr. Robert Sigh: Thank you very much Dr. Anand for that informative and insightful presentation. I just want to ask one more question before we continue. How do you - what is the best way to start a conversation with a client who is obese or overweight?

Dr. Shikha Anand: Thanks Dr. Sigh. So I think the - one of the big techniques in motivational interviewing is asking permission. And for those of us who have trouble starting these conversations this is a great way to begin.

So very simply asking - saying, you know, I noticed that according to criteria you're considered to be overweight. Would you mind if I talked to you about this in greater detail today? Now if they say yes, I would mind that's it, you're done. The conversation is over.

You're probably not going to get anywhere anyway. But the majority of patients will say yes, they're willing to talk about it. And they - it's disarming for the patient.

So they - you've now sort of leveled the playing field and you're going into this as a partnership and it really changes the tone of the conversation. So it's an easy thing to do and it's a really important thing to do and a great way to frame that conversation.

Dr. Robert Sigh: Okay. Well thank you very much.

Dr. Shikha Anand: Thank you for having me.

Dr. Robert Sigh: Now we will look at perspectives from the field from two health center grantees.

Our next presenter is Deborah Horowitz with - Deborah is the Care Process Coordinator and an adult nurse practitioner at CAMcare, a federally qualified health center which serves an urban population in the Southern New Jersey area.

In addition, Deborah directs the center's healthy weight program. Deborah?

Dr. Deborah Horowitz: Thank you Dr. Sigh. Let's continue our conversation on a local level in an urban center. Presently located in Camden we have about 79,000 people in Camden, New Jersey. Unfortunately in 2010 we had the unfortunate distinction of being rated the second most dangerous city in the United States.

Thirty six percent of the people in Camden are below poverty level. As that's compared to about 8% in New Jersey. Next please. Next slide please. Thank you. We have eight offices in Camden. Twenty six percent are uninsured patients there.

We serve internal medicine, pediatrics, OBGYN, dental and podiatry. We also have social workers and dieticians fortunately. At CAMcare we have 20 - excuse me, 33,000 active patients. That is approximately half, excuse me, about 41% of the population in Camden so we have quite a bit of work to do.

We have a large minority population at CAMcare. Eighty eight percent are Hispanic or African American. And 52% of our population is either overweight or obese. Next slide please.

The way we'd like to approach our healthy weight program is that we try to look at the organization, the program and the individual. We don't split them. We see them as a whole. But in order to start a program we kind of need to wrap our - get our head around three distinct areas.

We wanted the program to be part of the quality improvement plan. We thought that was really important for our organization to recognize healthy weight as a concern.

And we wanted it to be business as usual, the visits were planned, they were dynamic, that the whole organization was invested in weight reduction and healthy weight. We have a dedicated team that establish goals and outcome measures within the organization.

On that team is a nurse practitioner, a physician, a social worker, a dietitian, an outreach worker. The program needed to be flexible we felt with providers, staff, front desk, call center, business personnel working on the same thoughts and line of how to approach the patient.

The program itself we wanted to be comprehensive and utilize number of disciplines that I just spoke about and dietitian, social worker, outreach worker as well as providers.

We wanted to try to touch the patient as many times as we could with offices, phone calls, letters, get patients in for (fares) or outreach. Literature so they could talk about healthy weight during visits.

And also the individual patient - we wanted them to be well informed, goal directed, proactive in their healthcare and have self management goals. We wanted to guide the patient and - but we wanted them to have ownership of what their goals would be. Next slide please.

Really important when we started developing our healthy weight initiative is for a program to be successful we felt the organization itself needed to have outcome measures.

Seventy - our goals were that 70% of our patients would have self management goals, 25% of the patients, this slide's a little off, would have

10% loss of BMI within one year. Twenty five percent of patients would have attended a nutrition education program.

And 25% of the patients would have individualized exercise programs. Next slide. Well how were we going to do this, get this program off the ground?

First we'd like to define healthy weight guidelines, formalize a program, integrate healthy weight and nutrition referrals into our electronic medical record, track patients participating in the program and then improve our outcome measures. Next slide please.

This is CAMcare's healthy weight clinical guidelines. What we wanted to do is have everybody in the organization be able to number one, define what obesity was. We started about three years ago, the whole program so at that time people kind of didn't have that distinction, well they look overweight.

We wanted people to really define what overweight is, put that on the problem list of the patient. So that was an education period we needed to do for all the providers and staff. As you can see on the guidelines, they're a little different from Dr. Anand in that these are specific to CAMcare.

Where patients for BMI, the fasting glucose, A1Cs, but if you look down patients once they identified that obesity as a problem we wanted people to directly refer them to the healthy weight class and to our exercise program. Just like diabetes everybody gets an A1C.

Everybody would be referred to the classes and exercise. Next slide please. So what we did first - we wanted the community to know that CAMcare was very involved in healthy weight and healthy weight so we had a kickoff initiative.

We invited patient families - everybody in the community to a kickoff walk. There were balloons, you know, the whole type fair thing going on. We had an exercise class during that, cooking demonstrations, patients' BMIs were calculated, blood sugar, blood pressure, that type of thing.

We also had a referral system initially that was paper for our outreach for patients. So the provider would refer patients to our healthy weight program and to the dietitians through paper. And then we'd transfer that into an EMR referral.

Word of mouth for population recruitment - our outreach team and our fliers we tried to get into our programs. Next slide please. Next slide. There we go. This is what our - this is our electronic medical record.

As you can see closely, the providers are now able to, through their plan, go and into referrals and refer patients to the healthy weight program through the EMR and the referrals. I know everybody probably has different EMRs but this would be our referral into the healthy weight program.

So this would go - these refer to the dietitian and the dietitian could now call the patient, offer them a nutrition one to one visit and also refer to the healthy weight classes. Next slide please. Next slide. Thank you. We thought it was very important for patients, as I said before, to be goal directed.

So we laid out some patient learning objectives that they could be very clear in their mind where they were going with their weight. We wanted them to be able to identify conditions that were associated with obesity not to just think oh, I don't look good but to really understand what the problems were.

What - how to manage their chronic diseases, how to plan a menu and to describe how to prepare a healthy meal. We wanted them to incorporate an exercise as a way to sustain weight loss and to build a social network to support each other's efforts. Next slide.

I think it's really important to be able to outreach to other sources for support not just within the center. I think that's how, you know, everybody's been mentioning, Dr. Anan mentioned, to be able to outreach to get some other organizations to help you.

We have Rutgers University in Camden, New Jersey here and they have Rutgers University Cooperative Education Extension Program where they have community based educators, people that are from the community teaching our classes.

And you can see the curriculum on the side on that little flier we have. So people from the community teaching patients within the community those - they have a good give and take rather than a provider or a dietitian that's not from the community, teaching them about their healthy weight and nutrition.

The baseline BMIs were collected and tracked at each class. Self management goals are set and generally the program goals for the program were met except exercise. All classes were taught in English and Spanish. Next slide.

This is something that CAMcare, our team developed with Merck Drug Company. And this has been a really wonderful tool for us. Number one, it's low literacy, it's at a low literacy level. So it's been real good for teaching.

On the right hand side you'll see some goals for the patients to be active, eat healthy foods, smaller portions and eat breakfast, lunch and dinner with just the pictures and simple terms.

Why this has been really good is for the provider also it's a very quick tool to teach patients what they can do to lose weight. It's also bringing up how to talk to patients. It's very visual. This is how tall you are? This is your weight? And it's very visual. If you're in the red that might be an issue.

Where can we go from there? Merck has been wonderful. They worked with us to get this going and we're real interested in helping our healthcare centers with multiple chronic care problems. They've been really helpful with diabetes, etc. Next slide please.

So our baseline obesity data - we had 42 clients after this whole outreach with the health - excuse me, healthy weight initiative. Forty two clients were identified with a BMI greater or equal to 30 that were referred to the program.

All 42 clients were contacted by phone, by mail or called a week before starting the program. Two clients had a scheduling conflict and 16 clients did go to the class.

My recommendation over doing a lot of these programs is it seems like two to three times - you need to outreach to at least two to three times of what you're expecting to a class because it tends to have a low rate of people coming in because of probably many social situations.

Kids are coming home from school early that they can't get to classes. Anyway, next slide. At the end of six weeks the weight change of 2% or more

was achieved by 38% of our clients participating in the program. One client's BMI was reduced from obese to the overweight category. Next slide.

Next slide please. Okay. Next we felt we could move from the classes, our actual classes to integrate an exercise program. So in March of 2011 we did start an exercise program.

One of the goals was to improve the healthy weight class and also to improve the weight loss as though instead we're attending that healthy weight class. Next slide. Again we thought having patient learning objectives so again they knew where they were going and why they were doing what they were doing.

We wanted patients to be goal directed and develop a unique plan for themselves. And you can see there again they want - we wanted them to have - understand and name three conditions associated with a sedentary lifestyle.

Describe how exercise and lifestyle changes can reduce and help manage chronic disease. Plan a personal exercise routine and design target goals and timeframes to accomplish this. And excuse me, incorporate exercise as a means of achieving and maintaining health.

And build a social network to support each other's efforts. Next slide. Our exercise plans have been very, very successful. People are really excited about them. The group setting with these classes, people being in motion, very supportive of the whole group.

As you can see, good current - very good turnouts. We're really proud of that. Next slide. Next slide please. Okay. What you can see in this slide is March started exercise and in April you see people are in the healthy weight class. They're probably just getting to know what's going on.

The healthy weight classes are eight week classes. And by September quite a bit of people had lost weight from that group before present. December we're not sure what's going on but that's a new session of classes.

I'm hoping that at the end that group, which should be in March, we're going to be seeing an uptick again in loss of weight. Next slide please. Okay. The program successes - we really show you - the kickoff in the beginning really helped the community and our organization get up to speed on healthy weight.

Development of goals and outcomes has helped us move as an organization forward, integrating the healthy weight class with exercise has been really successful. Collaborating with our community, how the university at Rutgers has been essentially with teaching those classes with community leaders.

The implementation of our BMI self management tool has been, for myself as a provider, a huge rebound. Also the patient's being offered a one to one visit in addition to our classes. That's been very successful for people that might not want to be in a group situation.

So things are very streamlined and tailored to the individual's needs. The integration of the EMR with our referral systems have very much helped. You can query the patient for follow up and outreach. Next slide.

Educating the staff for the BMI as a vital sign besides temperature, pulse, respiration, pain and now the BMI, has been really good because people - it's right there in your face with the EMR because our - excuse me, our BMIs are calculated on our EMR.

So the provider now can see what the BMI is and then put the diagnosis of obesity or overweight in the problem list. Availability of the community support - with the drug companies and anybody else you can get out there to support you is very important.

CAMcare has transportation to classes which has been very successful and helpful. Our challenges as has been mentioned before, is poverty and lack of nutritious food. We have no supermarkets in Camden and very few corner markets.

There are a few fresh food markets and in the summer and spring there are gardens - community gardens. And of course patients' motivation and social considerations have been a big problem. Okay. Dr. Sigh, I'll send that back to you. Thank you.

Dr. Robert Sigh: Thank you Deborah for that important presentation that you have shared with us. Our next set of presenters will be from the RiverStone Health, a federally qualified center which serves a primarily low income population in the Billings, Montana area.

Billings is the largest city in Montana with a population of about 100,000 people. Mr. John Felton is the President and CEO of RiverStone Health and the Health Officer for Yellowstone County.

Hilary Hanson is RiverStone's Health Director of Population Health Services and the County's Deputy Health Officer. And finally, Megan Littlefield is Medical Director of RiverStone Health Clinic, a public model CHC. I believe we're going to start with John.

Dr. John Felton: Yes. Thank you Dr. Sigh. We want to first of all spend a little bit of time talking about our organization because we are a public model health center which as you know is a small minority of health centers.

RiverStone health itself is actually a DBA or an assumed business name for Yellowstone City County Health Department which is a local public health agency for Yellowstone County Montana.

Unlike CAMcare which serves an urban population, although we are the largest city in Montana ours is a much less densely populated area. Yellowstone County is the most populous county in Montana with only 145,000 residents.

And as noted, Billings is the biggest city in the state with about 100,000 people. RiverStone Health is a relatively diverse agency. We have about 35 different programs in the areas of public health, health services, education and social services.

And we have about 340 employees. One of those programs is RiverStone Health Clinic, a public model community health center that's operated since 1984. Next slide please. Can we go to the next slide? Okay. Our health center serves around 15,000 active patients.

Most of those patients do reside in Billings. However, we have three rural satellites that are 25 to 45 miles from Billings where we are the sole community provider in the small communities. We serve the Montana Women's Prison and we have several healthcare for the homeless sites.

Our program is a full scope family medicine program with comprehensive primary preventive care. We do have integrated behavioral health programming in our community health centers as well as dental services.

One of the kind of unique things about our organization is we are the home for the Montana Family Medicine Residency which as of now is the only graduate medical education residency program in the state.

And as a result of that, RiverStone Health Clinic is one of the original 11 teaching health centers in the country under that program. Next slide please. One of the core competencies of RiverStone Health has been collaboration.

We have a very long history of collaboration with the two hospitals in Billings and - as well as a number of other healthcare and social service agencies. One of the things that we're recognized for is our role as a community (convener).

A lot of things that are community wide and activities and programs really start here or we help organize them. And one of the really interesting alliance - or collaborations we have is known as the Alliance.

And that is the CEO and a couple of senior staff members, RiverStone Health, Billings Clinic and Safe (unintelligible) Healthcare, the latter two being the two hospital systems in Yellowstone County. And what that Alliance is really focused on is developing community solutions to community problems.

And I think our mission really summarizes what this Alliance attempts to do and that is that we improve the health of our community, especially for those who are underserved and vulnerable, in ways that surpass our individual capacity.

In other words, we can do more together than we can alone. And so collaboration is something that our organization has really focused on as a core competency and something we should both - we should spend a lot of time and attention on. Next slide please.

One of the things that we've done is - as a collaboration, as an Alliance, is the community health assessments. And we just completed our follow up. We did the initial one in 2005, we followed that up in 2010.

All three members of the Alliance did come together to cooperate on that and we used an outside contractor. There is a type on your slide. That's actually a 400 person telephone survey, not a 4,000 person telephone survey. We use a lot of other data as well. Next slide please.

We have a number of findings of this as you'd expect in any community health assessment. The one that's particularly relevant to this program is that our rate of overweight and obesity did increase significantly among adults.

We saw a slight decrease but not an insignificant decrease in overweight children. And the reason this has become such an important part of our focus is on the next slide. So if we go to the next slide what this shows you is the prevalence of various chronic diseases.

And you can see them, hypertension, high cholesterol, depression, suffering as part of poor health, diabetes, (unintelligible) and maybe depression.

And you see that the prevalence of those increases very significantly in the obese group compared to the healthy weight group and it increases slightly for the overweight but not obese group compared to the healthy weight group.

And really it's that finding that significant impact or relationship between weight and chronic disease prevalence that led our - to our healthy weight initiative.

So now I'm going to ask Hilary Hanson who is our Director of Population Health Services within our public health service, to talk about our community health assessment in a little more detail as well as our community health initiatives around the healthy weight program. Hilary?

Dr. Hilary Hanson: Thanks John. If you can go ahead and go to the next slide, slide 64. So as John discussed, we did our community health assessment in 2011. And here you can see that the results were kind of shocking to us that 72.9% of the Yellowstone County residents were overweight or obese.

And you can see this is higher than both the Montana and the US average. Next slide please. The other reason that this was pretty shocking to us is that this was a 10% jump in just five years from our 2005 community health assessment.

And so this really gave us some time to reflect and say we're working on some things but clearly we need to take this a step further. Next slide please.

So what the Alliance did is following actually the 2005 community health assessment and kind of re-hitting it hard after the 2011 community health assessment was the formation of a Healthy By Design advisory committee.

And this committee is made up of a wide variety of people from our community. Some of the people would be the traditional people you see at the table and then we've also started to try and get some of those non traditional partners involved.

The goal of the advisory committee is really to take a look at our community and say how can we make the healthy choice the easy choice? So how can we change our community so that everything is healthy by design? Next slide please. And you see from this some of our initiatives.

We are working with the Office of Women's Health on some women and children gender issues. We've done complete (streets) policies for our community so we've really gotten involved in how our roads are built and the ways that we can (send) our community.

And then we have some different - a recognition program for events in our community for those that are designed with health in mind. And then what I want to focus on right now is our healthy weight collaborative. Next slide please.

So we were one of the first ten chosen from the National Initiative for Children's Healthcare Quality to start working on the Collaborate for Healthy Weight.

And this was a great timing for us because the other thing our community health assessment showed is that we had not only this high overweight and obesity rate but in addition we had 35% of obese patients that reported that they had not only - sorry, only 35% of obese patients received that their healthcare provider had talked to them about their weight.

And so we had a great opportunity in that the involvement of the Alliance, our two local hospitals and the local health department with our community health center, allowed us the opportunity to start looking internally about what we

can do across the healthcare system in our community to work on healthy weight.

So what we've been doing across these three organizations is working with specifically primary care providers which between the three organizations, make up a majority of the primary care providers not only in the city and county but also really in the region to make sure that we all have standard processes and messages regarding healthy weight.

So we've started to work with primary care providers to measure BMI status at the visits. Ensure that the patient is informed of the weight status and then to talk to the patient specifically about modifiable health risks.

And so we've put together a healthy weight plan that has some easy things that were talked about earlier, a lot of the same things like less screen time.

I'm going to work on getting one hour of physical activity or taking a walk every night after dinner with my kids or some really easy just changes that people can make. The other thing we did is we have adopted the 5210 message which you can see on the slide.

And this is used across the United States. But it's the first time we as a community have had one standard message around healthy weight. And the physicians have found that this is a really easy message, gets the point across, talks about some easy changes that people can make.

And now people are starting to see this when they go to their primary care provider. We're getting our (unintelligible) child health involved. And so our goal is that this would be the one message our community hears about health to make it easy, simple and standard.

And with that I'll turn it over to Dr. Littlefield who is our Medical Director of our Community Health Center, to talk about some of the successes and challenges we've had with this collaborative.

Dr. Megan Littlefield: Thanks Hilary. I'm going to spend a few minutes speaking from the clinician's perspective of the impact that this project has had on our health center. So, you know, as providers we know that obesity is a major problem in the health of our patients in our communities.

And I think, similarly to smoking cessation counseling, I think we often think we're doing a better job at educating our patients about this issue and so when we see the statistics that we've only talked to 35% of our patients about their weight, that that's really shocking.

And, you know, many providers are also overachievers. And so when we see that only 35% of our patients have heard about counseling on their weight that really drives us or motivates us for us to become more focused in addressing this.

So, you know, over the last several months we've really focused our attention and our energy on addressing it individually with our patients.

The fact that this is a collaborative project with physicians from all over the city, it's enabled us to work as a team with these partners and address this on more of a systematic level. And so we met early on in this process with providers from other health centers.

And even though the other health centers have a bit of a different demographic than us because we have - we are a community health center, we

were able to talk about ways that we can address this issue with our patient and how we can approach the issue of time management and how you - how we can address these often challenging conversations in a meaningful way with our patients.

The second thing this did was it gave us - it focused our efforts and resources into thoughtfully developing action plans and to come up with a framework of how to have this dialog.

So for example, we realized that our community health center because about 55% of our patients are self pay patients, many of them don't come in for preventive medicine visits but they will come in to have their diabetes or their high blood pressure or their chronic knee pain addressed.

And so figuring out how to tackle this conversation of weight management and tie it into those conversations with chronic care follow up rather than just in preventive medicine visits, it helps us to really move our - move this work forward.

Finally, we had the opportunity to identify and share community resources for self management and to identify the areas that where we have gaps in our community as far as resources. So for example, many of our patients can't afford to join a gym.

Well we are working on developing maps of walking routes in the downtown area or maps in the local mall that we can give to patients to help to encourage them with their activity goals. Next slide please. As far as barriers are concerned time is always the major barrier.

So finding time to collaborate with our community partners is a challenge. Finding time to incorporate these conversations in - to our patients' visits is always a challenge. Secondly, because we are a residency program we have turnover providers on a regular basis.

And many of these patients are meeting their provider for the first time and so figuring out how to have these sensitive conversations as a provider that's meeting a patient for a first time is often challenging. Next slide please.

And finally, the challenge of figuring out how to capture a measure such as intervention or counseling so we can see how we're actually doing at implementing these action plans is challenging in our EMR. And that's something that we are working through.

To wrap up I'm going to hand this back to John Felton.

Dr. John Felton: Thank you Dr. Littlefield. Just one last comment we've made is the challenge of community collaborations and coalitions - they have great promise but they are very fragile. They're valuable things that they can break easily. They're a little bit like a Faberge egg.

You know, you really need to take good care of them and if you do you end up with something valuable. If you don't you end up with something that sort of crumbles under its own weight. So especially during these times where there are a lot of other priorities, a lot of challenge we're all facing.

It does take some work and effort and time and energy and resources to keep community coalitions up and going and effective. The next slide has my contact information if anyone has any questions about our organization. I'd be happy to get those to the right place.

And with that we will turn it back to Dr. Sigh for the closing comments.

Dr. Robert Sigh: Thank you very much RiverStone team. We appreciate your very insightful presentation. We would like to point out that a resource guide on healthy weight is posted on the BPHC's TA Web site along with the agenda slide and the speaker bios from today's session.

We encourage grantees to take a look at this resource which pulls articles, tools, excuse me, and recommendations from the CDC and the Healthy Weight Collaborative. At this time we will spend the last ten minutes or so taking questions about the content of today's presentation. Operator?

Coordinator: Thank you. Once again if you would like to ask a question please press star 1 on your touchtone phone please unmute your line and state your name clearly so that I may announce you. To withdraw your question please press star 2. Once again if you have a question please press star 1. One moment please.

(Peggy Olman), you may ask your question.

(Peggy Olman): Hi. I'm calling from Community Health's Integrated Partnership in Maryland where we're a health center controlled network and we run the EMR for six of the FQHCs in the State of Maryland.

And as we move forward trying to make sure that our health centers meet meaningful use requirements, one of the things that we're building as the clinical forms that evaluate the weight management plans that are part of meaningful use.

So I was interested in the last speaker's discussion about the challenge that they're having in capturing the information in their EMR. And I'm wondering in particular, if people had template forms that they were using, to track both a pediatric and an adult weight management plan.

Dr. Megan Littlefield: Yes. So we have eClinical works here and we were actually working on this very issue today. We have the capability to use smart forms that can store the action plan into discreet data points. And so I think that that's the route we're going to go.

But that's exactly the challenge and that's the challenge for the meaningful use requirement. Is how do you capture that discussion has been had in a way that is convenient for the clinician to document and not have to go out into a separate field and push a button so that it captures that data.

And so we are hoping to be able to utilize the smart form capability to do that.

(Peggy Olman): Okay.

Dr. Deborah Horowitz: This is CAMcare, Debbie speaking. I'm one of the presenters. We've been capturing it both when you ask the patient about their exercise and their healthy eating that's one place to capture it.

And then we link it onto the patient instructions in the back when you have - we have a patient instruction area and we use centrlicity so that's another place we track it.

So when we post for acquiring whether the obese or underweight patient has had an exercise or a healthy weight or a nutrition plan those two things can be queried out for us.

(Peggy Olman): Okay, thank you. That's helpful.

Coordinator: Dr. (Norma Villeneuve), you may ask your question.

Dr. (Norma Villeneuve): I was wondering, and the presentations were great, thank you so much. But can the presentation talk a little bit about transportation to the classes? And I was wondering how you were able to do that?

Dr. Deborah Horowitz: We're lucky enough to have a CAMcare little van. So that's - within our organization we have a little van that does pick up patients if they need it for access to appointments. So we've utilized that for our classes.

If we know in advance they're coming to our classes we'll call them up ahead of time and make sure, you know, they're available for the class and set up that appointment time. And then the driver will go and pick them up and take them home after class.

Dr. (Norma Villeneuve): Oh, that's great. And then my - thank you and my second question is in terms of exercise classes are you doing that in the health center and are there any liability issues around providing exercise classes for the community?

Dr. Deborah Horowitz: Yes. It is in the center. We've structured it so we have our healthy weight class. Well it's 1:00 to 2:00 and then it's followed by the exercise class from 2:00 to 3:00 which has really helped, you know, motivate people to go to the healthy weight class and then also for the exercise.

And yes, I actually - we taught our outreach worker, you know, the method of teaching, you know, everything we wanted her to teach. We went over video

with her. We've chosen, you know, low impact, warm up, self management goal in the beginning of the class.

And we also have what's it called, release forms for the patients to sign. And if they have like heart disease or diabetes they have to go to their provider and have that signed before they can start the class.

Dr. (Norma Villeneuve): Okay. Thank you.

Coordinator: (David Griswold), you may ask your question.

(David Griswold): Hello. Whenever you're - excuse me, starting an intervention that's going to be sort of a systems based approach it's usually good to assess the quality of evidence that your intervention is likely to make a difference.

And also the strength of recommendations - I think the programs that have been prevented are interesting and well organized. But is there any evidence that they provide long lasting benefits to the patient population?

Dr. Megan Littlefield: So this is Megan Littlefield from RiverStone. I don't know - I don't have an answer as far as the data to support using action plans in obesity management. Someone else might be able to speak to that.

But I think that we know from other diseases that self management and having patients help to drive action plans in using motivational interviewing to approach the - approach behavior change has fairly good data to support that.

Dr. Hilary Hanson: And this is Hilary from RiverStone too. Again some of the things we chose were evidence based such as the 5210 messaging. There is a lot of research and an evaluation that's been done specifically on that messaging.

Coordinator: (Esther Tolentino) you may ask your question.

Dr. (Esther Tolentino): Thank you. Well this was very informative and we had a couple of questions. One is that the self management tool that is being used that it looks very nice and it's very simple, is that reproducible or do we need to get a copyright if we needed to use it?

And the other one is, you know, we are starting sort of a diabetes prevention clinic and we were wondering if you have some insight as to what would be the best way to recruit patients.

Right now we're having the providers tell the patients directly but I was wondering if there was anything else you would recommend.

Dr. Deborah Horowitz: That tool - if you want to email me I could send you that. I could send you an original copy and you could scan it. Merck does not have that on their Web site since they did make that with us, that we signed a contract with them.

If you want to talk to me, that's Deb Horowitz. You have my email address. We could talk back and forth about that.

Dr. (Esther Tolentino): Okay.

Dr. Deborah Horowitz: Were you talking to me about trying to get a program together and get patients into a program?

Dr. (Esther Tolentino): Yes. So we are planning to start - we tried doing a healthy weight or obesity clinic and no one would show up to the appointment.

So now we are trying to advertise the program by the clinicians telling the patients that this is more of a diabetes prevention clinic so that we can have more of a buy in that this is more about health than instead of addressing their weight which sometimes they don't want to really hear that.

And so we're going to have a nutritionist, a provider and a health - a mental health person available so that they can meet all three of us on the same day.

Dr. Deborah Horowitz: And that's as a clinic, as a program itself?

Dr. (Esther Tolentino): Yes. It's going to be here at the clinic. We work for the (Southland) Health Center and this is part of the pediatric clinic to address obesity in children. I'm a pediatrician.

Dr. Deborah Horowitz: Right.

Dr. Megan Littlefield: This is...

Dr. Deborah Horowitz: If they're not...

Dr. Megan Littlefield: ...Megan Littlefield. And I can respond to that a little bit. One of the - we have a group right now that's run by our behavioral health team that's working on trying to improve overall health and reduce risks for obesity and diabetes. And a couple of different ways you can recruit.

One is by self referral if you have - if you just have that information available that you're promoting that you have a healthy group or promoting a health group that's starting you sometimes can get self referrals.

The other way that we haven't approached it this way but if you are able to pull data out of your medical records and be able to pull people who are at risk for diabetes based on overweight or categories are based on their glucose you might be able to outreach to them if you have other team members who can call them and invite them to join this group or send fliers out targeting those patients specifically.

Dr. Deborah Horowitz: Yes. What I was going to say, with our diabetes population we do query up all diabetics and send them letters for our screenings which we have bi-annually. And in those letters we send like for our healthy weight class diabetes eye screening, our exercise program.

So we do send a flier that attaches that onto it. But we've been successful in word of mouth between providers and staff. And diagnosing patients, you know, telling them with those BMI charts it's been incredible the feedback we've gotten with the patients that they know their diagnosis.

I'm not saying they know their diagnosis but they can visually see what, you know, their problem is or their concern. It becomes a reality. I'm sure a lot of people have experiences where the patient goes I'm overweight? You know, it's a, you know, they're surprised.

Coordinator: We have a question from (Amy Patterson). You may ask your...

(Amy Patterson): Hi. I am a licensed clinical social worker and I'm employed at an FQHC in Indiana and this is a trend that they're just starting to do to incorporate social workers to do behavioral health modification within a primary care setting.

And so I'm wanting to know - I remember one of you had mentioned that you had social workers on your team. And I'm wanting to know if there are any specific ways in which you are utilizing them.

Dr. Megan Littlefield: So I'm not sure if you were talking - this is Megan Littlefield again from RiverStone Health. So we have integrated behavioral health members that are in clinic every day that we are seeing patients.

One of the ways - we haven't been utilizing them yet for the healthy weight collaborative but we do utilize them to help us go over treatment plans with other patients.

So for example, with our chronic pain patients we come up with a comprehensive treatment plan that addresses lifestyle changes, diet, sleep, exercise. And we will have them go in after, we let them know that we're having them come in.

And when I'm done as a provider I go and grab one of them and they come in and go over the treatment plan. So I write up the medications and they go over the other aspects of the treatment plan so that we have a comprehensive plan that we give to the patient.

It works really well to have them be able to go in right after I've spoken to them because it really demonstrates that we are on the same team and coming up with a unified plan that is both behavioral health and medical.

Dr. Robert Sigh: Thank you very much for this question and answer period. At this time we're going to have to end the call.

But I just want to remind everyone that this recording has been - it has been recorded and the audio portion of this call will be at the Technical Assistance Web site several days following from this call. Once again thank you for all of your participation and have a good day.

Coordinator: Thank you for your participation. Your call has concluded. You may disconnect at this time.

END