ConneCTing with Families for a Healthier Future

Background

ConneCTing with Families for a Healthier Future is a collaboration between Connecticut health providers and children' health advocates aimed at improving the quality of childhood obesity prevention in primary care. Partners include Connecticut Chapters of the Academy of Pediatrics (AAP) and American Academy of Family Practice (AAFP), Opportunity Knocks for Middletown Preschool Children Collaborative (Opportunity Knocks), the Ethel Donaghue Center for Translating Research into Practice & Policy (TRIPP Center) at the UConn Health Center, and pediatric primary care practices statewide.

After two years of participatory planning, the collaborators are taking steps to initiate a Learning Collaborative for primary care pediatric providers and family physicians. ***The Learning Collaborative will advance quality and implementation of best practices around early childhood obesity prevention by providing effective strategies to improve patient education, clinical services, staff development, practice change, and office systems.*** Participating practices and clinicians will provide better care, and be more knowledgeable and efficacious. Most importantly, the families they serve will be more aware, able and motivated to adopt and sustain behaviors that promote optimal child health and development. Over time, these changes will support optimal child growth and development, and reduce the prevalence of childhood obesity in Connecticut.

The Learning Collaborative Model

ConneCTing with Families organizers propose working with 15 initial practice teams during an 18- to 24-month period. These teams will include three to four individuals, including a physician/APRN champion, clinical support staff and office management staff. Each will be responsible for spearheading the practice change initiative. To support this process, teams will gather for four 7-hour learning and goal-creating sessions. A project manager will work with the practices between learning sessions to help them reach their office-specific goals, facilitate data collection and maintain communication. ***This particular approach has been tested elsewhere and shown to be an effective mechanism to promote uptake and sustainability of childhood obesity practice guidelines.***

The ***ConneCTing with Families*** model addresses an important problem. Evidence-based tools are freely available, actively promoted, and widely distributed through organizations such as the National Institute for Children's Healthcare Quality (NICHQ), yet uptake and adoption of childhood obesity prevention guidelines at the practice level remain low. The learning collaborative model facilitates uptake and adoption through a tested approach that includes peer learning, goal-setting and accountability, and context-specific strategies. In Connecticut, the collaborative will employ an iterative approach: Initial teams will play a critical role in recruiting and mentoring the subsequent "wave" of practices, while expanding the learning collaborative to include new topics and areas necessary to achieve goals and sustain momentum. All participating practices are invited to assign staff and clinicians to project advisory teams focused on outcomes/quality standards; materials and integration (including tools deployed through electronic information systems); and learning session development.

Learning sessions will improve the overall effectiveness of preventive care by:

- Introducing health providers to such important skills as motivational interviewing,
- Working with other professionals toward a goal that will benefit Connecticut children; and

- Partnering with the broader community to better engage families, present consistent messaging, and identify and eliminate barriers that may stand in the way of families adopting and implementing health behaviors.

Current Stakeholders

Pediatric and family practices committed to being the "first wave" in this Learning Collaborative represent a broad spectrum of Connecticut practices. They include large and small private practices, federally qualified health centers, other community health centers and academic residency programs from all geographic areas of the state. While some are single provider practices, others include multiple primary care providers spread across several sites of care. Many serve primarily low-income, minority, or publicly insured children who are at disproportionately high risk of developing obesity; ***collectively, we estimate that the 15 initial practices serve as medical homes to approximately 21,800 children, 69% (15,000) of whom are enrolled in Medicaid.***

Uniqueness

This initiative is unique in many ways. Similar practice-based interventions have been implemented in Maine (KeepME Healthy) and New Hampshire (StayNHealthy), with an emphasis on identifying and treating overweight and obese youth. ***ConneCTing with Families*** targets ***early primary prevention***, directing significant attention to infancy and early childhood (ages 0 to 5), when health behaviors and family relationships are being formed, and when, without the benefit of protective strategies, the propensity for obesity becomes established.

This foundational work will be augmented by sessions around infant feeding, evidence-based, family-focused management of obesity in a primary care environment, and integration of co-management protocols for obese youth with co-morbidities, whereby primary care providers and specialists work together on a shared plan. ***Program materials and approach will be developed and adapted for clinicians, by clinicians, capitalizing on the depth of expertise among the organizers.*** For instance, content around infant feeding will incorporate the perspectives of an experienced community dietitian and a pediatrician who has expertise in parent-infant relationships. The primary care-based obesity management session will be developed in collaboration with a community-based pediatrician/endocrinologist who has been recognized for developing and implementing practice- and community-based programming.

Goals and Outcomes

While tailored goals will be created by each participating practice, the Learning Collaborative organized by ***ConneCTing with Families*** will take a unified approach to measurement, identification, documentation, appropriate laboratory testing, and documentation of discussions around "health" status for all children during health maintenance visits. Examples of measurable outcomes include the following:

- ***Documentation and Reimbursement:*** measuring and plotting BMI, providing evidence-based messaging during well child care consistently, assessing ability to perform and get paid for specific obesity visits;
- ***Provider change:*** improvement in ability to identify, document, order/evaluate recommended labs, and communicate effectively with parents around overweight and obesity prevention and

management; integration of tools to support decision support, tracking and evaluation, patient education, and referral;

- ***Family change:*** improvement in awareness and knowledge about healthy living, and motivation, self-confidence and identified strategies to implement that knowledge; positive changes in family choices around health behavior leading to better health outcome (breastfeeding, introduction of solid foods, activity, milk/juice choice, diet quality, family meals, attaining and maintaining an appropriate BMI for age, sleep patterns).
- ***Policy change:*** Implementation of provider-informed policies around reimbursement, provision of services, healthy community environments for children, and incentives/other support to help providers adhere to best practices around childhood obesity, and conform to the standards of a patient centered medical home in accordance with AAP recommendations.

Budget

This project represents collaboration between primary care, health advocacy and academic communities. Stakeholders have volunteered significant time, energy and resources in planning and organizing the Learning Collaborative. As a result, the project has grown substantially and achieved critical mass over the past year. Launching the learning collaborative in a manner that will fully benefit the community will require a full-time program planner/project manager, part-time research assistant to assist with initial data collection and reporting (10% FTE), and administrative support (30% FTE) to organize learning sessions. Funding to offset additional clinician oversight and development (beyond voluntary work on the project Steering Committee and Advisory Teams) is also required. Funding is also needed to pay for venue and supplies for the learning sessions and speakers, and to provide materials to participants. With continued in-kind support from organizers and practices, we anticipate a tight budget of about $130,000 per year for two years to complete the first 24 month phase. We hope to continue with a second wave of 20-30 practices in a subsequent cycle.

We consider the cost of this intervention a relatively small investment with potential for enormous returns. In fact, this investment is trivial when viewed in the context of providing care for obese youth and adults in primary care and specialty clinics, and the economic costs associated with lost productivity and decreased quality of life resulting from morbid obesity. A typical bariatric surgery "package" can cost $21,500 and bundled services for a year at a specialty clinic can cost $15,000. Costs for hypertension follow up, radiological exams for SCFE scares, podiatric and orthopedic visits leading to orthotics for weight induced flat feet and associated orthopedic problems, counseling for depression: these are just a few of the smaller costs that accumulate quickly.

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