ADDRESSING DIABETES RISK FACTORS THROUGH COMMUNITY PARTNERSHIPS

SESSION 4: SELECTING AN EVIDENCE-BASED PROGRAM FOR ELEMENTARY-AGED CHILDREN
School-Based Health Alliance

The national voice for school-based health care

• Supports school-based health centers (SBHCs) through technical assistance and training

• Advocates for SBHCs on the federal, state, and local levels

• Demonstrates the value of SBHCs with common standards, measures, data, and research
National Nurse-Led Care Consortium

The National Nurse-Led Care Consortium (NNCC) is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services
Reminders

• All attendees are in listen-only mode.

• We want to hear your questions! To ask a question during the session, use the "Chat" tool that appears on the bottom your control panel.

• This webinar is being recorded and will be archived on our website in 1 to 2 business days. https://www.sbh4all.org/training/webinars/webinar-archive/

• Please complete evaluation poll questions at the end of the presentation.
DESCRIPTION

• Convening learning collaborative of health centers interested in enhancing efforts to prevent, screen for, and manage pre-diabetic indicators among elementary school-aged children through school partnerships.

• Participants learned from experts as well as each other throughout the learning collaborative.
GOALS AND OBJECTIVES

• Each health center will select an elementary school(s) and develop an action plan for addressing elementary-aged children’s obesity and other pre-diabetic indicators.
• Action plans will include goals, specific school partners, evidence-based strategies and programs, deliverables, timelines, responsible parties.
PEER LEARNING

• Participants will have access to a group communication platform for on-going sharing across sites and learning collaborative facilitators.
• Upon completion of session four, the platform will remain active for optional coaching and across site communication.
SESSION OUTLINE

• **SESSION 1**: IDENTIFYING YOUR TARGET POPULATION

• **SESSION 2**: MAPPING YOUR MEDICAL NEIGHBORHOOD

• **SESSION 3**: IDENTIFYING SCHOOL/COMMUNITY PARTNERS

• **SESSION 4**: SELECTING YOUR EVIDENCE-BASED PROGRAM FOR ELEMENTARY-AGED CHILDREN
Addressing diabetes risk factors in the FQHC: MEND at Denver Health
MEND: Mind, Exercise, Nutrition, Do It!
MEND 7-13 RCT: Three month outcomes improved at six months

**Waist circumference (cm)**

- Start (pre): ns
- 3m (post): ns
- 6m (3m post): P=0.018

**BMI (kg/m²)**

- Start: ns
- 3m: ns
- 6m: P=0.046

**Recovery Heart Rate (bpm)**

- Start: ns
- 3m: P<0.001
- 6m: P<0.001

**Self-esteem score (out of 24)**

- Start: ns
- 3m: ns
- 6m: P=0.02

*Sacher et al, Obesity, 2010*
Outcomes sustained at 12 months

**Waist circumference z-score**
- Start: 3.0
- 12 months: 2.3
- Change: 0.7
- **P < 0.001**

**BMI z-score**
- Start: 2.8
- 12 months: 2.4
- Change: 0.4
- **P < 0.001**

**Recovery heart rate (bpm)**
- Start: 115
- 12 months: 95
- Change: 20
- **P = 0.01**

**Self-esteem score (out of 24)**
- Start: 16.7
- 12 months: 19
- Change: 2.3
- **P = 0.026**
Safety net health care organization
The US Preventive Services Task Force (USPSTF) recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. (B recommendation). JAMA. 2017; 317 (23): 2417-2426.
Demand

• 21,000 overweight/obese children
• Large numbers of Medicaid, minority/Latino, all <200% FPL

Access/barriers

• Despite access to several weight management programs in community settings in Denver, few patients were actually participating, and little info on those who did participate.

• How can we best comply with USPSTF guidelines?
Referral from PCP to program in a familiar setting (medical home)
MEND 7-13 schedule: compliant with USPSTF recommendations

10 weeks, twice weekly, 2 hours each session

<table>
<thead>
<tr>
<th>Who</th>
<th>First hour</th>
<th>Second hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>Mind (behaviour change) and Nutrition</td>
<td>Parenting discussion</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td>Exercise</td>
</tr>
<tr>
<td></td>
<td>Before MEND</td>
<td>After MEND</td>
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<tr>
<td>----------------------</td>
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</tr>
<tr>
<td><strong>BMI (kg/m²)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>65</td>
<td>26.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1</td>
</tr>
<tr>
<td><strong>BMI z-score</strong></td>
<td></td>
<td>2</td>
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<tr>
<td></td>
<td></td>
<td>-0.16</td>
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<tr>
<td><strong>Waist circumference (inches)</strong></td>
<td></td>
<td>34.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-0.8</td>
</tr>
<tr>
<td><strong>Physical activity (hours/week)</strong></td>
<td></td>
<td>6.5</td>
</tr>
<tr>
<td></td>
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<td>3.1</td>
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<tr>
<td><strong>Sedentary activities (hours/week)</strong></td>
<td></td>
<td>6.4</td>
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<td></td>
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<td>-4.3</td>
</tr>
<tr>
<td><strong>Heart rate (beats per minute)</strong></td>
<td></td>
<td>104.5</td>
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<td></td>
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<td>-14</td>
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<tr>
<td><strong>Nutrition score (score 0-28)</strong></td>
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<td>16.8</td>
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<tr>
<td></td>
<td></td>
<td>3.5</td>
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<tr>
<td><strong>Total Difficulties (score 0-40)</strong></td>
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<td>11.6</td>
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<td></td>
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<td>-2.7</td>
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<tr>
<td><strong>Body Image (score 0-24)</strong></td>
<td></td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4</td>
</tr>
</tbody>
</table>
What about weight-related comorbidities?

- 14% elevated cholesterol
- 12% elevated ALT
- 22% elevated BP
  - (pre-HTN 3%, stage 1 HTN 16%, stage 2 HTN 3%)
Integration of provider medical visits

- **Who**
  - Parents
  - Children

- **First hour**
  - Mind and Nutrition

- **Second hour**
  - Parenting discussion
  - Exercise

- **Group visit model (CenteringPregnancy)**
- **Improved evaluation and management of individual issues**
  - Lab screening, medical workup, F/U
  - Behavioral health and social work issues
- **Increased participation & “value add”**
Sustainability and Reimbursement

- Standard E/M coding – do what is medically appropriate and necessary and bill accordingly
- FQHC reimbursement
- Revenue generation helps to offset costs of program delivery
Jessica Wallace, MPH, MSHS, PA-C

Jessica.wallace@dhha.org

Information on MEND:
https://healthyweightpartnership.org/
Addressing Diabetes Risk Factors in School Children: the iAmHealthy Project

Ann M. Davis$^{1,2}$

1 Center for Children’s Healthy Lifestyles & Nutrition, Kansas City, MO
2 Department of Pediatrics, University of Kansas Medical Center, Kansas City, KS

In: Addressing Diabetes Risk Factors in Elementary School Children through Community Partnership – Session 4.
Acknowledgements

• Co-Presenters
• iAmHealthy team
  – Families
  – School nurses
  – Co-Investigators
    • Dr. Nelson
  – Graduate Students
• Rachel Muzzy
• Kim Pina
• Kendall Stagner

• National Institutes of Health
  - R01 NR016255
Pediatric Obesity: US

### Table 1. Selected Comparison Studies of Prevalence of Obesity and Overweight between Rural and Urban Children and Adolescents.

<table>
<thead>
<tr>
<th>State</th>
<th>Obesity and Overweight Comparison</th>
<th>Results</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan (rural northern)</td>
<td>Rural Michigan 4 to 17 year olds (N=993) were compared with state children overall.</td>
<td>Prevalence of obesity was 3 to 9% higher among rural children.</td>
<td>Gauthier, 2000&lt;sup&gt;120&lt;/sup&gt;</td>
</tr>
<tr>
<td>Iowa</td>
<td>Rural 4&lt;sup&gt;th&lt;/sup&gt; graders (N=457) were compared to a national sample.</td>
<td>Rural Iowan children were taller and heavier than the national sample.</td>
<td>Gustafson-Larson and Terry, 1992&lt;sup&gt;121&lt;/sup&gt;</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Children in grades 3 through 5 (N=54) were invited to participate.</td>
<td>One-third of rural children were overweight.</td>
<td>Crooks, 2000&lt;sup&gt;67&lt;/sup&gt;</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,000 rural and 1,000 urban school children from North Carolina were compared.</td>
<td>The odds of being obese were 50% higher for rural children.</td>
<td>McMurray, 1999&lt;sup&gt;65&lt;/sup&gt;</td>
</tr>
<tr>
<td>West Virginia</td>
<td>Fifth graders in three rural counties participated.</td>
<td>Forty percent were overweight.</td>
<td>Neal, 2001&lt;sup&gt;122&lt;/sup&gt;</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Sixth graders (N=352) in two rural counties were compared to national average. Three-fourths of the students were African American.</td>
<td>Forty-nine percent of the students were obese compared to a national obesity average of 21%.</td>
<td>Felton, et al., 1998&lt;sup&gt;123&lt;/sup&gt;</td>
</tr>
<tr>
<td>Central New Mexico</td>
<td>Rural American-Indian fifth graders (N~2000) participated.</td>
<td>One third of the students were overweight.</td>
<td>Davis and Lambert, 2000&lt;sup&gt;124&lt;/sup&gt;</td>
</tr>
<tr>
<td>South Texas</td>
<td>Mexican Hispanics ranging in age from 12-17 years old (N=4,375) were compared to national averages.</td>
<td>Forty percent were overweight, and 22% were obese (double the national average.).</td>
<td>Lacar, et al., 2000&lt;sup&gt;125&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Expert Committee Guidelines: Treatment Programs. But, how to treat rural?
Interactive Poll

• How would you deliver rural, family-based empirically-supported pediatric obesity program?
  A. During school hours as part of curriculum
  B. In after school programs
  C. Through environmental changes, such as walking school bus, changing school lunch offerings, etc.
  D. Family based behavioral groups via interactive televideo

Answer: D (in this case)
School Based Rural Obesity Work
Previous Telehealth Interventions

- Nutrition, Exercise, Behavioral
- Parent, Child, Family
- Rural

- **Red Foods** = Over 7 grams of fat and/or 12 grams of sugar per serving
- **Yellow Foods** = Less than 7 grams of fat AND 12 grams of sugar per serving
- **Green Foods** = Fruits and vegetables (with no calories added)
Table 5. Intervention Timeline (25 contact hours total per USPSTF guidelines).

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>iAmHealthy Intervention</td>
<td>8 weekly sessions</td>
<td>1 session</td>
<td>1 session</td>
<td>1 session</td>
<td>1 session</td>
<td>1 session</td>
<td>1 session</td>
</tr>
</tbody>
</table>

11 hours of homework help via remote technology
iAmHealthy

- Specific changes:
  - Directly into homes via iPads
    - 8 weekly and 6 monthly
    - 11 hours of individualized “health coaching”
    - 25 total = USPSTF guidelines
  - 2nd – 4th grade
  - Excluding children over 99th
  - Control – newsletter control
  - Typical measures plus also added Process variables (Living in Familial Environments Coding System), more psychosocial variables (HRQOL, Brief Symptom Inventory, CDI, Schwartz Peer Victimization Scale), and large focus on cost calculations
  - Operational changes: e-consent, Redcap, website
Partnering with Schools

• Previous projects
  • How can you help them?
    • Wellness committees
    • Wellness plans
    • School based BMI screenings
    • Other wellness initiatives you can help with?

• Current project
  • Flyers to state (principal, gym teacher, nurse)
  • Website
  • List serves
  • Try to minimize “red tape”
  • Try to make it convenient
    • Training is remote
    • Move at their own pace
    • Work around their schedules
  • Leave them with the intervention materials
Yes, We Can!
Integrating Community and Produce Rx into Wellness Group Visits

James Huang, MD, FAAFP
• Unity Health Care, Inc.
  • D.C.’s largest network of community health centers
  • Upper Cardozo Health Center
Obesity

• In Washington, D.C., nearly one in three children is overweight or obese, and many low-income families face barriers to accessing healthy foods
Intervention

• Group wellness visits / shared medical appointments (SMA) that engage families are a promising intervention for addressing chronic illnesses and improving health outcomes
Poll

• What kind of group visits does your health center have?
• What kind of group visits would you like to start?
Group Visits / SMA

• primary prevention
  • Centering in pregnancy – improved outcomes
  • encouraging smokers to quit

• secondary prevention
  • helping patients with COPD to avoid complications

• group-based programs such as Alcoholics Anonymous and Weight Watchers allow people to acknowledge that they have a problem and start working toward solutions in a supportive setting
<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Odds Ratio For Treatment Group Relative to Comparison Group (95% CI)</th>
<th>$P$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read nutrition facts on food labels</td>
<td>13.8 (6.7 to 28.6)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Eat more fruits and vegetables</td>
<td>7.2 (3.7 to 14.2)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Feel “stuffed” less often</td>
<td>6.6 (3.4 to 13.0)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Walk more steps daily</td>
<td>5.3 (2.8 to 10.2)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Eat more whole grains</td>
<td>4.8 (2.5 to 9.0)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Incorporate stress management</td>
<td>4.4 (2.3 to 8.4)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Increase hours of sleep</td>
<td>4.2 (2.1 to 8.4)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Eat less beef</td>
<td>4.2 (2.2 to 8.3)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Eat less frequently in front of screens</td>
<td>2.7 (1.4 to 5.3)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Eat more slowly</td>
<td>2.7 (1.4 to 5.1)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Exercise more</td>
<td>2.6 (1.4 to 4.7)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Eat more home-cooked meals</td>
<td>1.9 (1.1 to 3.5)</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Put effort into improving health before intervention</td>
<td>0.5 (0.3 to 0.9)</td>
<td>&lt; .05</td>
</tr>
</tbody>
</table>

CI. confidential interval.
Patient Weight Change During and After Wellness Groups

<table>
<thead>
<tr>
<th>Change in patient (pounds)</th>
<th>After group*</th>
<th>1 Year Out</th>
<th>2 Years Out</th>
<th>3 Years Out</th>
<th>1 Year Out, 1 Group Only</th>
<th>1 Year Out, Multiple Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>-16.6</td>
<td>-18.4</td>
<td>-19.2</td>
<td>-18.5</td>
<td>-16.1</td>
<td>-21.6</td>
</tr>
<tr>
<td>All patients weighed at least 1 year after group*</td>
<td>3.5</td>
<td>4.3</td>
<td>4.6</td>
<td>3.3</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td>All patients weighed at least 2 year after group*</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>All patients weighed at least 3 year after group*</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Patients at least 1 year, no additional groups</td>
<td></td>
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<tr>
<td>Patients at least 1 year, who attended additional groups</td>
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</tbody>
</table>

Sample size (N)

- After group: 168
- 1 Year Out: 105
- 2 Years Out: 60
- 3 Years Out: 45
- 1 Year Out, 1 Group Only: 53
- 1 Year Out, Multiple Groups: 35

* refers to first Wellness Group in cases where patients participated in multiple groups
** based on last recorded weight
History of Program Development

• 2008 - adapted NHLBI *We Can!* Curriculum

• national movement designed to give parents, caregivers, and entire communities a way to help children 8 to 13 years old stay at a healthy weight
History of Program Development

• **We Can! (Ways to Enhance Children's Activity & Nutrition)** is a
Learn more about
  • healthy weight basics
  • eat right
  • get active
  • reduce screen time
<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Test Mean</th>
<th>Post-Test Mean</th>
<th>Mean Difference</th>
<th>Percent Change</th>
<th>t Value</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy Balance Knowledge</td>
<td>2.19</td>
<td>2.38</td>
<td>.19</td>
<td>9%</td>
<td>2.94*</td>
<td>164</td>
<td>&lt;.05</td>
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<tr>
<td>Energy Balance Attitudes</td>
<td>7.04</td>
<td>7.70</td>
<td>.63</td>
<td>9%</td>
<td>4.49*</td>
<td>162</td>
<td>&lt;.05</td>
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<tr>
<td>Portion Size Knowledge</td>
<td>2.05</td>
<td>2.02</td>
<td>.01</td>
<td>1%</td>
<td>.93</td>
<td>156</td>
<td>.09</td>
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<tr>
<td>Portion Size Attitudes</td>
<td>4.01</td>
<td>4.36</td>
<td>.35</td>
<td>9%</td>
<td>4.09*</td>
<td>171</td>
<td>&lt;.05</td>
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<tr>
<td>Portion Size Behaviors</td>
<td>7.01</td>
<td>7.69</td>
<td>.71</td>
<td>10%</td>
<td>4.09*</td>
<td>171</td>
<td>&lt;.05</td>
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<tr>
<td>Healthy Eating Knowledge</td>
<td>2.79</td>
<td>2.80</td>
<td>.04</td>
<td>0%</td>
<td>.77</td>
<td>165</td>
<td>.44</td>
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<td>Healthy Eating Attitudes</td>
<td>12.08</td>
<td>12.73</td>
<td>.63</td>
<td>5%</td>
<td>2.65*</td>
<td>165</td>
<td>&lt;.05</td>
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<tr>
<td>Healthy Eating Behaviors</td>
<td>20.82</td>
<td>21.93</td>
<td>1.18</td>
<td>5%</td>
<td>5.09*</td>
<td>161</td>
<td>&lt;.05</td>
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<tr>
<td>Healthy Food Behaviors</td>
<td>10.03</td>
<td>11.30</td>
<td>1.32</td>
<td>13%</td>
<td>6.70*</td>
<td>163</td>
<td>&lt;.05</td>
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<tr>
<td>Physical Activity Knowledge</td>
<td>2.40</td>
<td>2.56</td>
<td>.14</td>
<td>7%</td>
<td>2.25*</td>
<td>162</td>
<td>&lt;.05</td>
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<tr>
<td>Physical Activity Attitudes</td>
<td>22.12</td>
<td>23.62</td>
<td>1.46</td>
<td>7%</td>
<td>5.00*</td>
<td>155</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Physical Activity Behaviors</td>
<td>18.62</td>
<td>20.05</td>
<td>1.45</td>
<td>8%</td>
<td>5.43*</td>
<td>154</td>
<td>&lt;.05</td>
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<tr>
<td>Screen Time Knowledge</td>
<td>2.55</td>
<td>2.53</td>
<td>-.01</td>
<td>0%</td>
<td>-.95</td>
<td>151</td>
<td>.92</td>
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<tr>
<td>Screen Time Attitudes</td>
<td>12.91</td>
<td>13.30</td>
<td>.40</td>
<td>3%</td>
<td>2.14*</td>
<td>149</td>
<td>&lt;.05</td>
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<td>Screen Time Behaviors</td>
<td>13.73</td>
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<td>7%</td>
<td>4.68*</td>
<td>146</td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

*Statistically significant finding
## CATCH Summary of Findings

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Test Mean</th>
<th>Post-Test Mean</th>
<th>Mean Difference</th>
<th>% Change</th>
<th>t Value</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Knowledge</td>
<td>18.23</td>
<td>18.98</td>
<td>.80</td>
<td>4%</td>
<td>4.01*</td>
<td>309</td>
<td>&lt; .05</td>
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<td>Food Attitudes: Self-Efficacy</td>
<td>14.86</td>
<td>15.79</td>
<td>1.01</td>
<td>7%</td>
<td>4.79*</td>
<td>310</td>
<td>&lt; .05</td>
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<tr>
<td>Food Attitudes: Intentions to Reduce Fat</td>
<td>10.13</td>
<td>11.10</td>
<td>1.00</td>
<td>10%</td>
<td>7.07*</td>
<td>273</td>
<td>&lt; .05</td>
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<tr>
<td>Food Attitudes: Intentions to Drink Skim Milk</td>
<td>1.35</td>
<td>1.49</td>
<td>.15</td>
<td>11%</td>
<td>4.55*</td>
<td>324</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Healthy Eating Behaviors: Reducing Fat</td>
<td>1.38</td>
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<td>-.08</td>
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<tr>
<td>Healthy Eating Behaviors: Eating Fiber</td>
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<td>2.08</td>
<td>.08</td>
<td>4%</td>
<td>1.14</td>
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<tr>
<td>Healthy Eating Behaviors: Eating Fruits and Vegetables</td>
<td>9.39</td>
<td>9.95</td>
<td>.62</td>
<td>7%</td>
<td>3.99*</td>
<td>302</td>
<td>&lt; .05</td>
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<tr>
<td>Healthy Eating Behaviors: Reading Labels</td>
<td>.89</td>
<td>.99</td>
<td>.10</td>
<td>11%</td>
<td>2.55*</td>
<td>348</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Physical Activity Attitudes</td>
<td>6.54</td>
<td>6.85</td>
<td>.26</td>
<td>4%</td>
<td>2.41*</td>
<td>330</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Physical Activity Behavior</td>
<td>.85</td>
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<td>-.02</td>
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<td>.69</td>
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<td>.49</td>
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<tr>
<td>Screen Time Behaviors: Weekday TV Viewing</td>
<td>4.61</td>
<td>4.26</td>
<td>-.34</td>
<td>-7%</td>
<td>-3.14*</td>
<td>336</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Screen Time Behaviors: Weekend TV Viewing</td>
<td>4.67</td>
<td>4.39</td>
<td>-.11</td>
<td>-2%</td>
<td>-.87</td>
<td>342</td>
<td>.39</td>
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<tr>
<td>Screen Time Behaviors: Weekday Video Gaming</td>
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<td>1.41</td>
<td>-.11</td>
<td>-7%</td>
<td>-.141</td>
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<td>.16</td>
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<tr>
<td>Screen Time Behaviors: Weekend Video Gaming</td>
<td>1.58</td>
<td>1.52</td>
<td>-.05</td>
<td>-3%</td>
<td>.72</td>
<td>345</td>
<td>.47</td>
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</table>

*Statistically significant finding
History of Program Development

• Growth through partnerships with community organizations
  • Fruit & Vegetable Prescription Program (Produce Rx)
Wellness Group Visit at Unity

- Collaborative effort that focuses on:
  - Engaging families
  - Healthy eating on a budget
  - Promoting physical activity
  - Connecting families to community resources
Program Structure

• Child/family referred by provider
• Weekly drop-in class/group visit, year round, bilingual
• Team: registration clerk, medical assistants, providers, and learners
• Register and vitals taken from 5-6pm
  • Unstructured play, healthy snacking (fruits/veggies)
• Brief 1:1 with clinician, documented in EMR
  • review health knowledge & behavior
  • financially sustainable, clinical session for provider
• Nutrition & Physical Activity for 90 minutes
• Usually 5-15 families per class
Unique Community Partnerships

• Enhanced programming
• Stronger community connections
• Richer experience for families
• Increased retention
Discussion

• What are challenges or barriers to creating partnerships with community based organizations?
Nutrition Education Programs: DC Central Kitchen
Nutrition Education Programs:
SNAP Ed
Nutrition Education Programs: Common Threads

- Health & wellness for children, families, communities through cooking & nutrition education
- Family cooking classes led by professional chefs in clinic’s demonstration kitchen
Nutrition Education Programs: CHOP CHOP Healthy Recipes
Community Garden: City Blossoms

- Fostering healthy communities by developing creative, kid-driven green spaces
- Plant/harvest in garden & prepare a healthy meal
Physical Activity

• Volunteer yoga and zumba instructors
• Community pool (DC Parks & Rec)
• Playgrounds
Access to Local Parks
Produce Rx

Doctors in D.C. write prescriptions for fresh fruits and vegetables that can be redeemed for free produce to help at-risk patients manage diet-related chronic illnesses.
Evaluation (2017 Season)

Participation:

Enrolled families completing program:
- 2 families
- 23 families

Prescription redemption rate:
- 94%
Evaluation (2017 Season)

• 50% reduced their BMI percentile

Health Knowledge/Behavior due to program participation:
• 92% agreed/strongly agreed that they were able to better care of their health & learned new things about how to care for their health
• 46% improved their rating of their children’s overall health
• 30% increased their knowledge about how to prepare fresh fruits and vegetables
• 38% increased their knowledge about where to buy locally grown produce
Success Stories

1. Community building
2. Connecting to local resources
3. Change in behavior
4. Knowledge & engagement
It also changed my life because it made me less shy to talk to people and I learned new fruits and vegetables, and that makes me help the people who need the names of the vegetables. Also, I learned how to cook different plates with new vegetables and fruit. This new and sort of amazing way I got this job changed my social life and also my life with eating healthy and learning healthy foods!
Key Points

This family wellness group visit model highlights the value of strong community partnerships, which enhance retention and increase support for families towards achieving their healthy lifestyle goal.

- Weekly billable group visit
- Family engagement
- Community partnerships & collaborative efforts
- Fruit & vegetable prescriptions
Acknowledgements

Wellness Team - MAs, PRCs, providers
Upper Cardozo Health Center
Unity Health Care, Inc.
Community Partners
Participating Families
Questions?