MN Partnership for Pediatric Obesity Care and Coverage (MPPOCC)

Best Practice Guidelines in Clinic/Community Collaborative Pediatric Obesity Services

Presented to:
MPPOCC Members and SHIP Grantees
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MPPOCC Clinic Community Collaborative Services Work Group includes representatives from six community-based service providers:

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- National Sports Center: Steve Olson, solson@nscsports.org
- YMCA: Robin Hedrick, robin.hedrick@ymcatwincities.org
- Youth Determine to Succeed (YDS): Melvin Anderson, manderson@youthdetermined.org
- YWCA (Strong Fast Fit): Chris Ganzlin, cganzlin@ymcampls.org
MN Partnership for Pediatric Obesity Care and Coverage (MPPOCC)

MPPOCC is:

• A partnership of the MN Council of Health Plans, the MN Chapter of the American Academy of Pediatrics and other community partners

• Supported by the Statewide Health Improvement Partnership, Minnesota Department of Health (MPPOCC staffing support provided by SHIP funds from the Minneapolis Health Department and the Hennepin County Human Services and Public Health Department)

• For more info: http://mnaap.org/obesitycoding.html
31.8% of children in the United States are overweight or obese

National NHANES data, for children 2-19 years old
Ogden et. al. 2014
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>African American/Black</th>
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<th>Hispanic/Latino</th>
<th>White</th>
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<tbody>
<tr>
<td>Percentage of children overweight or obese</td>
<td>35.2%</td>
<td>19.5%</td>
<td>38.9%</td>
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National NHANES data, for children 2-19 years old
Ogden et. al. 2014

MN data for overweight/obesity by race show greater disparities (Overall 23.1%, Hispanic/Latino 45.2%, African American/Black: 42%, White 20.1%).

National Survey of Children’s Health, 2012
Treatment Algorithm
(2007 Expert Committee* and 2013 ICSI Guidelines)

- Most overweight or obese children will begin with a stage 1 intervention.
- A child should progress to the next stage of management if no improvement in BMI after 3-6 months and family willing.
- Beginning at stage 3, the intervention has exceeded the capabilities of a typical primary care clinic.

*Staged Algorithm based on expert opinion
Obesity in children and adolescents
US Prevention Services Task Force Recommendation (Level B):

“The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral intervention to promote improvement in weight status.”

Intensive behavioral interventions:

Issues

- Lack of system capacity for stages 3-4
- Services at these levels are not required to be entirely medical
- Community-based services have demonstrated effectiveness and may be a better fit than clinic-based for many families
The evidence continuum

MPPOCC is supportive of services meeting top 3 levels
  ◦ Experimentally-proven
  ◦ Experimental
  ◦ Research-informed

  ◦ NOT "opinion informed"
Proposed MPPOCC best practice guidelines

Utilizing the 2007 Expert Committee and 2013 ICSI staged management algorithm\textsuperscript{3,9}, community-based interventions in collaboration with clinic partners should be considered as an alternative or as complementary to solely clinic-based stage 3 interventions.

These services fit in around stage 2.5-3 of the algorithm
Proposed MPPOCC best practice guidelines

Community interventions should include the following core elements as defined in the 2013 ICSI guidelines for the prevention and management of childhood obesity\(^9\) and other current evidence:

- Structure
- Staffing
- Content
- Evaluation
- Primary care relationship and communication
SERVICE PROVIDERS:
• Children’s Vida Sana
• HCMC Taking Steps Together
• National Sports Center
• YMCA Join For Me
• Youth Determined to Succeed
• YWCA Strong Fast Fit

Costs:
- $750-$1,500/participant
- $2,250/family
Proposed MPPOCC best practice guidelines: Structure

• Moderate-high intensity with >25 hours of contact with the child and/or family over a 6-month period

• Involve parents and other caregivers, particularly for children < 12 years of age
Proposed MPPOCC best practice guidelines: Staffing

• Include a team of instructors with expertise in nutrition, exercise, and behavior counseling

• A physician or advanced practice provider serving as medical director

• A dietitian with direct involvement in defining and developing service content as well as direct and regular engagement with participants

• Staff leading physical activities have experience in engaging participants in a safe and productive manner.

• Facilitators have expertise in evidence-based behavior counseling methods.
Health and Wellness
"Proof of Concept Pilot"

The 3.5 year pilot primary objective was to test our program approach, impact and viability in efforts to provide youth and families comprehensive health and wellness services to assist them manage and reverse their obesity and related diseases.

With the help of a grant from the University of Minnesota, pediatricians, and other health care professionals the YDS Pilot was launched in 2009 at the YMCA in North Minneapolis and later expanded to Brooklyn Center in partnership with the Brooklyn Center school District.

Pilot Program Approach

3 Days per week programming
12 week cycles
Youth and Adult programs
Services – Fitness, Nutrition, 1on1 Counseling, Evaluations

EXAMPLE: Youth Determined to Succeed (YDS)
Health & Wellbeing Services Pilot Phase 1
Major Outcomes

Patient Profile
$300,000 investment over 3 years

- 350 patients
  (304 youth, ages 8-18 and 46 parents, ages 35 to 54)

- 70% referred by pediatrician & health providers

- The patient ethnicity is African American, African & Hispanic

- 60% completed two or three 10 to 12 week treatment cycles
Results

4.3
BMI reduction
(33.52 to 32.08)

Improved health outcomes and pre-existing acute and chronic diseases

3-9 lbs
Average participant decreased weight by 3–9 lbs.

53%
of overweight youth moved to normal classification

56%
of obese youth moved to overweight classification

58%
of patients with higher than normal heart rates moved to normal averages

Weight loss & improved body image

27%
of patients with high blood pressure moved to normal range

Average reduction in Waist Line – 2”

50%
of morbid obese youth moved to obese classification

*The intervention was 3x more effective for those whom completed 2 to 3 treatment cycles
Proposed MPPOCC best practice guidelines: Content

• **Nutrition** – activities help participants target specific, evidence based nutritional goals (e.g. limiting sugar-sweetened beverage intake, eating breakfast daily, consuming a recommended amount of vegetables and fruits, and others).\(^3,9\)

• **Physical Activity** – services engage participants in regular moderate-vigorous physical activity and help them target evidence-based standards for healthy physical activity at home.\(^3,9\)

• **Behavior Management** – services employ specific behavior management strategies including motivational interviewing, structured goal setting, self-monitoring and others.\(^3,9\)

• Services may include additional evidence-base content such as encouraging participants to reduce screen time and obtain sufficient sleep.\(^9\)
EXAMPLE: YMCA, JOIN for ME

JOIN for ME is a weight management service for kids and teens at or above the 85th percentile for Body Mass Index (BMI).

HOW IT WORKS:

• Parent Information Session
• Child plus support person attend 16 weekly & 8 monthly group classroom sessions, 75 minutes each
• Weekly “Connect, Learn and Go!” Activities
• Kids class (6-12) & Teen class (13-17)
• Delivered by highly-trained, effective behavior change coaches
• Web-based technology platform manages enrollment, attendance, outcome tracking
YMCA, JOIN for ME

First empirically-informed, scalable treatment for pediatric overweight and obesity services initially launched in 2011.

KEY OUTCOMES*

- At six months, 3.5% reduction in excess weight
- Those with best attendance had 3x better BMI reduction
- The intervention was 3x more effective for kids than teens
- Overall sample experienced significant reductions in percentage overweight after six months
- Parents/guardians also statistically significant amount of weight

*Average BMI % of participants was 98.0
Proposed MPPOCC best practice guidelines: Evaluation

Participant Measures:

• Height
• Weight
• Nutrition and physical activity measures
• Other practical measurements

Performed for all participants at baseline, program completion, and other specific intervals as indicated.³
Proposed MPPOCC best practice guidelines: Evaluation

A list of core measures has been established through consensus by MPPOCC:

• Age
• Gender
• Race/Ethnicity
• Height
• Weight
• BMI%
• Blood pressure
Proposed MPPOCC best practice guidelines: Evaluation

Suggested additional behavioral measures to consider:

- Sugared drink intake
- Vegetable and fruit consumption
- Frequency of eating breakfast
- Frequency of family/group meals
- Screen time
- Physical activity (> 60 minutes per day)
- Eating balanced meals
- Consumption of high fiber foods
- Frequency of ordering/eating out (especially fast food)
Proposed MPPOCC best practice guidelines: Evaluation

Additional *optional* measures to consider:

- Improved healthy lifestyles of family
- Body fat %
- Sufficient sleep
- Food insecurity/access to healthy foods
- Safety/access to physical activity opportunities
- Patient quality of life (for example: PROMIS 10)
Proposed MPPOCC best practice guidelines: Evaluation

In-clinic measures:

• Blood pressure

• Labs screening for comorbid health issues based on age and risk factors as per guidelines (e.g. lipids, fasting glucose, ALT, AST, others as indicated)

• Counseling (5-2-1-0 suggested) (nutrition AND physical activity required by MN Community Measurement)
Proposed MPPOCC best practice guidelines: Evaluation

• A statistical analysis of service outcomes performed yearly

• Goals for clinic community collaborative services patients:
  
  After 4-6 months of services:
  ◦ stabilization of BMI%
  ◦ significant improvements in health related behaviors (both nutrition and physical activity measures)

  After 12-24 months of services:
  ◦ BMI% maintenance or improvement
  ◦ maintenance of healthy behavioral changes
Evaluation

EXAMPLE: YWCA, Strong Fast Fit

Culturally responsive fitness and nutrition youth development services that reduce childhood obesity and type II diabetes in Latino, Native American and Hmong youth, ages 7-17.

40 weeks of services over 12 months: nutrition education + twice weekly physical activity

Youth development approach focuses on wellness & positive self image

Parents attend 6-8 nutrition education session per year; YWCA Family Fitness Membership is included

Quarterly Assessment: BMI, Body Composition, Heart Rate, Blood Pressure (youth) + Goal Setting
YWCA, Strong Fast Fit

Number of Youth Participating in Strong Fast Fit from 2008 to 2015

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<td># of Youth</td>
<td>112</td>
<td>178</td>
<td>164</td>
<td>158</td>
<td>154</td>
<td>183</td>
<td>174</td>
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Strong Fast Fit Fitness Goals and outcomes 2008-2015

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<td>% Youth showed improved health by lowered blood pressure and/or lowered heart rate, and progress towards a healthy Body Mass Index appropriate for age and gender</td>
<td>75%</td>
<td>88%</td>
<td>81%</td>
<td>78%</td>
<td>83%</td>
<td>86%</td>
<td>68%</td>
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<tr>
<td>% Youth engaged in moderate to high level physical activity at least two times per week for 30 minutes</td>
<td>92%</td>
<td>91%</td>
<td>90%</td>
<td>89%</td>
<td>99%</td>
<td>84%</td>
<td>85%</td>
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<tr>
<td>% Youth with measurably improved diet: increased water, fruit, vegetable intake, and lower fat</td>
<td>88%</td>
<td>83%</td>
<td>76%</td>
<td>64%</td>
<td>90%</td>
<td>90%</td>
<td>83%</td>
</tr>
<tr>
<td>% Families with measurably increased use of meal planning and healthy eating</td>
<td>71%</td>
<td>80%</td>
<td>77%</td>
<td>79%</td>
<td>76%</td>
<td>76%</td>
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2014-2015 Outcomes (190 Youth)

Average Systolic blood pressure significantly decreased by nearly 5 points on average between baseline and final assessment (from 111.6 mmHg to 107.1 mmHg)

BMI percentile significantly decreased by an average of 3% (from 80.3% at baseline to 77.3% at final assessment)

Mean lean body mass significantly increased by about 2 pounds on average (from 67.2 lbs to 69.5 lbs)
Proposed MPPOCC best practice guidelines: Primary care relationship and communication

Primary care clinics and community-based services work together as a collaborative team in order to best serve the patient and their family:

◦ The primary care clinic manages the medical evaluation and management of the patient (e.g. diagnosis of weight status, assessment for co-morbid medical conditions, laboratory evaluation etc.).

◦ The community-based service provides the intensive behavioral intervention targeting key nutrition and physical activity goals.
Both the community-based service and the primary care clinic have a defined person or group of people responsible for maintaining communication between these two entities:

- For the community-based service this liaison can be any full-time staff member.
- In the primary care clinic, this role can be served by a community health worker, social worker, registered nurse or the primary care provider.
Proposed MPPOCC best practice guidelines: Primary care relationship and communication

Release of Information consents are obtained and HIPAA protocols are followed.

Verbal and/or written communication occurs between clinic and the community-based service staff at the following times/circumstances:

- At the time of referral, clinic staff contact the community-based service, and liaison provides key information and answers any initial questions.
- During the community-based intervention, community-based service staff communicate with the patient’s clinic if she/he discontinues her/his involvement, if new medical concerns arise or for any other concerns or questions.
- Upon completion of the intervention, the community-based service liaison communicates with the patient’s clinic, offering a brief summary of her/his participation.
Proposed MPPOCC best practice guidelines: Primary care relationship and communication

Community-based service staff convey the expectation that participants schedule a follow-up appointment with their primary care provider following completion of the intervention (and more frequent appointments during the intervention if deemed necessary by the patient’s provider).
Communication
EXAMPLE: HCMC, Taking Steps Together

Community-based Service Summary

• 17-week nutrition and healthy lifestyle service for families addressing childhood obesity

• Families are referred to the services by their child’s primary care provider through the electronic health record. Subsequently, program staff contact the family directly as well as the primary care provider if questions arise.

• Weekly 2½ hour meetings with three main components: group physical activity, group cooking and a learning activity

• Community-based service staff notify primary care providers of participants’ completion, and encourage a follow-up visit in clinic after graduation

• Service conducted at Minneapolis Park and Recreation sites

• Staff include: registered dieticians, pediatricians, guest educators and a bilingual coordinator (soon to be a certified community health worker)

Core Service Elements and Themes

• Family-centered

• Building self-efficacy

• Community-based

• Evidence based

• Promoting sustainable change through intrinsic motivation for healthy living

• Strong local partnerships
Policies supporting recommended services

• Affordable Care Act requires coverage for USPSTF recommended services (Level A and B) for all (not only public programs), without copays

• Minnesota Community Health Worker (CHW) coverage for children on public programs (MN Health Care Program Provider Manual changes):
  • “Pediatric obesity” added as an example of covered CHW services
  • Covered hours per month per participant increase from 4 to 12
  • Removal of “standardized curriculum” requirement for CHW services
ACA requirement re. USPSTF recommendations

Affordable Care Act requires coverage for USPSTF recommended services (Level A and B) for all (not only public programs), without copays

“Coverage of Preventive Services:

• Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved”

MN Community Health Workers (CHWs) overview:

MN has a 17-credit certification program for Community Health Workers (CHWs)

Services delivered to MN Health Care Program (MHCP) enrollees by certified CHWs must meet the following criteria to be covered:

- “MHCP requires general supervision by an MHCP-enrolled physician or APRN, certified public health nurse, dentist or mental health professional
- A physician, APRN, dentist, certified public health nurse or mental health professional must order the patient education service(s) and must order that they be provided by a CHW
- The service involves teaching the patient how to self-manage their health or oral health effectively in conjunction with the health care team.
- The service is provided face-to-face with the recipient (individually or in a group) in an outpatient, home, clinic, or other community setting
- The content of the patient education plan or training program is consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms and health or dental literacy of the individual patients.”

MNHCP CHW Provider Manual changes:

“Pediatric obesity” added as an example of covered CHW services

“MHCP will cover diagnosis-related patient education services, including diabetes prevention and pediatric obesity treatment provided by a CHW, with the following criteria...”

Excerpted July 11, 2016. See link for current language:
MNHCP CHW Provider Manual changes:

Covered CHW hours per month per participant increase from 4 to 12

"Use the following procedure codes:
- 98960 Self-management education & training, face-to-face, 1 patient
- 98961 Self-management education & training, face-to-face, 2–4 patients
- 98962 Self-management education & training, face-to-face, 5–8 patients

Bill in 30-minute units: limit 4 units per 24 hours; no more than 24 units per calendar month per recipient"

Excerpted July 11, 2016. See link for current language:

MNHCP CHW Provider Manual changes:

Removal of “standardized curriculum” requirement for CHW services

Old:

The content of the educational and training program is a standardized curriculum consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms and health or dental literacy of the individual patients.

New as of 4-26-16:

The content of the patient education plan or training program is consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms and health or dental literacy of the individual patients.

Three options to provide and bill for services:

1. Partner: Community-based providers can partner with a recognized clinical provider or public health nurse entity (city, county, school); develop a formal contractual relationship; clinic/PHN provides clinical oversight and billing functions

2. Restructure: Community-based providers can restructure themselves to become a recognized provider by payers; staff medical director and clinical supervision; internal billing functions

3. Contracted clinical support and online billing: Community-based providers can contract with a medical director; develop standing orders to deliver services; contract with nurses, dieticians or others to provide clinical supervision to CHWs; utilize MN e-Connect to submit bills to payers
Utilizing CHW reimbursement

EXAMPLE: Children’s: *Vida Sana*
Minneapolis clinic: Patients in 2015

- American Indian/Alaskan: 44%
- Asian: <1%
- Black/African American: 4%
- Hispanic/Latino: 20%
- Native Hawaiian/Pacific Islander: 4%
- White/Caucasian: 25%
- Other: 1%
- Declined/Unknown: 2%
Vida Sana Overview

• Began in 2012 as a partnership between Children’s Hospitals & Clinics of MN and Health Partners
• Partner with Latino families improve their overall health by connecting to resources
• Nutrition education and physical activity access in a whole-family, community-based setting
• Activate their power to put knowledge into action
• Family wellness services uniting primary care, public health and community organizations in the Phillips neighborhood of Minneapolis
• Families identified in the MPLS general pediatrics clinic: Spanish-speaking, overweight or obese children and their parents. Initially targeting school age children and adolescents, expanding to a whole family approach
• Clinic visits with certified community health worker in the clinic 1:1 and/or community-based services
• Waite House in Phillips Community Center (2323 11th Avenue South)
• Weekly services thought the year – Weds nights at Waite House
Children’s: *Vida Sana*
Participation

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<th>Year</th>
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<tr>
<td>2012</td>
<td>0</td>
<td>101</td>
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<td>2013</td>
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<td>340</td>
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<td>2014</td>
<td>125</td>
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Next steps

• Post guidelines on MN-AAP website

• Develop plans to support broader adoption of practices at Feb 1, 2017 annual meeting of MPPOCC’s full membership

• Work with MPPOCC member community-based service organizations to support delivery of best practice services, obtain available reimbursement, and report on any continuing reimbursement gaps
Resources/Links


MPPOCC Fact Sheet and Jan 2015 Coding Webinar: http://mnaap.org/obesitycoding.html

NICHQ Healthy Weight Clinic Guide: http://obesity.nichq.org/resources/healthy_weight_clinic_guide
References


