OPRE Methods Meeting Session 9: Implications for the Federal Context

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DISCLAIMER- The findings and conclusions in this presentation do not necessarily represent the official position of the Centers for Disease Control and Prevention.
We Know What Works: Pediatric Weight Management Interventions (PWMI)

Evidence Base:
Over 60 Randomized Controlled Trials show us that family-centered pediatric weight management interventions (PWMI) can result in 5-20% reduction in excess weight.

U.S. Preventive Services Task Force Recommendation:
Grade B*

Physicians should screen children ages 6+ using BMI and offer/refer children with obesity to intensive, family-centered PWMI.

Interventions should have 26+ hours of counseling over 2-12 months on nutrition, physical activity, and behavior change.

*The Grade B recommendation means that children on Medicaid have coverage for screening and treatment in intensive interventions as a preventive service.

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First, we need packaged interventions that contain all the components for implementation:

- Supporting materials in user-friendly formats
- Implementation manuals
- Training curricula
- Technical assistance
- Evaluation & quality control materials

Then, to ensure children are screened and referred, we need:

**Supply:**
Sufficient reimbursable interventions available

**Demand:**
Providers are aware, confident, and referring
The Childhood Obesity Research Demonstration Project (CORD 3.0) is taking 5 unique, effective interventions & preparing them for scale across systems and settings.

<table>
<thead>
<tr>
<th>Grantee and Intervention</th>
<th>Model/Setting</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Washington University (St. Louis, MO) Family-based Behavioral Treatment</td>
<td>Individualized Behavioral Model (Clinic Based)</td>
<td>Mean reduction in excess weight of 20% (1 year); average parent weight loss 28lbs (6 months)</td>
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<tr>
<td>Stanford University: Pediatric Weight Intervention</td>
<td>Group Model (Clinic Based)</td>
<td>Mean reduction in excess weight of 8% (at 6 &amp; 18 months); 68% of parents lose or maintain BMI</td>
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<tr>
<td>Miriam Hospital in Rhode Island: Join for Me</td>
<td>Group Model (Community Based)</td>
<td>4.3% reduction in excess weight at the completion of the intervention</td>
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<tr>
<td>Massachusetts General Hospital: Healthy Weight Clinic</td>
<td>Individualized Medical Model (Clinic Based)</td>
<td>Mean reduction in zBMI = 0.16 units/year</td>
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<tr>
<td>University of Nebraska Building Health Families</td>
<td>Group Model (Community Based (Rural))</td>
<td>Mean reduction in zBMI = 0.22 units/year</td>
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Progress: Advancing Evidence-Based Practices to Reach Low-Income Families

- Utilizing the only evidence-based PWMI currently available: Mind, Exercise, Nutrition, Do It! (MEND®)
  - Through partnership with National Association of Community Health Centers, we are implementing MEND® for low-income families at Federally Qualified Health Centers in 5 states. We are also developing best practice guides to support additional expansion.
  - One size does not fit all families. We need packaged interventions using multiple models to meet the needs of diverse populations and settings.

Moving us forward: PWMIs help address childhood obesity

https://www.cdc.gov/obesity/initiatives/commit/index.html
## Childhood Obesity Management with MEND Implementation Teams (COMMIT) in Community Health Centers

<table>
<thead>
<tr>
<th>Number and Duration of Sessions</th>
<th>Session Content</th>
<th>Team &amp; Target Populations</th>
<th>Measure and data entry</th>
<th>Other</th>
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<tbody>
<tr>
<td>e.g., Time of day, alignment with school schedules, weekend hours</td>
<td>e.g., Tailoring language, pictures, examples for local culture/context; Using motivators appropriate to population; Changing foods/recipes for local preferences</td>
<td>e.g., Child care for younger kids; Assistant for difficult behaviors; ANY staff member can be MEND trained; ANY caregiver can attend Synergy of Primary Care staff to COMMIT staff</td>
<td>e.g., Entering/storing data in EMR or other secure system; Interpret measures into another language or literacy level</td>
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<td>e.g., Duration of sessions</td>
<td>Frequency of sessions (&quot;intensity&quot;) Minor modifications likely ok, but...Higher-&gt;lower intensity over 2-12 months</td>
<td>e.g., Substituting activities; Changing session sequence; Adapting program to varying physical spaces</td>
<td>e.g., substituting or adjunct staff with sub-optimal training; Sibling involvement; Age group: 2-5 years, 15-18 years</td>
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<td>e.g., Total # of HOURS (&quot;dose&quot;) matters! Guideline recommends minimum 26 hours In practice: some children &amp; families need more than others “Booster” (post-MEND) dose -&gt; sustained family change</td>
<td>e.g., Nutrition &amp; physical activity education; Behavior change (ex: problem-solving, goal setting); Skill-building (ex: cooking, shopping, everyday physical activity)</td>
<td>e.g., Un- or under-trained staff as MEND leaders Age group: 0-2 years</td>
<td>e.g., Adding additional outcome measures (ex: self-esteem, a1c); Slimming process &amp; outcome measures</td>
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**GREEN LIGHT CHANGES**

- Intensity/dose still matters most! Necessary substitutions in a global pandemic – in-person group is not safe so what are creative adaptations? (phone, zoom, webex, google hangouts, online resources)
- Focus on providing nutrition + physical activity
- Can use existing MEND info and share virtually (powerpoint, emailed or mailed handouts)
- Tailor as needed for COVID – additional family resources, mental health needs
- Keep same trained MEND team if possible
- If previous MEND team redeployed/unavailable, are there other champions who have some availability to step up?

**YELLOW LIGHT CHANGES**

- Lack of in-person visits means objective measurements not easily obtained – can people come in for height/weight only?
- Surveys – mail, email, ask over the phone
- Covid-specific questions?