DNPAO Seminar Series - Childhood Obesity Seminar 06302022 Transcript FINAL

00:00:00:12 - 00:00:19:01

Eileen Bosso

Welcome. We're so happy that all of you could join us this afternoon for the DNPAO Seminar Series. Today's seminar will discuss the importance of childhood childhood healthy growth. During the session will highlight effective approaches that promote healthy growth in the early care and education and health care settings.

00:00:21:16 - 00:00:44:13

Eileen Bosso

My name is Eileen Bosso. I'm Team Lead for policy and partnerships in the Division of Nutrition, Physical Activity and Obesity, or DNPAO, as you'll hear it referred to today. And I'll be your moderator for today's session, I'm going to start out with just a couple housekeeping items. This Zoom call is being recorded. If you are not comfortable being on a recorded line, we ask that you disconnect at this time.

00:00:44:23 - 00:01:05:05

Eileen Bosso

We will be posting the session on our website at a later date so you'll have other opportunities to watch it. To have the best experience. We encourage you to use the zoom app or websites within the slides and participate in today's meeting. All participants will be muted. However, following the three presentations we'll have a question and answer session.

00:01:05:24 - 00:01:28:17

Eileen Bosso

The Q&A box is open, so at any time feel free to drop a question in. If you are using the Zoom app or website, you can type in a question by clicking on the Q&A icon and we'll get through as many questions as we can during the hour. So for those of you who are familiar with the DNPAO you may be aware that the division supports nutrition, physical activity and chronic disease prevention across the life course.

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Eileen Bosso

Today, you'll hear about just two of the strategic initiatives for our division. Before we jump into today's session, I would like to introduce our three amazing speakers. So first, I have Carrie Dooyema. She is the lead for early care and education team or ECE and the Obesity Prevention and Control Branch in DNPAO

at CDC. Carrie provides guidance and technical assistance to CDC grantees and partners on many facets of childhood obesity, including obesity prevention in the ECE setting.

00:01:59:04 - 00:02:27:09

Eileen Bosso

Dr. Alyson Goodman is a pediatrician and medical epidemiologist in DNPAO. She's also a commander in the United States Public Health Service. Dr. Goodman serves as the lead for the population health and health care unit, also in the obesity prevention and control branch. Her role includes improving access and uptake of evidence-based prevention for childhood obesity prevention and treatment, and she also manages a robust informatics and health services research portfolio.

00:02:28:14 - 00:02:56:11

Eileen Bosso

Jessica Wallace has been a family medicine physician's assistant for 16 years. She has worked at Denver Health. She works at Denver Health, a safety health a safety net health care organization. Since 2013, she is overseeing the creation of a collection of effective pediatric and adult weight management programs into the FQHC setting to help reach underserved populations. She completed her master of public health and physician assistant training at George Washington University.

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Eileen Bosso

She is currently a doctoral student in public health at the University of North Carolina. So here's a quick peek at today's agenda. To kick off the session, Carrie will discuss efforts in the ECE setting to help children from birth to five get a healthy start. Aly will then talk about effective family healthy weight programs and efforts to support interventions for children and families with low income.

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Eileen Bosso

Jessica will then provide and on-the-ground perspective from a federally qualified health center or FQHC in Denver. And again, then we'll have some time for Q&A. So with that, I'm gonna turn it over to my colleague Carrie to talk about efforts to improve children's healthy growth and the ECE setting. Carrie.

00:03:36:12 - 00:04:11:16

Carrie Dooyema

Thank you, Eileen, and good afternoon, everyone. I'm delighted to be here with you today to talk about healthy child growth and childhood obesity prevention in the early years. Before we begin, I just wanted to share a few slides on childhood obesity and the importance of healthy growth. So here is a slide using data from the latest National Health and Nutrition Examination Survey or NHANES, which indicates that about 19% of U.S. children and adolescents have obesity, including about 6% with severe obesity.

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Carrie Dooyema

Additionally, as you can see from the graph, obesity prevalence typically increases with age. We also know that there are disparities in childhood obesity prevalence. For example, there are disparities among racial and ethnic groups with Hispanic and Mexican-American and non-Hispanic black children having higher prevalence of obesity. As you see on the slide, also by household income, where children at higher incomes have lower levels of childhood obesity.

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Carrie Dooyema

Finally, location also matters with higher obesity rates among rural children compared to urban. It is important to view these disparities with a lens of disparate opportunities for healthy living, which often have historic and structural roots which persist to this day. Why is healthy growth important? Well, we know that the risks of having obesity are numerous and serious. And you can see those on the slide.

00:05:10:14 - 00:05:43:24

Carrie Dooyema

Obesity puts children at greater risk for a host of serious health conditions such as diabetes, cardiovascular disease, as well as mental health conditions such as anxiety and depression. Obesity is also very expensive, costing the US health care system approximately $173 billion per year. So how can we support healthy growth for all? Well, now, with that background in mind and out of the way, we are ready to switch gears and really discuss this idea of supporting healthy growth for all children.

00:05:44:11 - 00:06:20:02

Carrie Dooyema

Obesity prevention not only results in better physical and mental health outcomes, but also has broader school work, societal and societal benefits. As you can see outlined on the slide here, which brings me to the topic I spend most of my days thinking about. This is the early care and education setting, or I'll call it ECE where approximately 12.5 million children spend time. ECE can be an important setting for helping

children build a foundation for healthy habits and can really influence what children eat and drink and how active they are on a daily basis.

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Carrie Dooyema

So ECE, or education in general, first is a key equity driver in the United States and we know that ECE participation impacts short term outcomes for children such as health and school readiness. But there is also an extensive body of literature from many longitudinal studies that demonstrate that participation in high quality, ECE programs in terms both long term improves, both long term health and societal outcomes, including decreased substance use, substance use, decrease adult BMI, decreased cardiovascular disease risk, and also societal outcomes such as educational attainment, crime and income.

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Carrie Dooyema

Studies show that return on investment for ECE programs is high, which are largely also societal. Thus, access to high quality ECEs can also be a critical social determinants of health. For the past 12 years, DNPAO has supported work in this ECE space to improve nutrition, physical activity and support breastfeeding for kids ages 0 to 5 who are in care.

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Carrie Dooyema

We really do this through a triple prong approach. Maybe people have heard me talk about this before, but really just thinking about first how we support states to implement national standards into existing state systems. Second, how do we help local communities and support ECE facilities, those ECE centers and ECE family child care homes to improve nutrition practices and policies and environments?

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Carrie Dooyema

And finally, how do we support providers, or ECE teachers, to implement those best practices that are tailored to their facility context? And related to our topic area. We do this work through funding TA and surveillance. DNPAO has currently three state level cooperative agreements for ECE for improving the ECE setting in 33 states. We also have two local level cooperative agreements supporting 23 local jurisdictions.

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Carrie Dooyema

The reach of our programs is around covering about three fourths of children under five in the United States. And we really encourage our recipients to think about and aim for sustainable change. And here are two examples of sustainable change. And I just wanted to share with people. So first, we see improvements in state licensing and policy. This a policy lever largely so individual states are licensed.

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Carrie Dooyema

Sorry, ECE providers are licensed by individual states. And we at CDC have been reviewing and and producing an annual report on how well licensing regulations support our topic areas. And from 2010 to 2018, 39 states have updated their licensing regulations to include more physical activity, nutrition and breastfeeding support. Finally, I'm just thinking about that facility level change. The nutrition and physical activity self assessment for child care, also known as NAP SACC is an evidence based and publicly available intervention for the early care and education setting NAP SACC has found to be cost effective and also shows strong evidence for impacting early childhood obesity risk.

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Carrie Dooyema

Currently, 22 states are using Go NAP SACC to support ECEs in their jurisdictions and some states are even reaching large proportions of child care providers, including preliminary data from Iowa, showing them reaching around a quarter of facilities in 2021.

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Carrie Dooyema

Finally, this data can also be used for evaluation. So many of our recipients take that and used to go NAP SACC data for evaluation as well. So with that quick overview of our ECE work and kind of some of the foundational statistics around childhood obesity, I'm going to turn it over to my good friend and colleague, Dr. Aly Goodman, to talk about child healthy growth in the health care setting. Aly.

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Aly Goodman

It's a pleasure to be here today. So I'm just going to start with some context context around COVID 19, it's hard to talk about children and nutrition, physical activity, obesity but then now talking about the

last two years and the impacts of the pandemic on children. The pandemic led to disruptions in food and nutrition, accessibility, physical activity, opportunities, education, sleep and social connection for children and adults.

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Aly Goodman

But these had really significant impacts for children, including increased increases in stress and mental health and coping, food insecurity, and really exacerbated disparities that were already there. And this really put a spotlight on equity issues as it relates to all kinds of health and and non-health related issues for children. We know that obesity results from how people respond to short and long term disadvantage and the associated stress on their biological function over time.

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Aly Goodman

And the pandemic has just exacerbated these differences. So a couple of really important points to understand about the relationship between COVID and obesity. So first off, we know that among youth with COVID 19, under underlying medical conditions, including excess weight, seemed to increase the likelihood for hospitalization and severe COVID 19 illness. Right. So kids with obesity seem to get more severe illness.

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Aly Goodman

So that is a really neat biological interaction. There. But also during the pandemic period, we know that because of the disruptions and sort of the environment and life, that the average rate of BMI increased really significantly. In fact, it almost over doubled during the pandemic period. And those differences were even more exacerbated for children who started with obesity.

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Aly Goodman

There was also or has been also an increase in incident diabetes, and that's mostly type two diabetes among those less than 18 years old during the pandemic period. And there's also been an increase in emergency room visits for eating disorder conditions by youth. So overall, we're looking at, you know, not a great not a great time period for chronic disease risk among children.

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Aly Goodman

So now more than ever, we need to translate evidence to action in terms of prevention and treatment of obesity in children and adolescents. So in the health care setting, what evidence do we have? So we have some older recommendations from 2007 from the American Academy of Pediatrics that were really excited that in 2022, this fall, AAP will be releasing new clinical practice guidelines, we at CDC have had the opportunity to contribute and support those.

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Aly Goodman

And we're really excited those will be really released later this year. We also have the 2010 and reasserted in 2017. U.S. Preventive Services Task Force grade the recommendation for Child Obesity. I'll go over those in just a moment. So what is that USPSTF recommendation? It says that physicians and other clinicians should screen children ages six plus using BMI or body mass index and offer or refer children with obesity to intensive family healthy weight programs.

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Aly Goodman

So what are those programs? They should include at least 26 hours, which is a lot, we'll talk about that more, of counseling over 2 to 12 months on nutrition, physical activity and behavior change. And I'll unpack that a little bit more as well. But I just want to be clear that these programs have a lot of evidence. Over 60 randomized controlled trials have shown us that these family healthy weight programs can promote health and well-being and result in a 5 to 20% reduction in excess weight, not only for children, but also for their caregivers.

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Aly Goodman

So at DNPAO, we work, you know, in health systems across the pediatric care continuum, not only in prevention for children which should be universal, but meant for kids with excess weight. So on the left side of the slide, in the prevention space, we're talking about screening all children. It means that we want clinicians to be looking at healthy growth, to be observing healthy behavior screening for things like sugar sweetened beverage intake.

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Aly Goodman

And we want to we hope that clinicians are screening for social determinants of health, such as food insecurity that can lead to obesity and overweight risk and providing referrals to resources. And we're hoping that they're using growth charts and using decision supports that help clinicians make decisions based on the best available evidence. In the treatment column, on the right, again, hoping that clinicians are using the best available evidence from clinical practice guidelines providing families with family healthy weight programs.

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Aly Goodman

We are working on trying to help support payor reimbursement billing and coding for these programs, which are major barriers to spread and scale of them in the field and also trying to better support clinic to community linkage because of course, and most of obesity prevention and treatment occurs outside of the clinic walls. So just as an example of a space where CDC is is trying to work with health care is in a growth charts.

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Aly Goodman

So, of course, CDC growth rates are the mainstay, are the standard. And in the middle here, you'll see that the body mass index and growth chart that's been layered on with color coding with green, yellow and red. So an interpretation of our growth charts that really help clinicians and families to interpret CDC's growth charts. And we're really excited that later this year we'll be releasing the CDC color coded growth charts.

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Aly Goodman

Also on the right is a severe obesity growth chart. These are used by clinicians and families for children who are already living with excess weight and they're very helpful clinical tool. And again, we're working with the National Center for Health Statistics, which is a part of CDC to release new and severe obesity growth charts later this year. And we're really excited to be able to provide those as a tool for health care systems.

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Aly Goodman

So another major gap in the health systems field is packaging the existing family healthy weight programs and so that there have all the components that are needed for successful implementation in

in all settings, but especially the settings that serve our lowest income families. And so what does that mean? We need to have the materials available in user friendly format with all the implementation manuals, the training curricula, with the technical assistance available, and evaluation and quality control materials.

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Aly Goodman

In other words, like a package that can be picked up and implemented in a federally qualified health center, in a community venue, wherever it is that you need to serve children and families. And so you also need to ensure that there's sort of supply, right, in terms of sufficiently sufficient reimbursable interventions available, these package programs. And you have to have demand.

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Aly Goodman

So we need to make sure that providers are aware of these programs, that that they're competent and that the referring. And so we have a lot of health systems work to do to make sure that we're that this is happening. So what are the components of these programs? So the content, again, includes that nutrition and physical activity, skills and counseling.

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Aly Goodman

And that's a key piece. But really the focus is on behavior change. Right. And we all know how hard it is to change our behaviors. And so that is really the mainstay of these programs and their families centered because for children. Right. Like they're they're a part of a family unit and part of a household. And that is a really key component here.

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Aly Goodman

They have to be very much contextualized and addressing the social determinants of health, and they have to be delivered with an awareness of body image by a stigma and shame. We want to do no harm and this is really critical. Dose and delivery is also key here. We need a sufficient amount of quote unquote dose rates of 26 hours over 2 to 12 months.

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Aly Goodman

I know that sounds like a crazy amount, but it can be done. Jessica Wallace who's speaking next, is going to give us some information about how the actual real world of that booster dose or maintenance doses important to sustain effects in the real world. In terms of setting, this can be done in clinics or in community settings by a multitude of different types of providers.

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Aly Goodman

Groups and individual sessions can be done and combined, and they can be done virtually or in person. So one of the benefits of these programs? They they improve child and family wellness. Families come out of this feeling better in lots of different ways. They improve health behaviors and parenting, family stress and coping. And having just talked about the pandemic, I mean, how many families don't need help with family stress and coping?

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Aly Goodman

It's really great stuff. They improve quality of life, mental and behavioral health, this is key. And depression, anxiety, improved metabolic markers, right, diabetes. Look at fatty liver, blood pressure, health quality measures, this is really critical for health systems, reduced or maintained child and caregiver weight. The programs have been shown to be cost effective both for the child and the caregiver and even be cost saving.

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Aly Goodman

Right. So these investments in prevention and treatment can result in later, later savings, which is really critical. So just wanted to quickly show on a map that our group is already funding through CORD, our Child Obesity Research Demonstration project, that's where we're packaging those programs, as well as the project where we're implementing some of this family healthy weight programs in federally qualified health centers, which Jessica Wallace is going to speak to next as well some and a data initiative that could be project across the country.

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Aly Goodman

So we have a number of initiatives and we're looking forward to additional future spread in scale. So a few examples of programs briefly. This is just four of of many that exist with decades of research

funding. So one example is healthy weight and your child. Healthy weight and your child is based on the MEND program. MEND is the Mind Exercise Nutrition Do It program.

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Aly Goodman

It comes out of the U.K. It has decades of research and evidence behind it. The YMCA of the USA licensed MEND for like several decades. And so they you can join healthy weight in your child at the Y at Ys across the country. It's in a group format. It can be done virtually or in person. It's a 12 month program that includes 25 sessions that are led by trained laypersons.

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Aly Goodman

Really wonderful aspect of it. And there are opportunities for billing insurance. For example, in Milwaukee, Wisconsin, the Wisconsin Medicaid program is reimbursing $629 to be very specific for healthy weight in your child, which is really wonderful that they're having Medicaid reimbursed for low income children and families to join that program. The Bright Bodies program is another example. It's a 12 week program.

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Aly Goodman

It can be done in the clinic or community setting, though most of their implementations have been in school based health centers. It can be done virtually or in person. It is most commonly delivered by registered dietitians, but also has been done by social workers or exercise staff, exercise physiologist, and includes the same sort of components that you'll see standard as part of the is physical activity, nutrition, behavior modification as a sort of separate parenting group as part of it.

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Aly Goodman

And there have been cost saving settings showing an average savings of $930 per child over ten years. So Bright Bodies is another wonderful program. The last example for today is the family based Behavioral Therapy or RYSE program, which comes out of Washington University in Saint Louis. Just wanted to have you focus on a couple of of pieces. It is a behaviorally based program so it's predominantly behavioral coaches who who do the RYSE program.

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Aly Goodman

And I just wanted you to see that there's a really, really big focus on positive parenting and talking about being a healthy role model for your child, using praise, setting limits and rewards. And I wanted you to see that there's this one on one coaching aspects and setting goals, how it emphasizes using your community and engaging with community resources, and on building self-esteem, building body confidence, practicing healthy self-talk, all these wonderful skills that are good for all of us.

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Aly Goodman

Also in Missouri, there is a state plan amendment that went into effect this year to cover up to 70 hours per year of family based behavioral treatment in the state of Missouri for children and adults. So we're really excited about that benefit going into effect and look forward to hearing about the rollout of that program. So in summary, partners in many sectors are part of the solution, but what we want you to hear is that effective prevention and treatment access that focus on healthy behaviors right.

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Aly Goodman

And and ECE in schools and communities and clinics. But mostly these prevention and treatment programs have to be adopted right at the local level for acceptability, community type contact and cultural adaptations. And that's how we get to equitable implementation. That's how we reach our hard to reach populations, our low income populations who really, really need our help. And what we hear time and time again is that families are looking for help and supports.

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Aly Goodman

We just have to get it to them in a way that they can that they that they can access it. So with increased availability and access and coverage, which is another key piece, together we can meet families where they are right and support children's and families health and wellbeing. And with that, I thank you very much for your time and for listening. And I am going to hand it over to our wonderful colleague out in Colorado, Jessica Wallace. Take it away, Jessica.

00:23:45:21 - 00:24:08:21

Jessica Wallace

Awesome. Thank you so much. I'm really, really happy to be here with you all. I am a family medicine physician assistant. I've been a PA for 16 years. 15 of those have been working in federally qualified health centers.

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Jessica Wallace

And I'm speaking you to you today wearing two hats. I am the director of a collection of programs called Healthy World at Denver Health, which is an FQHC in Denver, Colorado. And I also work with the National Association of Community Health Centers on the CDC funded grant card COMMIT which Aly just spoke about. And that stands for Childhood Obesity Management Models and Teams.

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Jessica Wallace

And Commit is based heavily off of the MEND program, as well as informed by the U.S. Preventative Services Task Force Guidelines and also our years of experience around what what works. So I'm going to help dive a little bit into implementation in practice. And what I mean by that is doing the work of taking public health programs and integrating them into health care delivery settings.

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Jessica Wallace

I've done that first in Washington, D.C. in an FQHC network and now in Denver. So this is just a map to orient similar to what you saw earlier. So my health care organization is there in Colorado, but we also under COMMIT work with primary state primary care associations and FQHCs in Arizona, in Mississippi, Illinois, North Carolina, and Florida. And since we're talking more about the on the ground experience, my slides are just going to be pictures of kids and of families that are engaging in COMMIT and having fun while they're doing it.

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Jessica Wallace

You'll notice we're not professional photographers, so they're just meant to be snapshots in the background. As I discuss some of the successes, the challenges and opportunities that we've seen in this translation from research, which is of course a very controlled environment into the chaotic, messy and beautiful world that we all live in. So first, the why. And by that I mean why take these interventions and connect them into FQHCs.

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Jessica Wallace

So like was discussed earlier, there's evidence of strong to show that intensive interventions are what work best. The USPSTF guidelines inform a lot of the work that we do within primary care and so that does include how do we help our kids and families who are struggling with excess weight. There is a need and we see it every day and speaking honestly in primary care, it doesn't feel good to not feel like you have more than kind of basic advice or counseling to be able to offer to patients.

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Jessica Wallace

This is an equity issue, and so federally qualified health centers take care of patients regardless of their ability to pay. And so that means we mostly work in low income communities, often communities of color. And how this translates is on the individual level is, you know, when when I'm giving the advice about eating fruits and vegetables or other things like that, you know, can that family afford fresh, healthy food?

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Jessica Wallace

Do they have time to cook? Do they have quality physical activity programing, access to after school activities, gyms, pools, etc. and this is a disparity issue. And as the data has shown, it's gotten worse during the last two and a half years. And so we're trying to close a care gap to a public health emergency. The opportunities are there to implement these interventions in FQHCs.

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Jessica Wallace

So first off, I think historically there's been a role for FQHCs as innovators in health care delivery. This includes things such as integrated behavioral health, substance abuse counseling, group models of care and self management. The other thing is that we're medical homes and so often these are a stable and trusted presence in the community and neighborhoods where we work.

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Jessica Wallace

And we know that connection to medical provider advice and recommendations means a lot to patients. And so by embedding these programs into where families get their care, it really helps stress how

important and meaningful these kind of activities are. So this works over time. What we have seen with these programs is that we do have changes in health behaviors.

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Jessica Wallace

We have improved weight related quality of life, increased confidence and self-efficacy. And specifically, in the case of our Denver Health patient population, the CDC actually helped us analyze some of our data longitudinally compared to controls, and we saw change in BMI and blood pressure trajectories over time. So what we are learning over these last few years, first off, I have to say COVID's been a real bummer.

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Jessica Wallace

I'm sure nobody on this webinar would disagree, but specifically when it comes to programs like COMMIT or intensive interventions, you know, from one day to the next, it was suddenly not safe to continue in-person group programs, particularly for our patients who everyone realized were at risk, increased risk. And so a lot of the work had to go on pause and then it had to be completely rebuilt and in another format.

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Jessica Wallace

And that disruption continues today, of course. Another maybe more positive thing that we're learning over time with this COMMIT project is that FQHC leadership and staff have been tremendously invested in this work. It really does fit into the mission of the provision of high quality care. I would also say we've seen that success, not just the health outcomes that I mentioned earlier, but also patient satisfaction.

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Jessica Wallace

And they and they show us by coming and attending to these intensive interventions, which are hard for anyone to be able to commit, to pun intended. And there's a dose response. So the longer and more engaged families are able to be, the more changes they're able to make. So this is definitely seen as a value for patients as well as a value for the staff and organization.

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Jessica Wallace

So in addition, what we're learning is that we need those packaged innovation implementation programs that Aly mentioned. These implementation programs can really help reduce some of the barriers to initiating. However, they really do need to be flexible. As an example, FQHCs have issues with workforce and turnover, which we're now all feeling as well as a society. And so you really have to think through what are my training opportunities, how do I keep how do I train up new staff when I need to to avoid disruption, how do I provide refresher trainings?

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Jessica Wallace

The other piece with these packaged interventions is that you really do need to take into account culture that might be individual, patient culture, culture of the community where you work in culture of the organization you're at. But the reality that we've seen over and over again is that adaptations work to improve retention. And so how do you provide the structure to ensure fidelity but also celebrate those innovations?

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Jessica Wallace

The other piece is that the integration into primary care is really magical. FQHCs have behavioral health that can we can connect people to those resources when they need it, sometimes to nutrition, certainly to medical, particularly for weight related comorbidities, which, you know, we're seeing in very high numbers. But I have to, of course, say that this is outside of the workflow of primary care.

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Jessica Wallace

So it's just acknowledging that doing these intensive interventions is a heavy lift. So what do we need moving forward? This is really about that dissemination and implementation science and that translation of research into practice. I strongly believe that one of the important steps to reducing disparities and making the world more equitable is to go where the need is and FQHCs, I think can really serve a big role in that.

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Jessica Wallace

Sometimes with some seed funding, these health centers will come up with creative ways to staff based on their on the ground context and even opportunities to try and keep it going. The other thing that I

think we need and it's important to say is that packaged interventions, you have to be able to reduce the burden, to initiate and to continue.

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Jessica Wallace

You have to avoid excess cost as much as possible. No surprise probably, but primary care and FQHCs are not the moneymaking side of health care. And so I think in an ideal world, a lot of these things would be free. And then in that vein, finding ways to encourage and celebrate local and cultural adaptations, and then kind of elevating those best practices for scale and spread.

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Jessica Wallace

And that's all I have. That's my contact info as well as for NACHC and I'll turn it back over to Eileen.

00:33:13:22 - 00:33:39:21

Eileen Bosso

Great. Thank you, Jessica. And thanks to all our speakers today. Um, we are, we now have some time for question and answer. I already see several coming in through the chat, so if you haven't already, feel free to drop something in. So let me kick it off. We are seeing some questions about whether BMI is an appropriate measure, how it applies to different racial and ethnic groups. Aly, this is a question we get a lot in the division.

00:33:39:21 - 00:33:43:20

Eileen Bosso

Do you want to do you want to take a stab at this?

00:33:43:20 - 00:34:06:19

Aly Goodman

Sure. I'll be happy to. So I think the first major point about BMI is that it's used both for tracking obesity in the population over time. So it's a population health measure and it's used as a screening tool at an individual level, right, in the clinical setting. So if we start by talking about it as a population health tool,

00:34:06:19 - 00:34:41:17

Aly Goodman

when looking at the population, the widespread and longstanding use of BMI has helped public health professionals make comparisons across time, regions, and population subgroups. So by tracking trends in population body weight over time, we can prioritize resources to support chronic disease prevention. So there are other measurements out there, right? There's bioelectrical, impedance, DEXA or dual energy X-ray absorptiometry, did I say that right, and total body water which can measure body fat.

00:34:41:17 - 00:35:06:00

Aly Goodman

There's lots of other options out there, but they're higher cost. The skill level required, the time needed become really impractical to use routinely or for population health purposes. So I think the point of all of this is that for now, BMI is the most time and cost efficient screening measure for population health that's currently available. But now let's switch to the individual level.

00:35:06:00 - 00:35:41:09

Aly Goodman

So, you know, as a pediatrician and for clinicians, when considering individual patients, BMI should be taken into account along with other contextual factors. So as a provider, once I screen using BMI, I further assess risk right through a history of physical examination and appropriately appropriate laboratory assessments if needed. So for example, if I see an adolescent with a BMI at or just above the 90th percentile, which is the cutoff for obesity among children, and I'm examine and examination and assessment.

00:35:41:09 - 00:36:05:22

Aly Goodman

I find that this adolescent is super muscular with an athletic build and without any other chronic diseases like blood pressure, evidence of insulin resistance or whatever, and no significant family history. I'm not going to diagnose this patient with obesity because there's no evidence of excess weight for health or other chronic disease. So in this instance, the BMI is likely elevated due to high muscle mass and not due to excess body fat.

00:36:05:22 - 00:36:38:24

Aly Goodman

So now let's talk about BMI and the increased risk for mortality and morbidity among certain racial and ethnic groups. And I'm sorry, this is sort of a long answer here. So while BMI alone shouldn't be used to diagnose obesity in individuals, a USPSTF at the U.S. Preventive Services Task Force Review did find good evidence that BMI is reliable and valid for identifying adults at increased risk for morbidity and mortality due to overweight and obesity across gender, racial and ethnic groups.

00:36:39:23 - 00:37:08:14

Aly Goodman

So even for those with more normal pressure blood sugar, cholesterol levels, right, having overweight or excess weight alone can increase the risk of heart disease and severe outcomes from COVID 19. Right. So we just saw this in the pandemic and research outcomes and everything. So there's something really there. So in essence, I think, you know, BMI should not be used as a stand alone measure to diagnose obesity on the individual level.

00:37:09:02 - 00:37:41:05

Aly Goodman

And instead, the standard of practice is to take the initial BMI screening and to use the results when you're further assessing the patient. Right. Like you have to look at the patient in front of you. And BMI is not perfect at the nuances. It's not always going to be perfect across racial, ethnic or, you know, socioeconomic categories. But per the guidance that I get from, you know, our professional groups and etc. and, you know, you have to really just take things into account.

00:37:41:05 - 00:38:13:03

Aly Goodman

And this is one reason why major health organizations, including CDC and W.H.O. and NIH to the American Medical Association, continue to recommend using BMI to screen all individuals regardless of their race ethnicity, who could benefit from additional follow up with the health care provider. And that's that point, right? It's a screening measure because we want to make sure that we're catching people who need additional follow up with a health care provider and so that we can do more good, ideally than than harm.

00:38:13:11 - 00:38:32:04

Eileen Bosso

Great Thanks Aly. I know this is a complicated issue, so we appreciate you taking the time to kind of walk through it step by step. I'm seeing a lot of questions about concern, about talking with weight with

children that maybe it's not effective, that it can be harmful, that there's this risk with eating disorders. I think it really comes down comes down to weight stigma and bias.

00:38:32:04 - 00:38:50:07

Eileen Bosso

So, Jessica, I would love to hear from you how you integrate principles of health at every size, avoiding this weight, stigma and bias in these healthy weight interventions. And then, Aly, I know this is something that you think a lot about as well, so feel free to jump in.

00:38:50:07 - 00:39:12:15

Jessica Wallace

Yeah, thank you. I'll start. I have lots of thoughts and feelings about this, but also have to acknowledge that. I don't think that on the on the ground that we're at a place where we're in some ideal future state yet. It feels like something that is definitely still evolving. And even in terms of how our team and how our organization is is trying to learn and improve. At a base level,

00:39:12:15 - 00:39:39:15

Jessica Wallace

I do think that weight stigma and bias is very real and we've been trying to learn from patients, particularly adult patients who've, you know, kind of helped share their lived experiences and kind of use that to inform how to ensure that the medical system doesn't do harm. I think on a practical level, we do still look at BMI, and so it's not throwing the baby out with the bathwater.

00:39:39:15 - 00:40:05:22

Jessica Wallace

But we are thinking very, very strategically around how to have those conversations with patients and families, how to certainly knowledge that weight matters, but it's not a 1 to 1 correlate with disease. And so to the extent possible that we can expand resources for everyone and not use BMI as kind of a gateway between who gets what intervention or not.

00:40:06:15 - 00:40:27:04

Jessica Wallace

And also thinking about other ways to define success and really elevate patients and families and let them help determine what what success means to them, what being healthy and happy means to them. And again, really kind of celebrate and work with patients on those goals as well.

00:40:27:04 - 00:40:38:05

Aly Goodman

I totally agree with everything that Jessica said, and I think when you're talking about children and families, I totally get the concern and I agree with the questions in the chat.

00:40:38:05 - 00:40:55:13

Aly Goodman

Right. Like rule number one of health care is do no harm. We don't want to hurt anyone here. And I understand that concern, but I also don't think it's a reason not to intervene right. So we have to learn how to intervene the right way. We don't want boom and bust diets in anybody never mind in children, right.

00:40:55:13 - 00:41:20:12

Aly Goodman

That that's not helping anyone. But what we're looking for is building healthful habits. What we're looking for, right, is is happy and healthy people who feel good about themselves, who have less anxiety and depression and good coping skills. What we're looking for is healthy, functional families. And that's where, you know, what Jessica showed you is, you know, these wonderful group counseling sessions.

00:41:20:12 - 00:41:56:04

Aly Goodman

You can see how integrated they are, you know, and they're so behaviorally based and they're helping families to do what they do better. Right. So I understand the concern. We don't want to lead to it being harder at all. And I can tell you that research wise, the RYSE program that I mentioned earlier, the family based behavioral treatment, one of the lead researchers from that program, Denise Wilfley, and she is a lead researcher in the U.S. on eating disorder.

00:41:56:13 - 00:42:23:18

Aly Goodman

They track eating disorders very carefully in all of their research. And do they track that harm measure very carefully and they do not find increased risk of eating disorder. And they have published out the wazoo and people have picked up on a lot of the best practices from their publications, from their work and integrated it into programs like Jessica's in Colorado and programs around the country.

00:42:23:18 - 00:42:57:03

Aly Goodman

And we're making sure that we see as we're helping to promote spread and scale, are picking up on those best practices to again, make sure we're not, you know, accidentally hurting anyone. But there is so much hesitancy in health care. Talk about some of these, of our own provider stigma or bias when effective meant and not just these programs, there are effective medications now.

00:42:57:03 - 00:43:21:01

Aly Goodman

Right. And for really for for kids and adults who have a lot of excess weight, bariatrics is also a really effective option. And then and we need to be offering that from health care to to patients and families. It's not a good public health solution, but it's an important, you know, health care solution. So just putting it out there that we have to kind of take this on, especially when a fifth of children are affected by this disease already in childhood.

00:43:21:22 - 00:43:44:06

Aly Goodman

Oh, and I forgot which language I mean, sorry, which I think is sorry. The other thing that we want to do is make sure we're using really kind of person first language that we're not stigmatizing with the words that we use as much as possible. And so a person who is living with obesity, right, they are living with a disease.

00:43:44:11 - 00:44:03:15

Aly Goodman

They are not an obese person. Just like if I had diabetes, I wouldn't be a diabetes person. Right. Or a cancer person. I'm a person living with this condition. And so we just want speak to people in a kind and respectful way about this condition that they live with. And often they're going to live with this for a good portion of their lives.

00:44:03:15 - 00:44:08:22

Aly Goodman

And so we just want to be creating an environment in which people feel comfortable engaging with health care.

00:44:08:22 - 00:44:24:20

Eileen Bosso

Thanks Aly. That was great. Next. So Carrie, you discussed access to quality ECE as it relates to health equity? I think I know we have talked about it as a social determinants of health. Can you tell us a little more about that?

00:44:25:05 - 00:44:56:23

Carrie Dooyema

So yeah, the CDC defines can the social determinants of health as conditions in places where people live, where they learn, where they work, where they play, that affect a wide range of both health and quality of life and other outcomes. So really, if we think about the importance of education as a social determinants of health first and then we kind of hone in on that idea that I kind of presented of access to high quality child care or early care and education and what that really could do for children and families.

00:44:57:07 - 00:45:29:15

Carrie Dooyema

And the evidence is very clear from those longitudinal studies that that interaction with high quality, ECE really can impact in 30 year outcomes studies, those things that we care deeply about. So I think really just thinking this idea and this movement that we're having as a country to think about how we care for children and and, you know, how we can provide for and, and see this as an opportunity by accessing high quality.

00:45:29:15 - 00:45:46:06

Carrie Dooyema

ECE to kind of perhaps achieve more equitable outcomes is something that I'm really excited to watch here as, as we think as a nation about young children, how they're cared for and those kinds of things, and how that might affect us in the future.

00:45:46:06 - 00:46:08:01

Eileen Bosso

Great. Thank you, Carrie. So I think we have a lot of folks at the local level on the call. And we have one question about how local government can partner with local FQHCs to encourage the continuation and implementation of some of these programs. Jessica, do you have thoughts on opportunities for partnership? Or Aly?

00:46:08:23 - 00:46:31:03

Jessica Wallace

Yeah, I would say I think, you know, starting to create those connections in those relationships is an awesome first step. I mean, there's such overlap in terms of the work and I think also that mission of what we're all there for. You know, sometimes health care can be hard to get in the door and even get somebody to answer email just because we're really overwhelmed.

00:46:31:03 - 00:46:57:04

Jessica Wallace

But, you know, don't give up and again, where are there opportunities to provide even or some opportunities for seed funding, where they're opportunities to kind of share patients back and forth or, you know, programs can occur in any kind of setting, whether you refer out to something that's community based, is supported by local government, whether local government provides some seed funding to be able to implement in the FQHCs.

00:46:57:09 - 00:47:00:21

Jessica Wallace

There's lots of ways to do it, but I think there's great potential with that kind of a model.

00:47:00:21 - 00:47:39:14

Aly Goodman

I agree. I think that's a great point. I also we've seen like in Denver, a number of local communities have some real luck when they can get multiple organizations that are serving children together at the table, including health care. And when you can get parks and recreation along with, you know, ECE, along with WIC, along with health care, along, you know, at sitting at the same table and and everybody kind of says, oh, geez, we're all waking up every early, every day, you know, in the morning to serve these children.

00:47:39:14 - 00:48:20:06

Aly Goodman

We're just doing it in different ways. It really helps to open this dialog and start and start sharing information. With that said, we have a cooperative agreement with the National Association of Community Health Centers and I think can open some doors if you're looking to engage with an FQHC in your local community and so if that's a particular interest in your community, I think you'd be more than welcome to email us our policy group and we can help to connect you, you know, to try to help at least start making some connections for you to to, you know, at least shake some hands.

00:48:20:06 - 00:48:30:11

Eileen Bosso

Thanks Aly. And I forgot to mention earlier, we have people in the chat adding some resources and links, so feel free to take a look there. They're helping to answer questions as well.

00:48:32:16 - 00:48:45:02

Eileen Bosso

Carrie. We're getting a question. We have an ECE provider in Hawaii and we don't have DNPAO programs there. So she's wondering what other resources and programs might be available in her state.

00:48:45:17 - 00:49:10:16

Carrie Dooyema

So CDC, you know, it's funding 16 states across the United States in the SPAN program that state nutrition and physical activity program. But also we are we do have folks who are in unfunded states listed as ambassadors and ambassadors state. So that's a great way to get in contact with those who are working on nutrition and physical activity through that ambassador contact.

00:49:10:16 - 00:49:35:15

Carrie Dooyema

And then also, you know, I think the person mentioned I can't see the chat exactly, but something about the farm to ECE work. So I think that's really great to that work. CDC has a cooperative agreement with the national with excuse me, the Association of State Public Health Nutritionists to work with ten states and D.C. around the farm to early care and education topic.

00:49:35:22 - 00:49:57:23

Carrie Dooyema

So there's a lot of movement and momentum on that as well. So I'm happy to provide some follow up links of ideas and ways to think about how to connect at that at the state level. But reaching out to your state, either a nutrition contact, chronic disease department, or others is a good way to kind of get started and we can help facilitate that.

00:49:59:04 - 00:50:11:09

Eileen Bosso

This next question I'm going to throw out again to both Jessica and Aly. So one of our participants is wondering what your experience has been working with group settings as far as confidentiality issues and comfort level?

00:50:12:10 - 00:50:31:21

Jessica Wallace

I think groups are amazing. And you know, I will say that as a clinician who, you know, does most of my work individually with patients and it's a it's a little Groundhog Day, knock knock, to start over and have the same conversations over and over again. And that's beautiful and wonderful, too. But I think there's real power in groups.

00:50:32:04 - 00:50:54:00

Jessica Wallace

It kind of disrupts the otherwise hierarchy that exists within medicine. You know, where one person is the expert and has the power. Groups can really kind of elevate everyone and help with people learning from each other, feeling empowered to say what their experience is or what they really think when somebody tells them that they need to eat more vegetables.

00:50:54:00 - 00:51:20:09

Jessica Wallace

And so I love groups. And I will say within health care and within FQHCs, we do a lot of different types of groups. When we were first kind of building out our program in Denver, we used our experience with centering pregnancy and centering parenting models through the Centering Health Care Institute. You

know, and what I would say with all of these groups is you absolutely start with, you know, expectations of confidentiality.

00:51:20:22 - 00:51:44:13

Jessica Wallace

You do that with within the group, kind of deciding the group rules in their own in their own words. And you their own standards for how they communicate and what gets shared or doesn't get shared. You know, not everything is taken care of within the group, which is why a lot of these programs then build on other layers that can connect back to behavioral health or to medical providers.

00:51:44:13 - 00:52:07:24

Jessica Wallace

And and that's where anything that is not fit for for a group discussion can can still be addressed. And, and again, like the power of the group to really be able to have a longer period of time with people, to be able to work with them over a period of time and watch them support each other and build these new connections and relationships is beautiful.

00:52:07:24 - 00:52:35:13

Aly Goodman

Yeah, I can just I mean, Jessica has that on the ground experience that and there you know there's quite a few of these family healthy weight programs that are really solidly evidence based and there's some that have I think all of them, I believe, have at least some portion of group component and they found that to be really important for the social connectedness piece and for children and families to engage with each other.

00:52:35:13 - 00:52:56:04

Aly Goodman

And that seems to be a really important piece of of this puzzle, right. To to to helping families and others connect and kind of come to this better place toward the toward the end of it. And there's certainly plenty of precedent for group setting work, as Jessica mentioned, in chronic disease prevention and treatment.

00:52:56:19 - 00:53:16:13

Eileen Bosso

Great. Thank you so much, Aly. So I can't believe our hour is already up. We're coming up right on 3:00. So I'm sorry we weren't able to get to everyone's questions. Again, you know, it's a complicated issue and we can see that from all of these questions. And so I just want to take some time again to thank our three presenters for the time to do this.

00:53:16:13 - 00:53:37:19

Eileen Bosso

And for everyone who participated in the call. We know everyone's busy. And so we're taking an hour of your day to talk with us about these these really important topics, we really appreciate the time. I'm going to I'll close to say, keep an eye out for our next seminar series, which we plan to hold in September. We'll be putting out some announcements for that in the coming weeks.

00:53:37:19 - 00:53:47:22

Eileen Bosso

And again, we plan to post this session on our website, so keep an eye out for that as well. I hope everyone has a great afternoon and a great 4th of July weekend. Thanks so much.