Get Healthy Together

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TITLE V/MCH BLOCK GRANT MEASURES ADDRESSED
N/A.

BACKGROUND

Over the last three decades pediatric obesity rates have increased in virtually every region and population of the United States. The rapid increase in the prevalence of overweight among young children, in particular, has been deemed a public health priority. Among preschool children aged 2-5, obesity increased from 5.0% to 10.4% between 1976-1980 and 2007-2008. Consistent with national data, in New Mexico, obesity increased from 7.6% in 1998 to 12% in 2008. One important mechanism for addressing and preventing pediatric overweight is early intervention in populations disproportionately impacted by overweight and obesity. Because the Supplemental Nutrition Program for Women, Infants and Children (WIC) touches thousands of at-risk families, its staff and services are uniquely positioned to help prevent and monitor pediatric overweight.

The Get Healthy Together (GHT) intervention is one of five WIC special project grants supported in 2007 by USDA Food and Nutrition Service as part of the "Fit WIC 2" initiative. The GHT study design builds on insights gained from USDA's earlier Fit WIC 1 project, funded in five US sites in 1999, as well as primary care studies conducted by International Life Sciences Institute Research Foundation (ILSI RF) and its partners.

PROGRAM OBJECTIVES

The goals of the *Get Healthy Together* project were to: 1) increase New Mexico WIC staff self-efficacy regarding management of personal health including nutrition, physical activity and sedentary behaviors; and 2) improve WIC staff counseling skills with WIC clients related to pediatric overweight prevention and management.

The specific objectives related to Goal 1 were:

1. At least 75% of the WIC staff will report an improvement in two personally selected health behaviors;
2. At least 50% of WIC staff will achieve an average of 10,000 steps per day and 30% will at least double their daily steps from baseline;
3. At least 75% of WIC staff will report improved self-concept related to physical activity.
4. At least 75% of WIC staff will report improved self-concept related to body satisfaction.

The specific objectives related to Goal 2 were:

1. After viewing and discussion of "Beyond Nutrition Counseling: Reframing the Battle Against Obesity," at least 75% of WIC staff will be able to identify one barrier and one strategy for counseling in regard to childhood obesity prevention and management;
2. After participating in the skills training, there will be a 50% improvement in WIC staff practice patterns as measured by chart documentation of specific counseling practices at the certification visit when a risk code is cited that is linked to obesity; and,
3. After participating in the skills training, there will be a 50% improvement in reported obesity prevention/behavior management counseling self-efficacy by WIC staff.

It was further expected that WIC clients will have greater levels of satisfaction with the WIC experience, and:

1. WIC clients will report a 25% improvement in satisfaction with the way WIC staff member addressed pediatric overweight during a certification visit.

TARGET POPULATION SERVED

All permanent New Mexico WIC clinics were used for this study, excluding two used for pilot testing (n=48). NM WIC has approximately 208 staff, with 20 administrative staff at the state office. NM WIC is known for its cultural diversity with 45% of its residents white non-Hispanic; 42% Hispanic; 10% American Indian; 2% Black and 1% are Asian.
The number of at risk of overweight or overweight WIC children 2-5 years ranged from 7.09% to 19.35% (NM WIC internal data) depending on region. In fact, 12 of 32 counties in New Mexico have greater than 10% of 2-5 year old children with body mass indices exceeding the 85th percentile.

PROGRAM ACTIVITIES

Bandura's Social Learning Theory and its focus on self-efficacy inform the theoretical framework of GHT. These concepts suggest that pediatric weight-related counseling may improve through skills training and personal wellness promotion, both which can lead to improved nutritionist confidence in serving WIC clients and their 2 to 5 year old children. GHT also employs motivational interviewing (MI), a patient-centered approach to facilitating behavioral change.

The GHT study involved an 18-month intervention with two distinct components: one addressed the promotion of WIC staff wellness related to physical activity, nutrition and health behaviors; the other component involved the provision of training and tools to WIC staff to facilitate counseling on overweight in the WIC setting.

The skills training portion involved an 8-hour training done in 4 regions of the state. This was followed by a 4-hour reinforcement training approximately 1 year later. The tools introduced included a counseling flow chart, Nutrition and Activity Self-History (NASH) form, Report Card/Action Plan, Talking Tips, Healthy Weight poster, counseling case studies, and charting protocol. The Healthy Weight poster is intended to relieve some of the confusion in regard to BMI percentiles and what is considered to be a healthy weight. The Report Card/Action Plan (ReCAP) is a simple form filled out by the nutritionist that carries the vital information about the child's overall health. The Talking Tips counseling tool allows clients to select a topic that they would like to discuss from a list of choices presented in a laminated 8½ x 11 format. The NASH form was designed to have specific questions to help prompt WIC clients to express their level of concern regarding their child's weight-related habits; thus, allowing WIC staff to address these issues

For the wellness component, a "Volunteer Champion" was recruited from each Wellness Program clinic to facilitate monthly 15-minute interactive sessions on topics selected by WIC staff. These sessions highlighted the skills of goal setting and self monitoring, as well as featured group challenges. Staff received educational information via handout materials, bulletin boards and newsletters throughout the intervention period.

PROGRAM OUTCOMES/EVALUATION DATA

Prior to implementation, there were several focus groups with WIC staff to gather input on perceived usefulness of new counseling tools. As the project progressed, surveys were sent every six months to all staff. Clients were also interviewed at two times during the program and written client satisfaction surveys were collected three times during the 18 month program. The information collected through these processes was positive and also led to minor revision of the tools. Suggestions from staff for ways to reduce record keeping related to the research evaluation process were incorporated into the protocol.

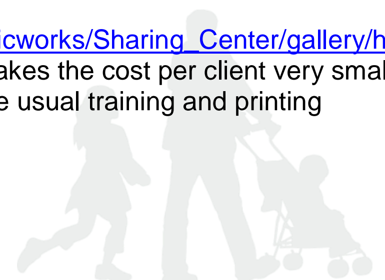
Outcome data was collected through anthropometric measures, step counts, online self-reports, client satisfaction surveys and peer interviews, chart abstraction, GHT Training and Tools ratings, and goal selection and status reports. New Mexico WIC clinics were stratified by clinic size (small and large) and rural status (rural and urban) then randomly assigned to one of four groups that resulted from the crossing of the following two between-subjects factors: Skill training vs. usual training; and, Wellness program vs. no program.

Evaluation data showed most participants in the wellness intervention perceived progress in reaching personal behavioral goals. Moreover, participants in the wellness intervention clinics were more likely than controls to report healthy dietary practices, including increased intake of fruit, vegetables, beans and bran cereal, and a reduction in the consumption of potato chips. Documentation of measurable behavioral changes was, however, more problematic. Analysis of step count data found no significant differences between intervention clinics and controls. Nor were any significant differences related to intervention status found in self-reported physical activity or body satisfaction. These findings indicate that achieving behavioral change, much less documenting such change objectively, is very challenging in a time-limited clinic environment.

Results relating to the skills training intervention were positive. Overall, over 90% of staff gave a positive rating regarding the usefulness of the trainings. Moreover, skills training was associated with improved charting of obesity-related counseling practices. Additionally, clients highly rated the usefulness of all tools in aiding their understanding of what the nutritionist was discussing.

PROGRAM COST

The cost for development and implementation of the research program included the cost for evaluation. It was funded as a 3-year research project by USDA Food and Nutrition Service for approximately $400,000. Supplemental funding was received from the General Mills Bell Health and Nutrition Institute and the New Mexico Department of Public Health. The cost for implementation in the future will only be for the coordination of the wellness program, providing the training and copying of the materials, which are all public domain and available at: http://www.nal.usda.gov/wicworks/Sharing_Center/gallery/healthytogether.html. This makes the cost per client very small and likely absorbable in the usual training and printing budget.



ASSETS & CHALLENGES

Assets

The continued media exposure to the health risks of childhood obesity helped to inform WIC staff of the importance of helping parents recognize the problem.

Overcoming Challenges

With regards to the wellness program component, time for additional meetings was scarce and there was less participation during the summers and holiday time. To keep participation and the program active, it was found that the Volunteer Champions played an integral role. Obtaining staff input on wellness topics was very valuable as were gift card incentives for participation.

State-wide implementation of the skills training in a geographically large state was challenging, but feasible with added resources. It is important to provide the skills training on childhood obesity to new staff and conduct refresher trainings for all staff. Without this training, new staff did not know the importance of addressing a child's weight with the parents and they were not aware of how useful the new tools are for counseling sessions.

Data collection was more easily done online rather than using paper surveys. Additionally, WIC staff having input into the final products used in the training helped with buy-in.

The NASH form was so well received that staff wanted to use it for all clients even though it was designed for use only with children age 2-5 years. It has now been modified for use with other WIC categories of clients, such as pregnant women, postpartum and breastfeeding mothers and infants. Final revision of these forms will be completed in 2012.

LESSONS LEARNED

The positive rating of the counseling tools warrants use of these tools in all WIC educational sessions. The NASH, in particular, is recommended as a replacement for the food frequency questionnaire formerly used to identify dietary intake and nutritional risk.

More training on obesity prevention and management should be provided to WIC staff to help them understand and communicate the serious health risks associated with pediatric overweight and obesity. More specifically, training topics cited as most useful included: 1) Additional discussion of barriers and solutions to pediatric overweight; (2) Additional information about WIC materials and resources to address pediatric overweight; (3) Review of procedures for using tools; and (4) More in-depth review of obesity trends, causes, and prevention.

Additionally, a program for staff personal wellness should be available for those clinics that express an interest in experiencing this form of staff development and personal improvement. Early in the GHT project, it was clear that WIC staff who had been allowed staff paid time for physical activity, once permitted by the NM Department of Health, took advantage of this policy. With budget and liability concerns, this benefit was taken away making it even more difficult to support the GHT voluntary wellness initiative.

FUTURE STEPS

The sustainability of the GHT project will be enhanced with additional training and tool adoption. The tools introduced to staff in intervention clinics as part of the GHT project are now disseminated to all WIC clinics in New Mexico. Control clinic staff who did not receive the skills training as part of the GHT intervention received regional trainings in August 2010. Further, the state WIC office conducted periodic staff training events in 2011-2012 to review GHT tool application in the clinic. Additionally, the GHT wellness program materials and model have been provided to the New Mexico Department of Health Wellness Committee. The GHT wellness program will be available to all clinics in support of the state's employee wellness program. Finally, at least five of the GHT Wellness Champions have volunteered to remain in that role for their clinics as part of the state wellness initiative.

COLLABORATIONS

This project was a collaboration between New Mexico WIC, the University of New Mexico, and ILSI RF. In addition to the WID Special Project grant funding, the Get Healthy Together project teams were supported by the General Mills Bell Institute for Health and Nutrition and the New Mexico Department of Health. The collaboration with WIC management and staff, who contributed their time, input and cooperation, was critical to the successful implementation and evaluation of Get Healthy Together.

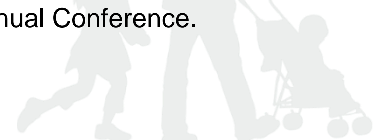
PEER REVIEW & REPLICATION

Peer-reviewed journal articles include:

- Marley SC, Carbonneau K, Lockner D, Kibbe D, Trowbridge F. Motivational Interviewing Skills are Positively Associated with Nutritionist Self-efficacy. J of Nutrition Education and Behavior. Jan 2011;43(1):28-34.

Additional program findings are currently under review for publication.

The Get Healthy Together program and its findings have also been presented at several national conferences and meetings including: National Initiative for Children's Healthcare Quality Childhood Obesity Conference, National WIC Association Conference, WIC Nutrition Education & Breastfeeding Conference, and Association of Maternal & Child Health Programs Annual Conference.



RESOURCES PROVIDED
The Get Healthy Together final report is available at:
http://www.nal.usda.gov/wicworks/Sharing_Center/NM/NMHealthyTogether/1finalreport.pdf

Materials developed through the Get Healthy Together project are available online at no charge, including:

- Nutrition and Activity Self-History Forms (English and Spanish)
- Discussion Guide
- BMI Explanation Tool (English and Spanish)
- Counseling Flowchart
- *Is Your Child's Weight Healthy?* BMI Poster (English and Spanish)
- *Your Child's Health* Report Card/Action Plan (English and Spanish)
- Talking Tips (English and Spanish)
- Case Studies

Download materials at:
http://www.nal.usda.gov/wicworks/Sharing_Center/gallery/healthytogether.html

For more information and resources, contact Gwen Bounds at gwen.bounds@state.nm.us.

Key words: Nutrition and Physical Activity, Health Promotion

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