

Coordinating Care for Obese Latino Youth to Improve Visit Adherence

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ABSTRACT

The increase in childhood obesity is cause for concern for health care providers. Childhood obesity disproportionately affects Latino youth compared with all other ethnic groups. In this report, we describe care coordination between a pediatric medical home with a majority Latino population and a tertiary pediatric weight management clinic that led to increased access to care.

Keywords: access, care coordination, Latino, pediatric obesity, referral, weight management

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Health care providers are faced with the complex task of treating and managing what has become a health care crisis caused by the alarming increase in childhood obesity. Obesity prevalence has nearly tripled among children and adolescents over the last 30 years. It is estimated that nearly 17% of children and adolescents aged 2–19 years are obese.¹ According to 2010 United States Centers for Disease Control and Prevention data, in South Carolina, where this study was performed, 15% of adolescents were overweight and 16.7% were obese. Among South Carolina children aged 2 to < 5 years, 15.2% were overweight and 12.8% were obese.¹

The Latino population is reported to be the fastest growing minority population in the US with an increase of 3.1% since 2010.² Similar to overall obesity prevalence, there has been a dramatic increase in obesity among Latino children during the previous decade. Childhood obesity disproportionately affects Latino children and adolescents in the US.^{3,4} Latino boys, aged 2–19 years, were found to be significantly more likely to be obese than non-Latino white boys. Obesity prevalence was higher among Hispanic youth (22.4%) and non-Hispanic black youth (20.2%), compared with non-Hispanic white youth (14.1%) in 2012–2014.⁵ It is reported that Latino youth have disproportionately poorer health outcomes as a result of obesity.^{5,6}

The consequences of childhood obesity can have substantial physical, emotional, and economic impact. Frequent outcomes include cardiovascular disease, type 2 diabetes, orthopedic problems, sleep apnea,

as well as social and psychological problems, such as stigmatization, discrimination, and poor self-esteem.^{6–9} Childhood obesity can also affect academic success. Gable et al¹⁰ found an association between weight status and math test scores among both obese boys and girls, who performed lower on math testing, beginning in the first grade and continuing to lag through the fifth grade.

Long-term implications of childhood obesity include greater risk for being obese as an adult, which further increases risk for adult-onset heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.^{11–13} The direct medical cost related to obesity can be substantial; however, indirect costs, such as job absenteeism and lower productivity, can impact the labor market.¹⁴ Such alarming data support the importance of intensive weight management treatment strategies for this vulnerable population.⁸

IMPACT OF OBESITY ON LATINO YOUTH

A study analyzing difference in weight status trajectories found overweight and obese Hispanic and black children were less likely to return to normal weight level than non-Hispanic white children. The same study found that obesity emerges earlier in this population.¹⁵ Stovitz et al¹¹ identified that Latino boys may be especially susceptible to metabolic syndrome. Although genetic differences are likely, sugar-sweetened beverages, physical inactivity, and sedentary behaviors are believed to be contributing factors. In addition, despite differences in body fat, Hispanic and non-Hispanic black children are more insulin-resistant than

non-Hispanic white children.^{11,16} A similar study found that children with metabolic syndrome had lower insulin sensitivity when compared with children without any risk factors,¹⁷ possibly representing an important indicator for the development of cardiovascular disease and type 2 diabetes mellitus.^{11,17} According to Marzuillo and colleagues,¹⁸ nonalcoholic fatty liver disease (NAFLD) has more than doubled in the last 20 years, mirroring the increase prevalence in childhood obesity and becoming the most common form of liver disease in childhood. Hispanic children have the highest prevalence of NAFLD. As such, a culturally based management plan, as suggested by Opalinski,¹⁹ may be key to decreasing the significant elevation in pediatric obesity rates among the Hispanic population in the US.

PEDIATRIC PRIMARY CARE CLINIC

In a pediatric medical home that serves a 70% first-generation Latino immigrant population that is 95% Medicaid-funded, there has been a steady rise in the number of obese patients in the practice. In a medical home of approximately 3,820 total patients, 39% of Latino youth have a diagnosis of obesity [body mass index (BMI) > 95th percentile]. This is significantly higher than the national average of 22.4% obesity in Hispanic youth.⁵ Of note, the clinic population of first-generation immigrant Latino children is 2,690. The increasing trend of obesity in the Latino population is thought to be related to an adjustment to the American diet, economic instability, neighborhoods not safe for exercise, and poor access to full-service grocery stores.⁷

Among the many barriers that Latinos face seeking health care, distance is a significant barrier when frequent specialty care visits are warranted.^{6,20} Although many tactics have been employed to combat the growing trend of obesity in this clinic, recently there have been higher success rates for decreasing weight and engaging in healthy lifestyle changes by initiating referral to the multidisciplinary pediatric weight management clinic. A commonly expressed barrier described by Latino patients is distance to the weight management clinic. Due to the increased obesity in this underserved area, the pediatric weight management clinic opened a second location in the primary care medical home clinic geographic area.

In the medical home, referral criteria include children aged 2–21 years, a BMI > 95th percentile, and evidence of motivation to change after screening using motivational interviewing with patients or parents. If a physician (MD) or pediatric nurse practitioner (PNP) provider identifies a patient and family meeting the criteria for referral, a referral is made through the electronic health record (EHR), Epic. A copy of this referral is printed and given to the bilingual patient navigator who then contacts the pediatric weight management clinic, sets an appointment time, and calls the family with the date, time, and directions for the appointment.

Once patients are established in the pediatric weight management clinic, there are differing practices among providers regarding how frequently they are followed in the primary care clinic for their obesity diagnosis. Some providers prefer to see them 3 months after the pediatric weight management clinic appointment is initiated to ensure care has been established. Providers continue motivational interviewing to ensure that families remain motivated to continue lifestyle changes and adhere to the scheduled weight management appointments. Other primary care providers choose follow-up appointments on an as-needed basis. Primary care providers have access to clinic notes and labs from the pediatric weight management clinic visits, as the clinics share the same EHR. The primary care clinic's goal is to provide seamless care between the primary care medical home and the pediatric weight management clinic.

PEDIATRIC WEIGHT MANAGEMENT CLINIC

The pediatric weight management clinic is a structured, multidisciplinary obesity treatment and cardiovascular risk reduction program with integrated medical, nutrition, counseling, and fitness components. The clinic is staffed by a pediatrician, a PNP, 2 registered dietitians (RDs), and a licensed social worker. Approximately 32% of the children receiving services in the clinic are Latino. The family-centered and lifestyle-oriented clinic serves youth aged 2–22 years at any stage of overweight or obesity, as well as nonobese patients with dyslipidemia.

The intervention program includes medical management care by the pediatrician and PNP, nutrition education and group sessions by the RD, and behavioral counseling by the social worker. Children work with personal trainers, physical

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