



the YMCA | FLiP FAMILY LIFESTYLE PROGRAM

CLINICAL COMMUNITY INTEGRATION REPORT

A resource for community-based and health care organizations in both Washington, D.C. and across the country to enhance the linkage between both providers along the health continuum.





Clinical-Community Integration Report

For some time, community-based organizations and health care organizations have partnered to address community health needs. The increased rates of diseases caused by social determinants necessitates these partnerships, yet best practices for moving forward still remain unknown.

In 2019, the YMCA of Metropolitan Washington and Children's National Hospital received funding from DC Health to formalize a partnership and establish systems that support healthcare's transition from volume-based to value-based care. The initial phase of this funding was primarily spent conducting research on the local and national landscapes for such partnerships, so to impact more change between such partnerships moving forward. Recognizing the potential gravity of a partnership between two local - but large - institutions, listening to both District residents and clinicians was imperative to the success of our current and future programs. Furthermore, the national presence of the YMCA warranted the need for hearing best practices occurring across the country.

The Clinical-Community Integration report was conducted using qualitative research methods: focus groups with clinicians from Children's Nationals Hospital, focus groups with residents of Washington D.C. (many of whom were affiliated with Children's National Hospital), web-based surveys for clinicians, and key informant interviews with YMCAs across the country and staff from YMCA of the USA.

There were four primary objectives for the report:

1. To examine current management and referral practices of local primary care pediatrics clinicians of patients with obesity and comorbidities, and what additional resources and trainings are needed for those to be used more frequently and effectively;

2. To learn how families of Washington, D.C. perceive the social services provided in their local communities and how their community and health care providers can better impact their health, as well as preferences for lifestyle programs that exist or are needed within their Washington, D.C. communities;

3. To explore key content that primary care clinicians and families desire for a comprehensive obesity management clinical community collaborative program;

4. To identify best practices of YMCAs across the country working with clinical providers, particularly during the initial startup phase. It should be noted that though this paper focuses primarily on YMCAs, many of the best practices can be utilized by any community-based organization.

Additionally, it is the goal that this report will be a resource for community-based and health care organizations in both Washington, D.C. and across the country to enhance the linkage between both providers along the health continuum.

Table of Contents

There are three sections to this report to match the initial research goals:

SECTION 1

Clinical and Community Qualitative Research

Although the District of Columbia is considered one of the fittest large cities in the country, there is great disparity between Wards within the city, which contributes to worsening health. Moreover, the lack of training of providers, in addition to the lack of more comprehensive resources, potentially worsens management of chronic diseases, such as obesity. In order to design a family centered, clinical-community collaborative to better address the disease of obesity, it was required that the needs of clinicians and families be determined.

Children's National Hospital (CNH) and the YMCA of Metropolitan Washington conducted research to inform the development and implementation of a robust, community-based obesity prevention and treatment program (Program) tailored to meet the needs of the DC community. The study objectives were to:

- Examine the current management practices of local primary care pediatric clinicians of patients with obesity.
- Examine family experiences with local clinical and community obesity programs and the desire for future programming.
- Explore the key content that primary care clinicians and families desire for a comprehensive obesity management clinical community collaborative program.

A mixed method research design was employed, using both quantitative and qualitative methodologies in the form of survey and focus group research. This report addresses the qualitative portion of the research.

Focus groups were conducted with subjects working and/or living in areas of DC considered high risk for obesity (Wards 5, 7 and 8): CNH primary care physicians practicing in Wards 7 and 8, and the parents/caregivers of CNH patients living in Wards 5, 7 and 8. From primary care physicians, researchers were interested in learning about their: perceived barriers to addressing obesity with patients and parents/caregivers; opinions on potential program design and elements, and ideas of how best to strengthen the referral process to community-based programs. From parents/caregivers, the goal was to understand the type of program that would best meet their needs and lifestyles.

From August 16th through September 24th, 2019, seven focus groups were conducted: three with primary care clinicians; three with parents/caregivers living in Wards 7 and 8, and one with parents/caregivers living in Ward 5.

An analysis of the findings from both sets of focus groups revealed several themes that were consistent across the relative groups. A summary of those themes, along with a full discussion of the study methodology, focus group findings and recommendations for program implementation are provided in this final report.

Clinician Focus Groups: Consistent Themes

- Lack of time during regular office visits is a major barrier to effectively addressing overweight and obesity with patients and families. Tight scheduling of appointments coupled with both the clinician and family's focus on the reason for the visit, often means there is little time for meaningful discussion of these topics.
- Trust between clinicians, patients and families is an important prerequisite for discussing a patient's diagnosis of overweight or obesity, and then following medical advice or suggestions concerning changes in behavior change.

- Clinicians need support on multiple fronts to effectively address obesity with patients and families, including: additional staffing to assist with counseling; culturally competent patient education materials for distribution, and current research on best clinical practices for screening, as well as patient and family engagement.

- Because clinicians are unsure or unaware of available community programs and resources, they find it difficult to refer patients into programs that address healthy lifestyles.

- To be successful, a program that focuses on healthy lifestyles must consider the unique needs and preferences of the target population, and in doing so ensure it is: convenient in terms of schedule and location; culturally competent, and is flexible with enrollment and attendance.

- The proposed Program, as presented and explained, was well-received. However, assessing family readiness for such an intervention was cited as an important first step prior to referral. Also important - tailoring the Program to the culture, needs and preferences of the community, and ensuring it is educational yet fun and engaging.

- In terms of the referral process, clinicians were most concerned about adding work to their already busy schedules. Recommendations centered on an electronic and paperless process – one that can be integrated into the existing EMR.

Clinician Focus Groups: Key Findings

Barriers to Effectively Addressing Obesity with Patients/Families:

◊ For clinicians across focus groups, lack of time is a major barrier to effectively addressing obesity with patients and families, with many reporting that tight scheduling of appointments leaves little time to engage in "meaningful intervention." Several clinicians noted that families are busy, as well, which they said further exacerbates the problem.

> Time – a big barrier.
>
> Not enough of it.
>
> You don't have the time because it's like a revolving door. You have other patients that you have to see.
>
> The ability to educate; we're really just talking with patients...and that just takes lot of time.
>
> Some parents are just doing what they can to get something on the table and sometimes that's fast food.
>
> It's hard to break habits. We see them maybe once a year, and we say this one thing in a 30 minute visit.

◊ Readiness of families to discuss, what is for some, a sensitive issue:

> Parents are not always willing or ready to have you point out that their child's weight or weight gain may not be in the healthy range. Sometimes they are resistant to hearing that information.
>
> They say, 'This how we're built; this is our family.'
>
> Bringing it back to the kid is hard when the parent takes it personally.

◊ Inability of families to act on advice due to limited access to healthy and/or affordable food choices or suitable options for physical activity.

> It can be hard for a family to get the healthy foods that we're recommending they eat; the non-processed food we're recommending....and preparing it as well.
>
> So I think we give advice or counsel that's not rooted in a person's reality, it just kind of goes over their head, and it makes it really hard for them to root it into the things they do.
>
> And then also, it's like resources. You know [they're] not going to purchase fresh fruits and vegetables if they going to go bad in a week. [They] just don't have money to waste on that and so that's a real thing.
>
> Finding a suitable way to get more physical activity on a more routine basis is kind of hard.
>
> A lot of the schools, they don't have PE or they alternate years. It's pointless to ask these kids, whose friends are dying outside, 'Do you go outside and play?'

◊ Lack of trust between providers and families can result in the tendency for some to dismiss or ignore advice. This, some said, is often an issue when the provider and patient are of a different race/ethnicity.

> So I think that one of the barriers is trying to communicate with them that there are better options without saying that your mother or your grandmother was wrong.
>
> I'm very aware that many patients might not deem me as part of the same community because I'm a different race and I try to sound nonjudgmental and just give them the clinical, like more objective information....so it doesn't come off like a subjective judgement to the family like, 'I'm looking at your child and I think they're overweight.'
>
> It's a level of trust in the provider. Difference in ethnicity also can be a barrier between provider and family...It may not be expressed, but over many years it's underlying especially for those families that I don't know well...where we haven't established the trust.
>
> We want them to be healthier but somehow our messages are getting crossed...I think it comes with building a rapport and meeting with families and just having an understanding of where [they] are coming form, what their experiences are. It's the responsibility of a physician to engage patients and families in that way so we have a better understanding.

◊ When asked about barriers specific to the clinical setting, many clinicians noted that often discussions about issues, such as weight, are not priority for families when compared to the reason for their office visit. Also lack of time and being distracted by their other children can also be barriers.

> There may be times when there were some distractions from families who bring younger children and they're trying to manage their behavior as well as address the one thing there here for.
>
> You know with our patients, they have so many things that are affecting their lives. They need school forms or kids have asthma. You just don't have enough time sometimes to really just sit down and talk to them.
>
> Probably the number one thing is it's not the number one concern of the day for a lot the patients when they come in. They're here for some other reason, whether they need their paperwork done.
>
> Competing interests. They're here for a specific reason. They need their asthma medicine refilled...If they have so much else to focus on, this is not the number one thing on their list.

So there are a list of things that they want to discuss and its [obesity] bumped to the lowest level for whatever reason; maybe for good reason.

They may have had a little wait or something and had to leave.

One clinician pointed out, and others agreed, that sometimes when it appears that weight loss is not a priority for the family, clinicians reprioritize it, as well.

We might have somebody come back in three months and there's no improvement or they don't come back at all and they've gained 15 pounds over a 12 month period of time. You still try to do the counseling, but at some point, you're like, 'Is this a concern of yours, Mom?' And if they say, 'No, I'm not super concerned.' I've also got to cover asthma, ADHD, the kid is getting locked up. You just kind of do what you can and move on.

◊ When clinicians do talk with patients and families about the topic, most indicated that they adapt their approach, language and counsel to the family's particular "situation" in terms of readiness for the discussion, socio-economic factors and behaviors. Furthermore, most agreed on the importance of meeting families "...where they're at" by offering realistic suggestions, and by not appearing overly judgmental, insensitive or critical.

I've definitely gone to being more motivational. I'm taking what they're telling me and finding the one little success and capitalizing on that. I used to just try to have like a perfect plan.

I try to make it more about health concerns and less about the body-image issues. It's a little easier pill to swallow.

Sometimes the lifestyle the family lives in general, you know when you ask the kids about fruits and vegetables, they'll list a few but say they either don't have it a home or they don't like the school lunch. It's [fresh fruits and vegetables] also expensive and it takes longer to cook some of those things. So often the solutions we have is not part of their lifestyle.

◊ When asked to describe what it would look like to address obesity effectively in their clinical setting, clinicians overwhelmingly agreed that the most important feature would be having additional staffing to counsel patients and families. They discussed a "team effort" that might involve nurses, health educators and/or nutritionists.

There would be a team member right there by my side who could spend more time counseling. They could even set up a time to go to someone's home to look at meal prepping, what's in their cabinet, any other barriers that they could help with...maybe therapy to get underneath why they're eating.

Sometimes I wish that we had a system where, you know, after they see us and we kind of address the issue, that there would be another person - while they're there in that moment. Maybe they could sit down with them and have the time to just really go through a lot more information with them.

You don't necessarily need an MD, an NP, a DO to tell you, 'Gosh you've gaining too much weight.' Right? So there could be a nursing team and dietician team. These visits may not even have to involve the provider.

There are lots of family navigators that are now becoming a popular ting that people are funding.

Clinicians also agreed that, ideally, the discussion with families about the risks associated with overweight or obesity would happen at a young age – before there is a problem. Having some education on the most constructive language to use with both patients and family at different points in the child's development would be helpful as well.

> It's easy to have everyone kind of understand in the teenage years or even the like middle adolescence 'Okay we need to address this now," but it's with the younger kids, based on the some of the research I know of, when you really want to start making the change. It's hard...there's so many excuses. So I would love some education on how to talk to the younger kids themselves and their families.

In addition, some said having access to evidence-based research on the topic, as well as patient materials that are racially/ethnically, culturally and age appropriate would be beneficial.

◊ In terms of advice they offer to patients and families where overweight and obesity is a concern, clinicians said they most often counsel families to:

- Drinking less sugary beverages;
- Snack less on "junk" foods;
- Add more fresh or frozen fruits and vegetables to their diets, and
- Increase physical activity.

Awareness of Community Resources

◊ When asked if they are currently referring patients to community resources, most had difficulty citing specific programs other than those af filiated with Children's National.

> We don't know of any.
>
> Other than Children's IDEAL Clinic, I'm stuck. I don't know.
>
> That's [Children's IDEAL Clinic] the only place that I refer to.
>
> Really, the issue is that we don't seem to have any resources that are known to us...
>
> We feel like we're in it alone.

Some said that, in the past, they referred patients to a nutritionist or class at Giant Food. Others mentioned referring patients to local community or recreation center programs, but were not specific.

> I think of Giant...
>
> [A] family...reached out to [their] insurance, which was AmeriHealth. They ended up getting told about the nutritionist at Giant. The AmeriHealth Community Center around the corner actually has resources around nutrition and other things.
>
> Giant has cooking classes on a regular basis.
>
> The community centers...a lot of families aren't comfortable going to them for different reasons, but often I will say, 'You can go there and take classes or swim.'

◊ The consensus among participants was that these types of resources undoubtedly exist within the community, but they are unaware because of a lack of communication and coordination between organizations or programs. Ultimately, several participants said, they would like to see more coordinated messaging from schools, local government, health insurance plans and other community-based organizations around the topic, as well as a comprehensive, up-to-date listing of existing community programs and resources.

> We have several programs here [at Children's National]....but there's probably a dozen non-profit organizations that we don't even know about in Southeast that are working on things like this.
>
> I don't think there's a poverty of resources. I think it's a lack of coordination of all of these things and a good way of closing the loop for the things that are done to facilitate communication.
>
> Something that would certainly help is that, you know, any initiative should have branding and marketing; something that can reach the community. Through the radio stations they're listening to; the TV shows they're watching; the social media they're on. You know, having messages that echo what we're saying in a way that is from someone that looks like them... it would ring true.
>
> Have YouTube videos even with local folks or celebrities that they might admire.
>
> Having a list of resources, like the District would put out that would say, 'Hey on our DC Health Department website, we have a link that has these types of programs and activities in the city

◊ In terms of community resources needed to support clinical efforts, suggestions centered around the need for:

> • More safe spaces for physical activity.
>
> I do think there are a lot of families that say it's harder to walk and exercise every day in their neighborhoods and they're like 'Well, sometimes on the weekend, we get on the Metro and go somewhere we feel safe.' That's a lot to ask.
>
> Safe space where [children] can play freely without fear of a bullet.
>
> • Wrap around services with programs that incorporate both physical activity and nutrition.
>
> Programs that provide parents with more structured guidance on what they can and cannot do and eat than what I'm about to provide and am trained in.
>
> I don't know of any that just focus on healthy eating or anything like that.
>
> • Educational videos or other materials that focus on such topics as eating healthy on a busy schedule and healthy cooking on a budget.
>
> I often wish I could have some kind of video that I could show them where I'm trying to explain a little bit of physiology of elevated cholesterol and heart disease and having some kind of images.
>
> Food models or something like that.
>
> A standardized set of things to cover. Standardized things to say about drinks and a handout and some visuals and just some things that would really help parents to understand how much sugar is in drinks.
>
> The fact that I say something and another provider might say something is fine and good, but if they see it, like on the wall, and then they see it in multiple confirming areas, it has more impact.

Opinions on Designing a Family-Centered Program

◊ For clinicians, the two most frequently cited factors planners should keep in mind when considering how to structure a healthy lifestyle program for families, were:

• Selecting a convenient time and day that meets the needs of families' work and personal schedules. Understanding what a day in the life of that family is like. It has to work for them.

Do they [families] have the time and what time of day is it?

Has to be at the time that works for the family or at the place that works.

Know their schedules. Meeting them at places where they are comfortable.

Sports. It runs their lives

• Flexibility with enrollment, start dates and attendance so families are not penalized too heavily for missing classes.

• Other important program elements included:

  • Interesting topics

  • Offering childcare

  • Providing incentives

Perceptions of Training Needed to Effectively Address Obesity

◊ Clinicians offered a variety of types of training they believed they need to effectively discuss obesity patients and families, including:

• Information on successful evidence-based programs involving similar populations.

Knowing of new evidence of programs that work or things that are helpful for families, especially in this type of community setting.

The most current studies or just understanding of the issue.

• Updated demographic and needs assessment research on residents of Ward 7 and 8.

We need the most current needs assessment of what's going on with our families.

• How to conduct motivational interviewing and help families with goal setting.

• Education on clinical protocols for screening and monitoring overweight and obesity, including labs to collect.

Didactic sessions as far as when to screen, what labs to order, what do about them.

In-person training would be helpful like part of our staff meeting.

Quick teaching sessions works here and there, but it has to be something you can reference.

I like webinars

- Bias training.

Suggestions for Referral System

◊ When asked what they would consider to be the ideal system for referring patients to the Program, clinicians uniformly said they would prefer an electronic, paperless process – one that can be integrated into the existing EMR.

I prefer no emails. I don't want it not to be part of the medical record because they're participating in this great program that has to do with their health. Let's make sure it gets in the chart.

Checking a box at the bottom of the check-out form means that when the family goes to the front desk, the referral can be generated.

Yes, then someone can pick up the phone and coordinate with the family.

Clinicians were receptive to the idea of having a Program representative onsite recruiting, educating families about what to expect once they have been referred, and promoting it in general.

Closing

◊ The clinician focus groups closed by asking participants for their suggestions on who might be a trusted community partner that could help lead some of the classes. Recommendations included:

- Sports celebrities, such as Redskins or Wizards players
- Local restaurant chefs, such as Jose Andres or a chef from Busboys and Poets
- DC Central Kitchen was the organization mentioned most often.

Family Focus Groups Themes

• The neighborhoods where families live do not offer food options that support living a healthy lifestyle.

• Cooking plays an important role in the lives of patients and families – and most enjoy it as well. However, lack of time tends to be the factor that prevents many from cooking more.

• It is important for any long-term program focused on healthy eating and physical activity to be held in a safe environment and affordable. It must also be convenient – both in the time and day it is offered, and by providing families on the go with a meal and childcare for children too young to participate. Programs must also work to keep families interested and engaged by providing incentives for participation and/or rewards for reaching milestones and benchmarks.

• The proposed Program, as presented and explained, was well-received by families and each component was met with positive reactions and thoughtful suggestions. Program planners should be careful to tailor it in ways that reflect the culture, preferences and lifestyle of the target population.

• Families would be extremely or very likely to participant in the Program if referred by their child's physician, and would be willing to pay for it if the cost was kept under $25.

• Families desire open and honest communication with clinicians about weight, but in a nonjudgmental and sensitive manner.

Family Focus Groups Findings – Introduction

As a way to introduce the discussion and settle into the topic, the discussion with parents/caregivers began by asking them to think about their favorite kitchen utensil, gadget or appliance, tell what it is and why it is their favorite item.

• Appliances and utensils that promote healthier eating and convenience were ones most frequently cited as favorites. Three of the most popular items mentioned were air fryers, coated skillets and rotisserie-type ovens, mostly because participants view them as appliances that require less cooking oil, and are therefore better for their health.

In terms of convenience, crockpots – and air fryers again – are favorites because of they feature all-in-one meal preparation. A few participants also mentioned non-stick skillets as favorites, not only because they allow for healthier cooking, but because they also are easy to clean.

> [The airfryer]…it's healthier eating.
>
> And it's quick and easy
>
> The NuWave oven…it cooks without a lot of grease.
>
> I enjoy the crock-pot, when you're on the go…you put your whole meal in there and it will cook itself."
>
> I have a favorite pan I use…the Red Copper Pan…because it doesn't stick and you don't have to add oil.
>
> My non-stick skillet…it makes it easier to clean-up

Perception of Community Impact on Family Health

Participants across focus groups agreed that farmers' markets, affordable recreation centers and convenient public transportation are important features in their community that promote a healthier lifestyle.

> We have lots of farmers' markets.
>
> All our recs have updated themselves…and every rec does have a gym in it.
>
> Being able to access [recreation centers] to maybe being able to walk or to take the Metro.
>
> Because of the transportation available…[going to the grocery store] is more convenient now than it has been in the past

However, when it comes to features in Ward 5 neighborhoods that promote healthier lifestyles, participants who reside there mentioned more outdoor features than their Ward 7 and 8 counterparts.

> Parks
>
> Bike trails
>
> Up past Michigan Avenue and Fourth Street they have a garden… They plant fruits and vegetables there.

Participants were in agreement on key barriers in their community to living a healthier lifestyle, citing the dearth of "quality" grocery stores and restaurants with healthy food options, along with safety as major obstacles. Some participants also said that, when stores or programs offering healthy foods or programs do come to the neighborhood, it is often short-lived and they end up closing.

> [Playgrounds] just aren't safe. I'm not going…Mine don't come to this community.
>
> Benning Park is dangerous….I'm not sending my daughter to Benning Park
>
> We don't have healthy stores to buy food…We don't have a Whole Foods.
>
> We don't have a Wegmans over this way.
>
> I'm one that eats vegetables, but those vegetables are horrible…in the Giant – in that Safeway.
>
> There's not that many nutritious fast food options…We've got to really work hard to find something that can work, which is pretty much rotisserie chicken.
>
> For the most part, everything they have is fried. You got Popeye's. The neighborhood is full of fast food.
>
> We tried Mom's Organic down there on Pennsylvania Avenue, but you see they left.
>
> [The ARC] used to have the dance classes. That was good and the dance classes from youth to adult could attend, but they don't have that no more.

Participant were asked to share their opinions on the most important factors an organization should keep in mind if developing a healthy lifestyles program for their community. To the majority of participants, the most important factors to address include:

- Safety. The site should be in a safe and easily accessible location.
- Convenience and flexibility. Program sessions should meet the scheduling needs of participants.
- Affordability.
- Education. Teach people how and where to buy healthy foods.
- Food. A meal should be provided so families can attend right after work/school.

Make people feel safe

Accessibility. It needs to be somewhere where people can access it.

[Near] public transportation.

Flexible hours…get people's input.

Sometimes I think I can be consistent…but then the weather…the work cycle comes up. I think a program that understands [when] you just can't be at that location.

Free parking; free classes, free period.

Cost and transportation.

Food will definitely bring people in.

Definitely the part about the kids getting dinner…You might want to do it a little later so the kids and eat…it's a one-stop shop.

I think something that has a combination of physical activity and…teaching at the same time. I see challenges in certain people with buying some food [they're] uncomfortable with.

Teach how people can get healthy food

Other factors mentioned include: involving local officials; providing childcare; giving frequent reminders; providing incentives to attend, and a variety of physical activities for kids.

Participants were asked to share what role, if any, their child's doctor plays in helping their family improve its health. Most said their child's doctor mainly:

- Gives advice on making healthier food and beverage choices;
- Explains about portion control, and
- Makes referrals to nutritionists or CNHS' IDEAL program.

So we've been seen at the IDEAL clinic. We go to a nutritionist.

Just to stay away from sugars. Nothing more detailed. Just no sodas, no sugar, no chips. Just to stay away from junk food.

Cut back. Push her plate away.

Sent [child] to a nutritionist

When asked about the type of role they believe their child's doctor should play in improving family health, there was a mix of responses. Suggestions included:

• Fostering a relationship with patients and families – "literally like part of the family" - so patients feel "comfortable expressing their feelings." One participant suggested doctors should make house calls to view first-hand how people are living and what they are eating.

• Providing honest assessments without being judgmental or overly critical.

• Offering advice on nutrition and cooking, along with educational materials.

• Suggesting physical activities for the entire family.

• Schedule appointments just to discuss nutrition.

When asked to recall ways in which their community has helped them or their family maintain or improve its health, community efforts mentioned by several participants included: healthier school breakfast and lunch choices; more farmers' markets, and more food sharing and pantry programs sponsored by churches and other community-based organizations.

Michelle Obama tried to bring healthy foods to DC's children, the schools, but alot kids didn't like it.

I think the schools played a big role in President Obama, First Lady Michelle Obama were in the White House. She was trying to have the schools serving up nutritional breakfasts and lunches...but these kids rather have fast food.

I know my daughter's school this year, she said they have vending machines... Guess what? Ain't nothing in there but healtyh food; not one piece of candy, no junk.

I will say this for Ward 8, they have implemented more...Now, we have have more pop-up famers markets.

Martha's Table comes into the schools – but not all.

I go to Bread for the City once a month. They have like give-away specials and they cook it and prepare kale and stuff.

Food pantries in the area help you out and give you nutritional stuff...like bread, vegetables and fruits.

I can say we had this program in our church called SHARE, Project SHARE... which is on the healthy side.

However, some said they would like to see community-based organizations focus more on affordable programming, bringing higher quality supermarkets to the area; additional playgrounds; and finding ways to keep needed programs open and running.

Better supermarkets

I wish there were more playgrounds...They're building all these dog parks, but there is nowhere for the children to play.

Or the playground is specifically for the school, and the school's closed after a certain time.

I wish there were more places for my daughter to play outside.

I used to be in a program called the Covenant House. It got closed down, but I was one of the best programs I had been in. I was learning African dance. And it was completely free, too.

I'm going to be honest, if ain't free, they not going to attend.

Experiences with Health/Wellness Activities and Programs

Most participants reported that, as a family, they had never attempted a formal health/wellness program in the past.

No, we do that [healthy eating/physical activity] on our own

No, not really.

One participant reported having had a medical intervention requiring appointments with a nutritionist. A few reported taking cooking, nutrition, exercise and gardening classes at various recreation centers.

Yea, me and my daughter took a cooking class, but we didn't stick to it, honestly.

So I've done that with my son. They have one [a program] over at the rec center in Forestville where I live. My son ...his blood pressure tends to be a little high, so we had to change the way he was eating because he eats very heavy. So you know, he drinks the smoothies...[you learn] how to make the smoothies, things like that.

We all joined the gym, but because of our schedules we're not able to go together.

[My son] has been regularly engaged in some sort of exercise program, but it's not enough.

I took one [gardening class]. It was nice. I put a grow-box in my backyard. So I grew tomatoes, thyme, sage and stuff like that...It's therapeutic.

Specific programs mentioned by participants included:

- Girls on the Run – yearly 5K
- Kofi's Cooking Class

Those who had participated in family health and wellness programs, were asked if they felt the programs were successful and if not, what did they feel were the barriers to success. Most often, time was cited as the barrier to successfully completing a program, along with simply "sticking with it", and the high cost of fresh fruits and vegetables.

Having enough time in the day...When you're a parent, you got kids, you got to get home. They got to eat.

I think the biggest problem for anyone is sticking with something.

"sticking to the commitment."

Just being consistent and focused.

We took some of the recipes and we implemented at home. However, for the fresh fruits and vegetables, it was too costly for me and they don't last long. I `m not wasting my money on something I can't keep a whole week.

For most participants, cooking plays an important role in their household and most said they enjoy it, as well.

We love to cook! My kids, my girlfriend and I, we look at different recipes and we try to make it a little healthy.

I cook all the time!

I cook most of the food in the household – breakfast lunch and dinner. Every meal is usually sound and three square meals. Everything's on the plate – a starch, a vegetable and something else.

I love to cook and when they [children] we coming up, I cooked every other day, plus dessert.

Among those who said they do not or rarely cook, the primary reason given was lack of time; a few said they lack the skill.

It's a necessity, but it's a stressor for me...I don't really like to cook and I'm not that great at it.

I like it, I just don't do it. No time.

I'm not much of a cook.

I'm not that good at it...I'm learning, but it just don't – it don't come out right.

When asked if their children assist in the kitchen, the response given by parents/caregivers was mixed. Some said their children enjoy cooking and routinely help with dinner; others said their children simply are not interested. In one instance, age was cited as the reason the child does not assist in the kitchen.

He's young and we're really careful. If we're out and he wants something to eat, then he'll use the microwave or he might use the oven. That's about it.

My daughter loves to cook.

My kids didn't want to learn, but I have an oldest grandson that does.

My son and my daughters, they didn't want to stay in the kitchen too much. They just want to show up when it's time to eat. But my grands, they're totally different. We get our aprons and we cook.

Now my 22 year old, she will go to the store, buy her food. She will cook it and will meal prep for food for the week.

Every day in my house – like every day, somebody has to be designated to cook. And throughout the week, we just cycle around and we cook.

Most said they are not missing any utensils, appliances or other items that might make it challenging to cook. A few participants said proper cookware and knives would be helpful, but quickly acknowledged that those items "cost too much."

Giant Food and Safeway were the two grocery store chains participants mentioned most when asked where in the community they typically food shop. When shopping outside their neighborhoods, many said they frequent outdoor markets, such as Eastern Market or Amish Markets, or fresh format grocery store chains, such as Whole Foods and Trader Joe's.

For some, however, where they shop depends on how much money they have available to spend. When there is more to spend, some said, they will shop at what they consider higher quality stores, such as Whole Foods or Trader Joe's.

> Generally, I shop at the grocery store. But Eastern Market sometimes – because it's fresher.
>
> It's wherever my money can take me. Sometimes if I got a little more, I might go to the better stores. I love Trader Joe's.
>
> I will go to Harris Teeter. I will go to Giant. Wherever they've got the best sales for the week.
>
> I used to look at Murray's, Safeway and Giant and we'd compare prices and items and I'd drive around to each store. You've got to read the papers. You've got to cut the coupons.

With regard to eating out, while no one restaurant emerged as a favorite, participants in Wards 7 and 8 reported eating out mostly at fast food restaurants, such as Popeye's, McDonald's, Chick-fil-A, Chipotle, Red Chicken on H Street, and other neighborhood carryout restaurants.

However, Ward 5 participants reported eating out at more casual dining restaurants , such as Carolina Kitchen, Lauriol Plaza and Uncle Julio's, than fast food chains.

Opinions on Ideal Structure and Content of a Long-Term Health and Wellness Programs

Participants said they would be more likely to complete a long-term health and wellness program under the following conditions:

- A meal is provided.
- Childcare is available for siblings too young to take part in the program.
- Incentives are provided, such as gift cards, tickets to sporting events, or rewards for meeting goals or reaching milestones.
- The program is interesting.

> Serve dinner, so then it's checked off the list. You don't have to worry about cooking that night.
>
> Are you going to feed me? I'm going to stay.
>
> Make it interesting; fun for the kids.
>
> I think if you sell the children and the children say, `Mom, I want to go,' then parents will bring them.

Don't make it another task because that's what I think a lot of us don't want. You're already working everyday – 10, 12 hours a day.

Childcare. What if you have a little baby?

Incentives like gift cards, tickets to games.

I get my [air] fryer if I lose 6 pounds. You gotta recognize things like that!

Rewards for reaching your goal. Certificates of completion.

Barriers most likely to prevent completion of a long-term program included: transportation issues; time of day, and boredom.

Transportation issues – like being able to get to the location.

Maybe provide transportation for people who are not close enough to walk or catch the bus.

The time is the most important thing, which a lot of people don't have because you've got the kids.

For the long run, you definitely have to schedule it around everyone's schedule to the point that people can continue to participate.

Time. It starts as soon as I get off of work. How am I going to get there in time? If I have to stop to pick up the kids, how am I going to get there. Things like that make me want to say 'nevermind.'

When presented with the idea of progressing through a program with other families, as a cohort, nearly all said they liked the idea and had no reservations about that model.

For me, I would like to be in a group with people from my community then you're building more community.

You have a common goal; a common interest.

You can support each other. You can support the team kinda thing.

Opinions on Proposed Program Elements

Like with the clinician focus groups, families were provided a written description of the proposed Program, which provided details on each stage and step involved. Reaction among participants in the family focus groups was uniformly positive, with most saying they would be either extremely or very likely to attend if referred by their child's doctor. Suggestions and ideas included the following:

- **Step 1:** Screening reveals patient is overweight or obese; physician refers family into the Program.
  - Open the program to children who are not overweight or obese as a preventive measure.

- **Step 2 (even weeks):** Children and parents/caregivers prepare a meal in each class together and go home with a bag of groceries to recreate the meals at home.
  - Allow families to adapt their own recipes to meet nutrition standards.
  - Encourage families to videotape the preparation of meals at home and post to social media.
  - Arrange field trips to grocery stores to demonstrate selection of healthy foods.

• **Step 3 (odd weeks):** Families break into groups – children focus on physical activity and parents/caregivers participate in sessions on goal-setting, stress-relief and healthy lifestyles.
    • Tailor the adult educational sessions to children, especially ones on goal setting and mental health topics.
    • Children's activities should be appropriate for all age ranges
    • Other session topics for adults: parenting; portion control; yoga and the importance of sleep.

• **Step 4:** Quarterly dinners, updates on progress/challenges and to reconnect with cohort and instructors.
    • Structure as potluck dinners with families bringing their choice of healthy dishes.
    • Organize a "cook-off" between adults and children.
    • Show videos of families at cooking at home or engaging in a physical activity

    I mean I think that's cool. Just to check in. Somebody might have a success story like 'We have definitely been keeping up with this. And the whole family lost weight!'

• **Step 5:** Instructors circle back with referring physicians to share and measure patient progress.
    • Overall, this part of the program was positively received, with one participant pointing out that "…it encourages accountability."

When participants were asked if they would be willing to pay for the Program as it was explained, most were not opposed to paying something, but said that the cost should be kept to a minimum. They also questioned whether the cost would be per person or cover the entire family; and if the amount would be per class or for the entire program.

You're taking home food six times out of that program!

If they're not willing to pay then they don't need to be a part.

Between $5 and $10 was an acceptable amount for most; any price over $25 was considered too much.

That's too much [$25}

I don't think no parent will pay $25.

Anything under $25 is okay.

When asked if they would be open to traveling outside their communities for a one-time orientation session, most parents/caregivers said they would, but stipulated that the location should be metro accessible or have free parking.

With respect to frequency of sessions, most said they would prefer a 12-week program, with 1 session a week for two hours. Because of work schedules and after school activities for kids, participants said that they would prefer sessions be held later in the week during the evenings, or on Thursdays or weekend.

Preferred Channels of Information and Communication

• Most participants said they receive information about health and wellness programs through social media platforms – the most frequently cited ones being Facebook, Instagram and Twitter.

• Flyers in neighborhood recreation/community centers; word of mouth, and advertising on metro-rail and metrobus and radio were the ways most participants said they learn about community activities and events.

SECTION 2

Clinician survey results of perceived barriers to care

After an extensive evaluation of the literature our research team designed a survey for primary care clinicians to complete in order to understand their knowledge, experiences, and barriers to care. We achieved face validity through testing with primary care clinicians, psychologist, community based organizations staff, and dietitians. Survey questions were uploaded into Children's National Hospital REDCap for distribution. Primary Care Clinicians from the Children's National Health Network(CNHN) received the survey. The CNHN is a local community-based pediatric network that reaches over 1500 pediatric providers in the Mid-Atlantic region and is one of the nation's largest dedicated pediatric provider networks. We will be using a subgroup of 380 pediatric providers in the Washington, DC and surrounding metropolitan area.

Survey was disseminated from August 19th-October 19th, 2019. Three $50 visa gift cards were raffled to clinicians who completed survey.

Chart

Chart

Chart

SECTION 3

Clinical-Community partnership models and best practices

The need for clinical-community partnerships:

Clinical and community partnerships are uniquely positioned to address population health. When the 2011 Affordable Care Act accelerated a shift in the healthcare industry away from volume-based care to value-based care, healthcare organizations (HCOs) began understanding they have a greater responsibility for addressing individual health-related social needs (HRSN), which are often outside of their traditional prevue. As such, partnerships between HCOs and community-based organizations (CBOs) prove to be effective models for increasing population health and decreasing health systems' costs because they leverage the strengths of both parties: medicine and social services .

Approximately 80% of an individuals' health contributors exist outside the clinic, as demonstrated in figure 1 . An individual's physical environment and social and economic factors alone account for approximately 50% of their health outcomes; their income level, safety, housing, transit and employment are more indicative of health outcomes than their individual health behaviors. Coordination between the CBO and HCO is especially important for lifestyle diseases that are often caused or exacerbated by local policies, systems and environments, and where oftentimes, CBOs already exist and/or are providing relevant services. Just as most factors that impact an individual's heath exist outside of the clinical setting, so should their services.

Healthify. Incentivizing Collaboration Between Healthcare Organizations and Community-Based Organizations. January 10, 2019.
Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135.
https://www.chcs.org/media/Working-Together-Toward-Better-Health-Outcomes.pdf

Partnership Models

Opportunities exist to bridge the gap between clinical and community-based organizations. Such partnerships are often established to improve care quality and reduce cost for HCOs, and address social determinants and experiences of those they serve, for CBOs. Common initiatives and programs include care coordination services, access to healthcare, chronic disease management, case management services, or a combination of these services.

As partnerships between HCOs and CBOs grow and evolve, so do their formal agreements, funding sources, payment models and evaluation. The 2017 Working Together towards Better Health Outcomes report found that:

- Partnership funding often initially begins as grants, and eventually shifts to private foundations, government agencies, fee-for-service contracts, and public and private insurance reimbursements.

- Most partnerships required multiple sources of funding.

- Demonstrating the value of partnership is necessary for sustainability, and therefore data collection and data sharing alignment is critical. Partnerships are encouraged to collect outcomes not outputs.

- Mission alignment and cultivating trust are a core component to establishing shared visions of funding, payment models, and data collection.

Similarly, the 2018 Integrating to Improve Health report from the Nonprofit Finance Fund and the Center for Healthcare Strategies identified common forms of clinical-community partnership service models and funding sources. Their report, based on national best practices, identified three service delivery and funding categories, each progressing from a partnership model to one of integration. Figure 1 outlines the three forms of services models, beginning as a referral service from the HCO to the CBO, and ultimately progressing to a joint service delivery model. Figure 2 shows the three common forms of funding. These often begin as grant funding and ultimately progress towards an outcome-based reimbursement model.

Figure 1:

Figure2:

The Role of the Community Based Organizations in Value-Based Care

Integrating care and health promotion into the community shifts care towards the patients – where one lives, works, and plays. It encourages patient-centered care. Furthermore, a CBO's longstanding community roots - often with at-risk populations - may increase the perceived accessibility, trust and comfort for individuals. Those in most need of care are often likely to seek services at a CBO than at their local HCO (Sullivan report).

Specifically, the YMCA is uniquely positioned to enhance patient health outcomes because of its long history of social services, health promotion programs, and community engagement. As a national institution, local associations rely and benefit from the guidance and pilot programs that YMCA of the USA (Y-USA) provides and organizes across the country. Y-USA has an abundance of resources and technical advisors for associations interested in building a clinical-community partnership. Those affiliated with a YMCA are encouraged to find them on Y-USA's LINK. Y- USA's Core Principles for Clinical Integration are shown in figure 5, which are included in the Y-USA Improving Health through Clinical Integration report .