Efficacy of the Parenting at Mealtime and Playtime Learning Collaborative: Replication and Sustainability Results

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INTRODUCTION
The Parenting at Mealtime and Playtime Learning Collaborative (PMPLC) is an innovative, sustainable approach to building healthy habits among birth to five year olds. The PMPLC focuses on enhancing obesity risk assessment, recognition and prevention counseling at the WCV. The counseling ties nutrition and play enhancing obesity risk assessment, recognition and prevention habits among birth to five year olds. The PMPLC is focused on pre-kindergarten critical window for achieving a healthy weight is younger than previously thought. Therefore, PMPLC targets the pre-kindergarten population and their caregivers.

OBJECTIVES
I. To improve clinician evaluation and documentation of obesity-related health risk at WCVs.
II. To replicate results of the pilot wave in different pediatric practices
III. To evaluate sustainability of PMPLC from pilot wave participants.

METHODS (Efficacy)
Learning Collaborative (adapted IH Breakthrough Series Model) - Primary care practices were recruited through the Ohio Chapter AAP and self-selected to participate in each learning collaborative (LC) wave
• Pilot Wave 1 - March to October 2014
• Replication Wave 2 – September 2014 to June 2015
• Learning session (LS) was comprised of an evidenced-based training on age-appropriate & developmentally appropriate diet and activity anticipatory guidance, risk assessment, and management of overweight for birth-5 years old; IQI methods; motivational interviewing and data collection
• Teams participated in 6 monthly action period calls & a site visit
• Providers received CME for attending the LS, family incentives, MOC Part IV & a practice stipend for meeting LC requirements

Data:
• Risk assessment measures from 24 random charts/provider/month were reviewed and entered into the Ohio AAP IQI database
• Practices submitted 2 PDSA cycles & monthly practice narratives
• Run charts were constructed for monthly action period calls
• Rates were calculated for documentation of risk assessment measures
• Statistical variance determined through chi-squared analysis

RESULTS
Post-Learning Collaborative – Holding the Goals
• Pilot Wave 1 Practices (March to October 2014) were invited to participate in post-collaborative data collection
• Teams attended a 15-minute data collection call with the PMP IQI consultant
• Practices received a stipend for completing each phase of data collection

Data:
• Risk assessment measures from 24 random charts/provider/month
• Retrospective data collection occurred in two phases:
  • S1: April, May & June 2015 – 6-months post-PMPLC
  • S2: October, November & December 2015 - 12-months post-PMPLC
• Statistical significance was determined by chi-square or Fisher’s exact tests, as appropriate

REPLICATION OUTCOMES
• Similar trends were observed for documentation of weight status, family history collection, and counseling on nutrition and physical activity

Sustainability Demographics of Pilot Wave 1 Participants
• 2 Pediatric Practices and 1 Residency Program elected to participate
• FPC – 1624 Patient Load, 48% Medicaid – Suburban
• MCd – 2400 Patient Load, 40% Medicaid – Rural
• Omitted from overall analyses
• TOH (Residency) – 6000 Patient Load, 70% Medicaid – Urban

Sustainability Risk Assessment Outcomes
• Post-collaborative rates were not maintained, but practices were doing significantly better than baseline
• Post S1 and S2 feedback from providers
• Failure to note provision of PMP handout and lack of dot phrases lowered counseling documentation rates

CONCLUSIONS
PMPLC made great strides in building office systems to advance pediatric obesity prevention for both physicians and patients. This:
• Promoted patient-centered counseling and standardized assessment of obesity risk and diet and activity habits that led to
• Significantly improved vital measurement, risk assessment and documentation of risk and counseling; results that were replicated in a second iteration.
• Post-collaborative rates of documentation were not maintained but practices maintained improved risk assessment and counseling rates over baseline. Increasing rates of documentation observed between S1 and S2 may be attributable to contacting practices and reminding them of PMPLC involvement, suggesting that periodic interaction with practices may promote lasting PMPLC benefits.

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