



March 23, 2012
First Things First
4000 North Central Avenue, Suite 800
Phoenix, Arizona 85012

MEETING MINUTES & SUMMARY OF DISCUSSION

Nutrition & Obesity Prevention and Well Child Visits Sub-Committee

- Committee Members in Attendance** Diane Fellows, Chair, Chris Linn, and Jane Pearson, Karen Sell
- Committee Members Attending Telephonically** David Dube, Roy Teramoto
- Staff Members in Attendance** Karen Peifer, Amy Kemp, Kelley Murphy, Elsa Romero and Karen Woodhouse
- Staff Members Attending Telephonically** Melissa Begay, Regional Director Navajo Nation
- Members of the Public in Attendance** Asata Virgo, Intern First Things First
- Telephonic attendance** Leslie Anderson, Leslie Anderson Consulting, Inc.

Call to Order

The regular meeting of the First things First – Arizona Early Childhood Development and Health Board, Nutrition & Obesity Prevention and Well Child Visits Sub-Committee was held on Tuesday, March 23, 2012, at First Things First Board Room, 4000 North Central Avenue, Suite 800, Phoenix, Arizona 85012. The meeting was called to order by Chair, Diane Fellows at approximately 10:10 a.m. A brief welcome was made by Chair Fellows; everyone in attendance introduced themselves and the organization which they represent.

Review of Sub-Committee Structures and Role

Chair Fellows gave a brief overview of the structure of the organizational charts of the committees.

Developing State Level Benchmarks for School Readiness Indicators

Karen Peifer, Sr. Director for Children’s Health gave an overview of the indicators and benchmarks that the committee is tasked to accomplish, recommendation for the board. Ms. Peifer stated that Indicator 8 - #/% of children receiving timely well child visits - also is to be included as indicator to be reviewed by this committee. Goal is to determine what benchmarks would look like for 2020 based on data sources available. Continuing to review data resources, what data is available and what data is not available. Are benchmark and indicators aligning, on-going process which will be measured over period of time and vetted in 2020. The sub-committee is tasked with reviewing the data for Indicators 7 & 8 and to begin the process of setting benchmarks.

Indicator 7- #/% of children ages 2-5 at a healthy weight (BMI)

1. WHAT DO WE KNOW ABOUT THE DATA?

BMI is not calculated for children under age of 2; it begins at age 2 and continues through adulthood.

- Reviewing children BMI ages 2 – 5, over weight defined as BMI at or above 85 %, and obesity as having a BMI over 95% of expected height and weight.

Dr. Amy Kemp, Sr. Director of Research Evaluation stated the two sources of data for this indicator is the WIC data or survey data and when there is a choice between survey data and administrative data, administrative data chosen. Dr. Kemp noted that this indicator has most trend data available at regional level.

2. METHODOLOGY FOR WIC DATA COLLECTION

WIC data is administrative data that is collected through the WIC program. It includes height and weight for all children enrolled in WIC.

Karen Sells, Chief, Bureau of Nutrition and Physical Activity, Arizona Health Services stated that the State of Arizona collects the data that is reported to the CDC but the CDC will no longer be aggregating the data after the end of year 2012. The State of Arizona will continue to collect WIC data at the county and state level and she will make available to FTF as needed.

3. IS THIS DATA ADEQUATE FOR SETTING A STATE LEVEL BENCHMARK?

Ms. Sell informed committee that in 2014 electronic medical record system will be used by all WIC providers to collect and aggregate data for children eligible for the WIC program. This covers around 46% of all children born in Arizona, it can be broken down into zip code areas which can also be used to determine rates of change in FTF regional areas for this population

Chris Linn, Executive Director P.O.P. SICLE Center requested the committee consider including underweight children. Many children are under-nourished as a result of a medical condition.

Ms. Peifer commented that would be considered and that is available through the WIC data. It has underweight, normal weight, over- weight and obese categories that can be used to track changes.

Dr. Roy Teramoto, Maternal and Child Health Coordinator, Indian Health Services suggested reviewing ACCHS data for under nutrition, additional information such as height, weight and medical diagnosis is included to understand the failure to thrive and other medical diagnosis within the under-weight category. Dr. Teramoto also suggested that WIC data could be included to measure underweight children but the reasons behind being underweight would not be possible without a medical diagnosis.

Dr. Kemp stated that maybe benchmarks could be set on obesity, underweight, over weight and monitor failure to thrive. May not be able to match data, but could be used as a key measure.

Jane Pearson, Associate Director for Programs, St. Luke's Initiatives asked: what direction do we want these underweight children to move? If it is towards a normal weight how can this be achieved?

Data may be affected by lack of insurance, waiting list for Kids Care or reimbursement to providers. Sick visit versus well visit. Different data from different sources will be reviewed and determine which data

will best inform this committee, many factors to consider. What indicator represents best practices across the board? What indicators are we moving toward?

4. IS THERE A BASELINE OR TREND LINE?

There is data available through WIC that can look at 4 lines of indicators- underweight, normal weight, overweight and obese. The indicator is the normal weight or normal BMI range for this population. Using the 4 indicators should result in downward movement of the overweight and obese trend lines and possible increase in the underweight trend lines.

5. WHAT ELSE IS NEEDED FROM THE EXISTING DATA SOURCE TO MAKE A STRONG JUSTIFICATION FOR DEVELOPING A BENCHMARK BASED ON THIS DATA?

More details on the underweight child would be useful in determining the difference between the medical reasons for being under-weight and the poverty reasons for food insecurity if it is possible.

ITEMS FOR FURTHER CONSIDERATION: The discussion indicated that it would be better to have data from children who are not on the WIC program to include in setting this benchmark but that using the WIC data to set the benchmark was adequate for now. It can offer trend lines for the past couple of years as well as for the next eight years; it can be broken down into regional levels which would help with regional variability based on funding priorities.

Further inquiry into AHCCCS data (EPSDT) and commercial insurance data systems was asked for by the committee for the next meeting if possible. Dr. Kemp has begun discussions with them about obtaining this information.

Important notes: Ms. Sell informed the committee that beginning in October 2012 all mothers with child over weight, participate in WIC Program will be asked if they wish to speak with dietitian regarding child's weight. They may choose to decline. Dietitian services are available to all children at risk.

INDICATOR #8 #/% OF CHILDREN RECEIVING TIMELY WELL CHILD VISITS

1. WHAT DO WE KNOW ABOUT THE DATA?

There are 2 possible sources of data for this indicator. One data source for this indicator is the St. Luke's Health Initiative survey that is conducted in Arizona every two to three years. Parents who answer the survey are asked if their child has had a routine health checkup during the past year. The results can be divided by age, ethnicity and geographic service area.

The other data source is the National Survey of Children's Health. The question asked of parents is if their child did not receive one or more preventive health visit. There is data from 2003 and 2007. There may be data available for 2010-11.

2. METHODOLOGY FOR DATA COLLECTION

Each data source is based on representative samples and would not permit breaking down the data into zip codes or regional levels at this point. The SLHI survey could however, be augmented to increase the sample size and zip code to be used by the regions in the next eight years.

3. IS THIS DATA ADEQUATE FOR SETTING A STATE LEVEL BENCHMARK?

The discussion among the group was that both surveys did not ask a question specific to timely well child a visit which is the indicator. Children receiving one well-child visit or one preventive visit during the past year are not considered a timely indicator for this age group.

The data may be affected by lack of insurance, children being on a waiting list for Kids Care or the reimbursement rates being paid to providers for doing well child visits. There is a difference between sick visits versus well child visits in terms of screening and vaccinations.

There was a discussion on determining what routine, timely well child visits are and how to determine it with the existing data would be difficult. Would looking at immunization rates hat indicator represents best practices across the board? What indicators can we move forward?

It was also suggested to look at the Bright Futures 2 and 4 year old health indicators for refinement of the language in this indicator if warranted. Discussion will occur at the next meeting s

It was also suggested that we could add questions to the SLHI Survey to reflect the meaning behind this indicator more thoroughly. It can be used to set a benchmark and then refined in subsequent surveys.

4. IS THERE A BASELINE OR TREND LINE?

This question remains because it is unclear what % of children actually receives well child visits.

5. WHAT ELSE IS NEEDED FROM THE EXISTING DATA SOURCE TO MAKE A STRONG JUSTIFICATION FOR DEVELOPING A BENCHMARK BASED ON THIS DATA?

ITEMS FOR FURTHER CONSIDERATION: Different data from the different sources will be reviewed and determine which data will best inform this committee, many factors to consider. It was suggested that we look at AHCCCS data, EPSDT data and or data from commercial insurance before the next meeting to see if we can augment this information. AHCCS and EPSDT data might give us an indication of screening that was doing periodically as well as routine lab work that was done.

Karen Sells suggested looking at the Vital Statistics birth records and matching the data to insurance records. She stated that the 2 year old Immunization rates were around 78% for the state which reflects children not getting timely well child visits.

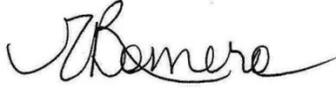
Next Steps

Data details if available, what is available. Next meeting is April 20, 2012, 10:00 a.m. – 12:00 p.m. First Things First Board Room.

Adjournment

There being no further business the meeting was Member Linn motioned for adjournment. Member Dube seconded. Meeting adjourned at approximately 12:00 p.m.

SUBMITTED



Elsa Romero, Executive Staff Assistant

APPROVED



Karen Peifer, Sr. Director of Children's Health

COMMITTEE APPROVAL

Diane Fellows, Chair