CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

Project ECHO®

ADVANCING INTEGRATED HEALTHCARE

Pediatric Weight Management ECHO®

Session Topic: Weight Bias/Stigma and impact on mental health

Presenter(s): Katy Darling

Date: October 20, 2022

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting

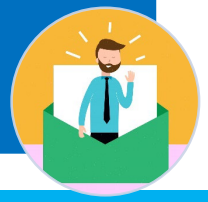
Care Transformation Collaborative of RI

Welcome

- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

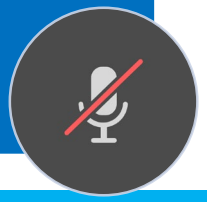
Introduce Yourself

- Please turn on your video
- Please enter your name and organization in the chat box



Microphones

- Please mute your microphone when not speaking



Agenda

- 7:30-7:35 Introduction
- 7:35-8:00 Lecture
- 8:00-8:25 Case/Discussion
- 8:25 Close

CME Credits

(currently available for MDs, PAs, Rx, RNs, NPs, PsyD, PhD)

- CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.

- Evaluation/Credit Request Form: https://www.surveymonkey.com/r/PediWtMgmtCMEEvaluation

The AAFP has reviewed 'ECHO Series Focused on Best Practices and QI' and deemed it acceptable for AAFP credit. Term of approval is from 09/16/2022 - 09/16/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

Agenda

Time	Topic	Presenter
7:30 – 7:35 AM	Faculty Introduction	Liz
7:35 – 8:00 AM	Didactic: Weight Bias and Stigma	Katy Darling
8:00 - 8:25 AM	Tri-County Case Presentation & Discussion	Casey Sardo, Jennifer Caffrey
8:25 – 8:30 AM	Wrap up; Evaluation; Announcements	Linda

Today's Faculty

- Katy Darling, PhD, is a pediatric psychologist and researcher at the Weight Control and Diabetes Research Center (The Miriam Hospital/Alpert Medical School of Brown University).
- Dr. Darling's research focuses on improving physical and psychological health outcomes for youth with excess weight and developing interventions to decrease weight bias and stigma for these youth. Her work is primarily centered around adolescents from low-income backgrounds.

Disclosures

Session presenters have no financial relationships with a commercial entity producing healthcare-related products used on or by patients.

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.

Learning Objectives

1. Recognize the sources of weight bias and weight-based stigma in healthcare settings.

2. Describe the negative consequences of weight stigma on children's health and wellbeing.

3. Identify strategies to decrease weight stigma while addressing higher weight status in youth.

SELF ASSESSMENT

Rate the following questions on a scale from 1 (strongly disagree) to 5 (strongly agree). You will not be asked to share your answers.

Self-Assessment

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

1. Weight is a major way I judge my value as a person.
2. Obesity is caused by lack of willpower.
3. Obesity is usually caused by not getting enough exercise.
4. Most people with obesity have poor eating habits that lead to their obesity.
5. Although some people with obesity are smart, in general I think that they tend to not be as bright as normal weight people.
6. I feel disgusted with myself when I gain weight.

Self Assessment

Total scores range from 6 (very low weight bias) to 30 (high weight bias). Where do you fall?

This module will focus on addressing some of those misconceptions and biases about weight.

Weight Stigma and Bias

- Weight Stigma/Bias – discriminatory acts and negative attitudes/beliefs about individuals because of their weight
  - **Weight bias stems from:**
    - **Stereotypes –** beliefs that people with obesity lack willpower, are lazy, non-compliant with treatment, or lack self-discipline to improve health
    - **Prejudice** – negative attitudes towards individuals because of their weight
    - **Discrimination** – unfair and unequal treatment of people with obesity

Types of Weight Stigma

- Experienced Weight Stigma
  - Being teased, rejected, or criticized based on your weight
  - Having others make unfair assumptions about you based on your weight
  - Having others make comments that reinforce the idea that fat is bad and thin is desirable
  - Obstacles in the physical environment
- Internalized Weight Stigma
  - Negative thoughts (“no one attractive would ever date me because of my weight”) or negative feelings (self-hatred, disgust) about oneself based on one’s size
  - Negative beliefs/fears that one will be stigmatized in the future based on weight

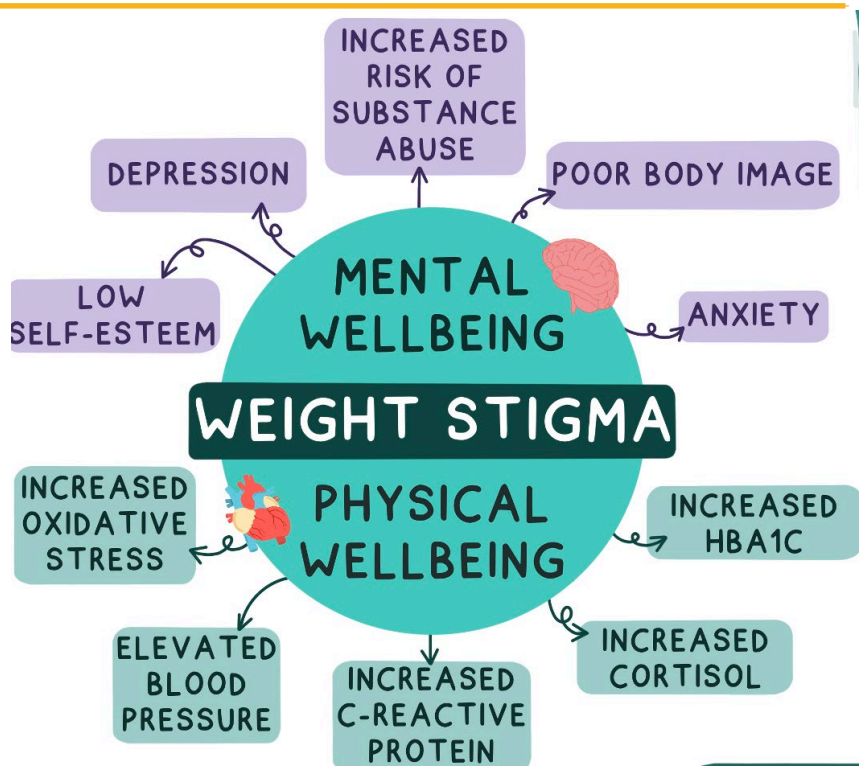
Weight Bias in Healthcare

- Healthcare settings are one of the most common places that individuals (including kids) experience weight bias
- Weight bias in healthcare settings can include:
  - Inappropriate comments from providers
  - Belief that individuals are less likely to adhere to treatment or are more unsuccessful due to their weight
  - Dismissing medical concerns due to weight
  - Derogatory humor
  - Lack of appropriate equipment (e.g., only having chairs with arms, lack of gowns for larger individuals, blood pressure cuffs that are not the correct size)

Why do we care?

Consequences of weight bias/stigma include:

- Avoidance of future medical care
- Poor body image and body dissatisfaction
- Increased rates of disordered eating
- Avoidance of physical activity
- Depression, anxiety, other psychological disorders
- Poor physical health outcomes, including increased risk of mortality



Recap

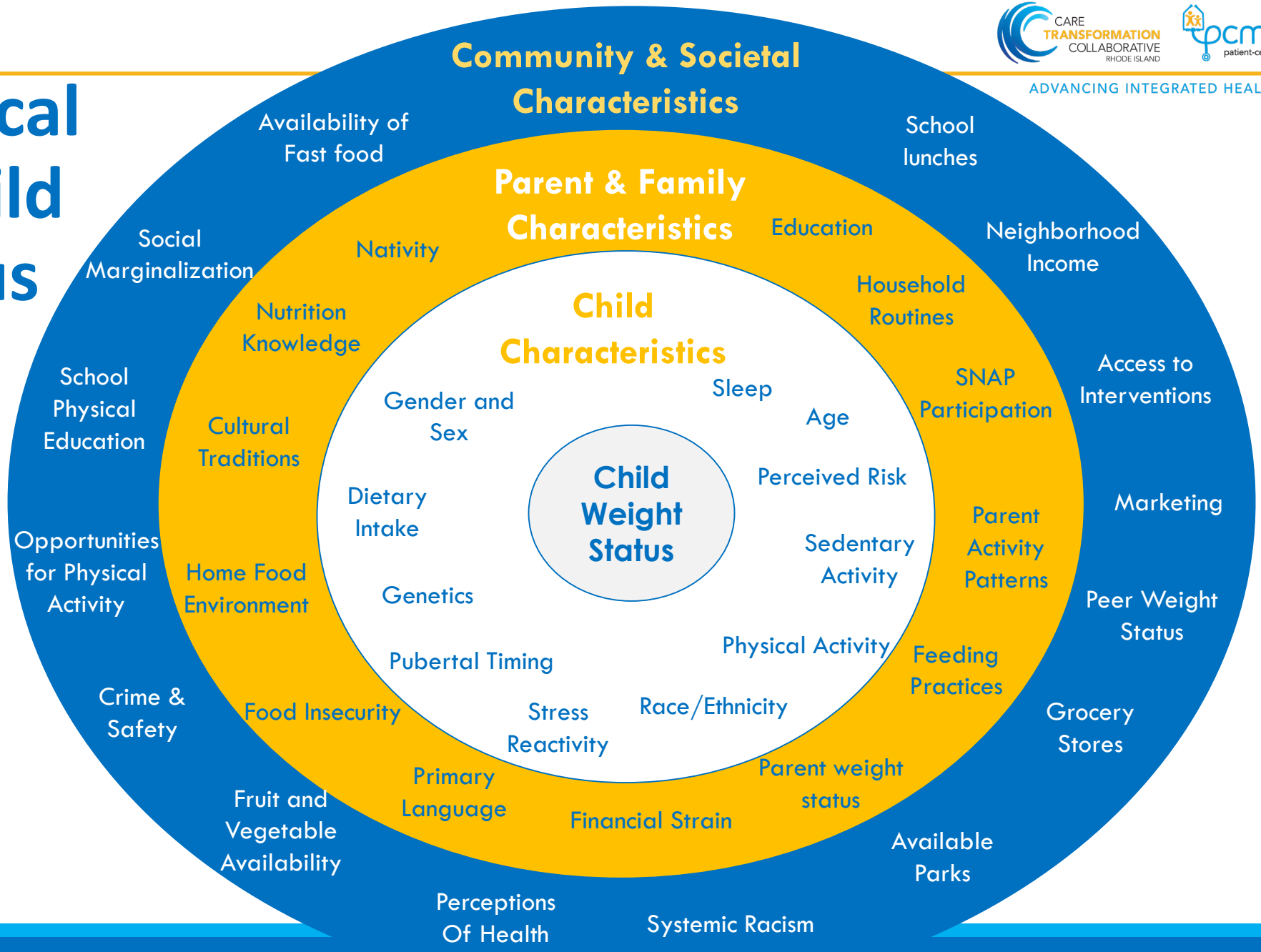
Weight bias is common in healthcare.

Weight bias has significant negative consequences for children and families.

Our goal is to eliminate the experience of weight bias while also helping families effectively address excess weight in children.

Ways to Combat Weight Bias in Conversations with Children and Families

Socioecological Model of Child Weight Status



Ways to Combat Weight Bias

- Use respectful language
  - People-first language (e.g., “child with obesity” instead of “obese child”)
  - Be sensitive to the words used to refer to someone’s weight
    - Neutral words like “weight” and “body mass index” are preferred to “obese” or “fat”
  - Model respectful language
    - Talk to children or families if you notice disrespectful language being used

Ways to Combat Weight Bias

- Avoid blame
  - Parents and caregivers are often blamed for their child's weight status
  - Caregivers drive the change in diet and physical activity recommendations - they are an important part of the solution
    - When caregivers or children feel blamed for their weight, they are less likely to make changes and engage in care
  - Team up with the whole family to support healthier choices

Ways to Combat Weight Bias

- Address weight bias when you see it
  - Notice when parents/caregivers, peers, or children in the group engage in negative weight-related comments
  - Talk to parents/caregivers separately if you hear them perpetuating stigma, bias, nor modeling negative language for their child
- Call out derogatory humor
  - “Fat jokes” are not funny and should not be allowed

Ways to Combat Weight Bias

- Focus on the whole family
  - Caregivers and other children in the household can also benefit from healthy lifestyle changes, no matter their size
  - Emphasize the importance of focus on health eating and physical activity when parents are talking with their children
    - Decrease focus on child's weight in conversations at home

Ways to Combat Weight Bias

- Direct attention to changes in the body when health behaviors improve
  - Improved mood, increased energy, easier physical activity
  - Decrease focus on change in appearance
- Be conscious about stereotypes related to increased weight
  - An individuals' weight status does not tell you that they are lazy, active, hardworking, have self-discipline, or poor willpower
    - Be aware of these stereotypes and call them out when present

Do

Use person-first language.

Talk with both children and parents.

Ask what is important to children and parents to help them feel healthy.

Listen.

Affirm and acknowledge responses – even if you don't agree with them.

Talk about benefits of healthy lifestyle changes for the whole family.

Assume families are doing their best to engage in healthy behaviors.

Don't

Oversimplify the problem (e.g., just eat less, use more willpower).

Assume you know the reasons for the child's weight gain.

Be judgmental, use shame, blame, or scare tactics.

Only focus on weight and body size.

Key Points

- Obesity is not a personal choice
- Recognize your own biases
- Be mindful of the words you use
- Prepare resources to help the child

Resources

- UConn Rudd Center for Food Policy & Health
  - Healthcare Providers Module has specific training and guidelines for the management of pediatric obesity in a sensitive, stigma-reducing manner
- Obesity Action Coalition
  - Weight Bias Resources and Guides Available
- WorldObesity.org
  - Weight Stigma Policy Priorities

Questions?

Email: Katherine_Darling@brown.edu

Phone: (401) 793-8688

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ADVANCING INTEGRATED HEALTHCARE

Pediatric Weight Management ECHO® Case Presentation

Presenters: Tri-County Community Action

Casey Sardo RD, LDN, CDOE & Jennifer Caffrey MSW, LICSW

Date: 10/20/2022

Contact Info: Csardo@tricountyri.org; JCaffrey@tri-countyri.org

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Stop Recording

Reasons for Selecting this Case

Do Not Include PHI

Why did you choose this case?	*We chose to highlight this case due to the complexity of its cultural, behavioral health and nutrition concerns.*
What questions do you have for the group?	*-How to encourage adolescents to make healthy choices independently of their parents influence* *-How to handle issues of stigma and shame in the home environment* *-Ideas for family interventions* *-Ideas for ways to help the patient express her feelings at home*

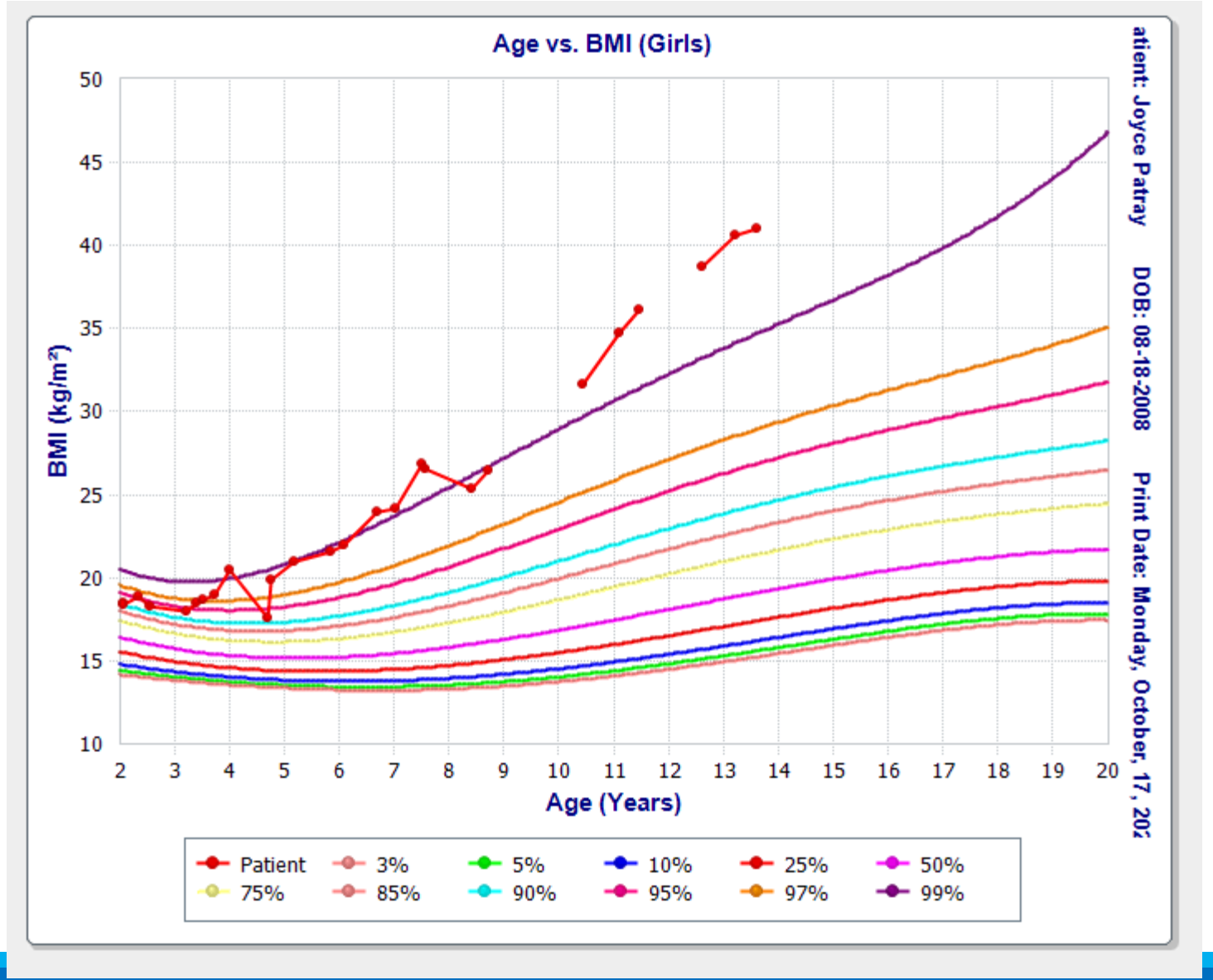
Basic Patient Information

Do Not Include PHI

Age	14
Gender Identity	*Identifies as a heterosexual female*
Race/Ethnicity	*African American*
Current Weight and Height	*Weight: 221.60lbs (100.52kg)* *Height: 61.61 inches (156.5cm)*
Current BMI and BMI%/Obesity class	*BMI is 153% of the 95th%ile which is class 3 obesity.*
How long has the patient had concerning growth trends?	*Age The patient has had concerning growth trends since the age of 2.5.*
How long has this individual been in your care?	*Primary Care – Since birth* *BH – 6 Months* *Nutrition – on and off for ~16 months*
Insurance type (Commercial, Medicaid, Uninsured, Other)	*NHPRI*

Growth Curve

BMI/Age (CDC 2-20)

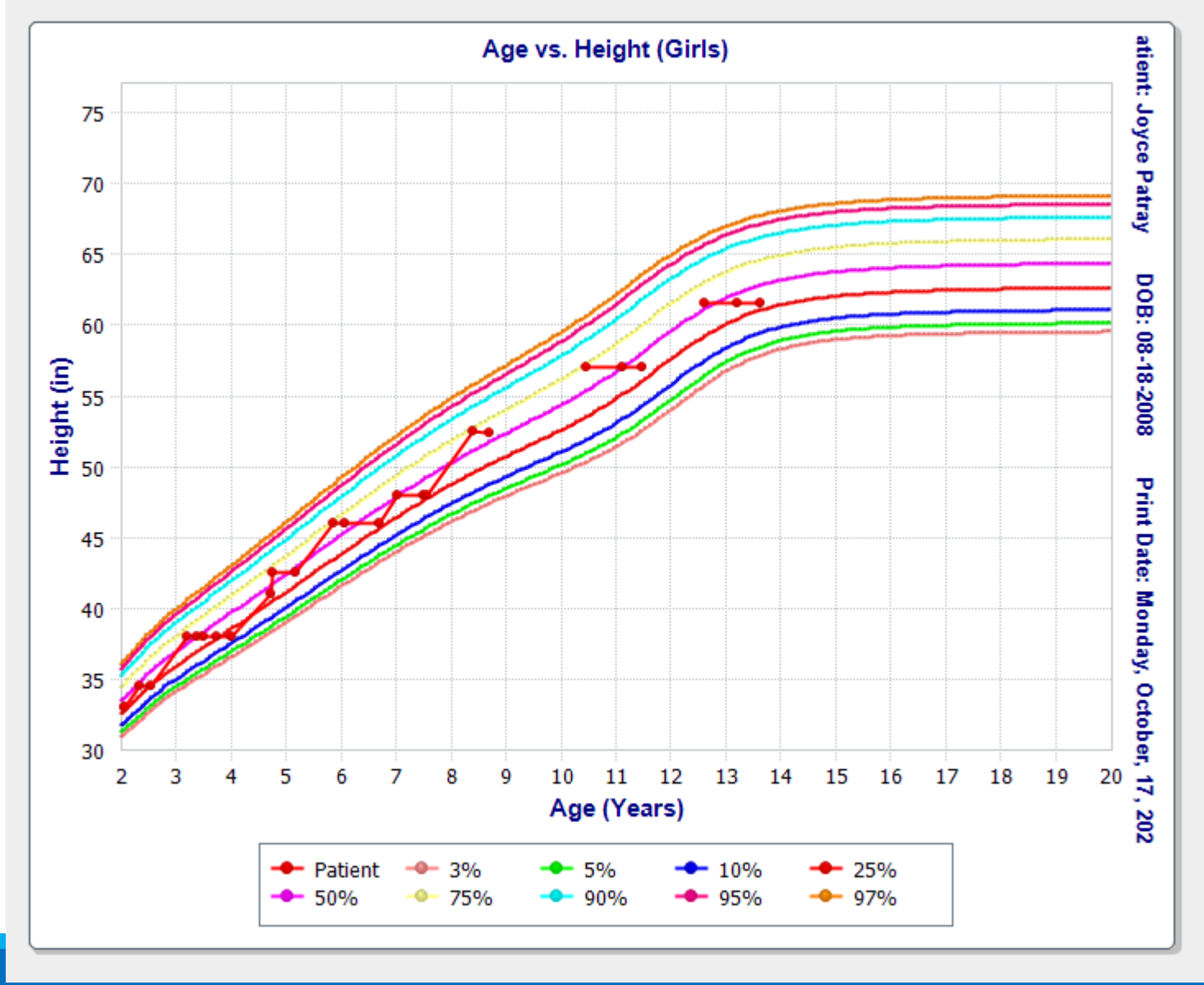


Growth Curve

Weight/Age (CDC 2-20)

Growth Curve

Height/Age (CDC 2-20)



Does the Patient/Family have a weight management goal? Please describe.

Do Not Include PHI

- The family did not communicate any weight management goals.

- The patient's father voiced that he just wants his daughter to "be happy and healthy."
- The patient's father voiced concerns that JP eats too much "sugar" and "is too sedentary."

- The patient voiced that she would like to be healthier, but does not have the "motivation" to make changes.
- The patient routinely compared herself to "celebrities" and her younger brother who can "eat whatever he wants" and still be "smaller."

Relevant Background

Do Not Include PHI

Relevant medical and/or behavioral comorbidities	*Acanthosis nigricans; impaired fasting blood glucose; poor sleeping pattern*
Relevant medications	*melatonin*
Relevant lab results	*Bloodwork done in 2021 – indicates fasting blood glucose of 109mg/dL, A1c of 5.3%, lipids WNL*
Relevant BH Screening results	*Initial BH screenings including GAD-7, PHQ-A and CRAFFT all negative, Patient rescreened in initial session by clinician due to clinician's observation of depressive/anxiety sx,* ***GAD-7=11, PHQ=12,*** *during treatment screenings steadily decreased during school year, increased over the summer*
Relevant SDOH Screening results	*No SDOH concerns noted*

Relevant Social History

Do Not Include PHI

Relevant obesity related family history?	*The patient's **father is obese**. Her brother's weight is WNL and consistent with established growth patterns. The patient's father was unsure about family history of diabetes or cardiovascular disease.*
Family/patient history of trauma?	*Parents grew up in Liberia, **mother reports witnessing violence and living in poverty** as children, mother states she needed to "growing up fast". Mother describes cultural belief that women need to be strong and responsible and has expectations for patient to be a caregiver for her brother when mother is not home and for patient to have more responsibilities overall in the home.*
School related concerns?	*School related concerns surfaced **during the pandemic** while patient and brother were not attending school in person, patients states this was due to having so many responsibilities at home and feeling **"everything I did wasn't good enough",** academic performance remained poor for that school year.*
Other social history concerns?	***Parents have been separated** for several years. **Parental conflict and poor communication**. Parents often "talk through the children", leaving both children to have to relay messages or concerns from either parent. Patient often feels this responsibility is burdensome and overwhelming. Parents also **expect patient to "watch out for brother"** at school, patient at times has spoken to brother's teachers about concerns with brother's grades/motivation in school. Patient resides at mother's home with mother, brother, maternal grand-mother and maternal aunt. **Father sees both children daily** and transports to/from school and to all appointments.*

Nutrition

Do Not Include PHI

What interventions have been tried? How responsive has the family been to nutrition intervention?	• *We have done a lot of goal-setting surrounding increased self-monitoring, participation in grocery shopping and cooking, increased physical activity, mindful eating, increased intake of whole grains, increased intake of non-starchy f/v (the plate method), etc.* • *reviewed the "health at every size" model with the patient* • *The family has not been very responsive to nutrition interventions. The patient's father seems very willing to help with interventions, but her mother is not interested.*
What barriers have the family identified for improving nutrition?	• *The patient splitting time between mom and dad.* • *The patient's brother being able to "eat whatever he wants" (also allowed by both mom and dad).* • *The patient's ability to order food on Door Dash 24/7.*
Does the patient have any of the following: - **Excessive hunger** - **Night-time eating or binging** - **Sneaking food** - **Other**	✓ *Excessive hunger, emotional eating, binging* ✓ *Night-time eating/binging on fast food and candy* ✓ *Sneaking food* ✓ *No known history of purging or other compensatory behavior*
Other concerns with nutrition/eating (such as cultural considerations)?	*The patient communicates that she likes the "Liberian food" that mom makes, but does not eat breakfast and dislikes the lunch options offered at school. States that it is "uncool" to bring lunch from home and would rather buy snacks after school from the market.*

Physical Activity

Do Not Include PHI

What interventions have been tried? **How responsive has the family been to physical activity recommendations?**	• *RD assisted in local YMCA enrollment.* • *Encouraged participation in school sports and extracurricular programs.* • *Patient participated in goal setting surrounding exercise and increased physical activity.*
Does the patient engage in regular physical activity? (yes/no) ***Please describe***	*No, the **patient is sedentary** other than "gym class" at school.*
Is screen time a significant part of the patient's social time? (yes/no) ***Please describe***	*Yes, JP has been getting **>6+ hours of screen time daily**. Often on her cell phone.*
Other concerns with physical activity/exercise (such as physical restrictions, access, environmental safety)?	*The patient's father communicated that it is **unsafe for JP to walk alone** (to exercise) in the neighborhood they live in. "Even the park isn't really safe."*

Were other approaches used for managing this patient?

Do Not Include PHI

Behavioral Health Intervention

Targets:

- Negative self-talk which was often reinforced in the home
- Not feeling “good enough” - efforts to complete chores or take care of her brother were often unnoticed or incorrect per standards of mother/grandmother.
- Weight - father highlighted this as the main concern for beginning counseling
- Communication pattern between parents (patient felt anxious relaying messages between parents)
- Impact of negative remarks about patient’s weight and appearance

Engagement:

- Father more engaged than mother
- Mother attended 2 sessions - practicing communication techniques, how to validate feelings, and how to identify patient strengths

Cultural/familial issues:

- Mother identified the impact of MGM/cultural expectations for young women vs young men.
- MGM is “loud, direct and often insensitive”, which patient has identified as a trigger in the home.
- MGM and maternal aunt often make negative comments about patient’s appearance.

Patient /Family Successes and Strengths?

Do Not Include PHI

Behavioral Health:
Patient began **expressing feelings** in therapy and at home outside of sessions. Patient **practiced learned coping skills** and presented eager to learn and apply new strategies to manage emotions. **Parents did become involved in treatment** although mother's involvement remained inconsistent. **Both parents have high expectations** for patient and were receptive to clinical interventions during session.

Nutrition:
The patient had begun to make **small diet/lifestyle changes** around January 2022 – May 2022. She voiced that she felt more motivated and confident in her ability to eat better and exercise. She kept a few nutrition appointments across summer 2022, but has not returned for MNT since ~August.

Summary & Clarifying Questions

Reasons for Selecting this Case

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Announcements

Next Session: **November 17, 7:30-8:30AM**
Topic: **Cultural Considerations**
Presenter: **Yovanska Duart-Velez, PhD**
Case Presentation: **St Joseph Health Center**

Liz will follow up with practices regarding monthly IBH PediPRN Conferences 2nd Friday starting in December.


thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
merci
obrigado
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