

MATERNAL AND CHILD HEALTH BUREAU (MCHB)
SPECIAL PROJECTS OF REGIONAL AND NATIONAL SIGNIFICANCE (SPRANS)

FINAL REPORT AND ABSTRACT

At the end of the project period of each SPRANS grant, the grantee is required to prepare a final report and abstract, both of which should begin with the project identification outlined below. The following instructions provide guidance for developing the report and abstract.

A comprehensive but concise summary of the project results/outcomes should be presented in the narrative section of the report. It is particularly important to indicate clearly if all the originally stated goals and objectives have been attained. If any goals or objectives have not been achieved, reasons should be given.

The report should follow the topical outline below. Statistics and other data may be presented in tables, charts or graphs integrated into the text of the narrative section. Significant information which must be reported in the narrative section may be expanded in an appendix. Since the narrative section will become a stand-alone document however, reference to an appendix without substantial information in the narrative section will not be acceptable.

The report should be double-spaced and should not exceed 30 pages in length. A list of each appendix and its page number should be provided. Appendices are not included in the 30-page limit.

- Margins should be 1 inch on all sides.
- Please use no smaller than 12 pt font, not reduced or justified.
- Each page including the appendices should be numbered sequentially.

1. PROJECT IDENTIFICATION (Place at beginning of Abstract).

Project Title: Get in Shape

Project Number: H17MC07856

Project Director: Helene Josselyn

Grantee Organization: Weeks Medical Center

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Project Period: FROM: 03/01/2007 THROUGH: 02/29/2012

Total Amount of Grant Awarded: \$ **247,381.00**

FINAL REPORT AND ABSTRACT

Narrative:

1. **PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS:** Briefly describe the major purposes of the project and the needs and problems it addressed. Indicate the program priority under which the project was funded. Explain the relationship to the Title V MCH Program and state/local AAP chapter(s).
 - a. The major purpose of our Get in Shape project is to provide direct services with an intensive structured program, to overweight and obese children and their parents. We have utilized best practice curricula such as “Shapedown” and more recently “Trim Kids”, and also used an interdisciplinary approach (primary care physician, pediatrician/mid-level provider, certified dietitian, psychotherapist, and recreational therapist). The program implementation and oversight, has been the responsibility of the Pediatric Obesity Advisory Board and the principal evaluator.
 - b. We have been successful in maintaining a collaborative and coordinated effort for our Get in Shape program. The interdisciplinary team has consisted of the director of physician services, pediatric providers, mental health providers,, case managers, registered dietitian, and trainer, all of which have worked together collectively to provide coordinated services to our target group. Our original Pediatric Obesity Advisory Board consisted of all members of the interdisciplinary team as well as two members of the American Academy of Pediatrics, a Maternal Child Health representative, school nurse, nutritionist, child psychologist, program evaluator, a parent, grant administrator, and administrative support. The Board has been instrumental in developing organizational structure, policies and direction for the program. Although we have had some difficulty maintaining the entire Board, we have had a core group that has provided excellent oversight for our program.

- c. The Get in Shape program has proven to be a great referral opportunity for our primary care providers who identify at-risk children and adolescents through the regular BMI screening process during a well child check.
- d. Our goal has been to address the “whole” child, rather than just concentrate on obesity. With this in mind, we contracted with an outside evaluator to provide outcomes on Physiological, Behavioral, and Mental Health. Some of the key “success” elements for children and teens who participate in the Get in Shape program include, improved self-esteem and peer relationships, adopting healthier habits and normalize their weight. We have incorporated family therapy and psycho-educational techniques to address underlying psychosocial correlates of the child or adolescent's weight. Included are (1) problem solving, (2) assertive and emotionally expressive communication and (3) parenting skills (e.g. limit-setting and nurturing techniques). In addition, (4) cognitive therapy, (5) stress management techniques and (6) body image therapies and dietary recommendations (7) physical activity (e.g. increasing daily endurance activities), (8) enhancing overall activity levels (e.g. chores, interests and social activities) and (9) decreasing sedentary pursuits (e.g. television viewing). In addition (10) food behaviors are targeted (e.g. eating regular meals and eating in response to hunger and satiety).
- e. We established the following pre and post test tools to help measure outcomes:
 - i. Child Behavior Checklist – parent and child/adolescent self-report tool that describes children’s behavioral and emotional problems and provides information about subcategories of problems related to anxiety/depression/withdrawn, somatic complaints, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior. Age and gender specific norms are available.

- ii. Self-perception profile – child/adolescent self-report of their competence and global perception of self-esteem. Assessment areas include academic, social, athletic competence, physical appearance, behavioral conduct, and global self-esteem. Age and gender specific norms are available.
 - f. We have maintained a close relationship with our State Maternal Child Health program in connection with our primary care and home visiting grants; as well as the child immunization program. A MCH representative has been an active participant on our Pediatric Obesity Advisory Board. We also have had at least one active member of the American Academy of Pediatrics on our advisory board. In addition, our pediatric providers utilize the Bright Futures guide as a “best practice” model.
2. GOALS AND OBJECTIVES: Describe the goals and objectives of the project and show how they relate to the item above.

Goal 1: Team Coordination (Interdisciplinary Team, Weeks Teams and Coalitions)

Objective 1: Interdisciplinary Team

- a. "Trim Kids" curriculum used
- b. Focus on 8-12 age pop., & 13-18 yr old able to commit to program
- c. Assess coordination and efficiencies of processes
- d. Meet on monthly basis to evaluate participants' progress
- e. Evaluate for other services beneficial to participants

Objective 2: Weeks Teams/Coalitions

- a. Coordinate services (Primary Care, Pediatrics, Case Management, Home Visiting & Family Planning)
- b. Work with fitness trainer/providing physical activities to children.

Objective 3: Outreach to schools, DCYF, WIC, Head Start, etc.

- a. Advocate health issues through State of NH, AAP, & other agencies
- b. Collect statistical data
- c. Utilize electronic medical record for referrals

Goal 2: Program Participation-Improve interest in program with advertising, positive image, & requiring contract.

Objective 1:

- a. Continue to develop interest in and promote the program.
- b. Provide on-going in-service for our providers & staff to encourage referrals.
- c. Work with area school district, (i.e., health & wellness coordinators, school nurses, officials, and teachers) to identify students in need of this program.

Objective 2:

- a. Advertise program in school & local papers & Weeks' website.
- b. Maintain positive image of "Get in Shape" to encourage participation.
- c. Maintain & establish new memberships and partnerships with other agencies, organizations and provide informational presentations.
- d. Provide incentives for participation (i.e., parties, games, prizes & certificate).

Objective 3:

- a. Provide positive ads so that kids are encouraged to join, utilizing an outside ad agency for public relations.
- b. To provide quality service enrolling up to 6 children/adolescents per session in program.

Goal 3: Evaluation Tools to measure programs success.

Objective 1:

- a. Continue to use the child's prior history as a means to measure success with the program.
- b. Continue to monitor the weight and other health indicators of the child over a 2 year period in order to provide a measurable means of our Get in Shape program's success.

Objective 2:

- a. Continue to produce and distribute periodic reports on the proposed model (and its successes and challenges) from data collected and evaluated by an experienced program evaluator.
- b. To survey participants and parents for the purpose of gathering information on their perspective of the program.

Objective 3:

- a. Advisory Board will meet semi-annually to review evaluation reports; surveys; discuss what successes and challenges the interdisciplinary team determined during prior months. Evaluation tools will help the Board direct program changes in order to continue providing a successful Get in Shape program.
3. **METHODOLOGY:** Briefly describe the program activities used to attain goals/objectives and comment on innovation, cost, and other characteristics of the methodology.
- a. Offer an intensive best practice research-based program "Trim Kids" in a primary care setting. Child will be followed for a 2 year period. Therapy sessions would involve an Interdisciplinary Therapy Team (ITT) consisting of a pediatrician/PNP, registered dietitian, fitness specialist, psychiatric mental health provider; each child is referred by

their primary care provider.

- b. Each child and parent referred would be administered a pre and post test against outcome measures.
- c. Goal is to provide Get In Shape sessions consisting of a minimum of 6 kids. This will be offered once per year and session will occur from March through May to avoid conflict with school sports and other activities.

4. **EVALUATION:** Briefly describe the evaluation methods used to assess the effectiveness of the project in attaining goals/objectives.

The evaluation process recommended will include four outcome areas:

- a. Physiological outcomes: health status related to overweight and fitness status
- b. Behavioral outcomes: food questionnaire and activity assessment
- c. Mental health outcomes: depression, behavioral problems, self-esteem, peer involvement
- d. Adverse effects of identification of overweight

5. **RESULTS/OUTCOMES (INTENDED & UNINTENDED):** Summarize the major results. Highlight any health status outcomes, systems changes, lessons learned and outcomes which have potential for transfer and replication. Provide the number of individuals identified by racial and ethnic group who were served.

Year One Accomplishments:

- a. Developed policies to cover all aspects of the program, from structure of the advisory board, Interdisciplinary Team, processing of referrals, assessments, visit schedule, billing, Have one policy left to complete, that of data collection
- b. Developed a brochure, which is available in all of our waiting rooms
- c. Advertised the program to our primary care providers as well as to the community,

which generated interest and referrals to the program

- d. Identified the process of how kids can be referred to the program utilizing our electronic medical record
- e. Developed documentation tools in our electronic medical record
- f. Developed a program outline and format
- g. Completed creation of the Teen manual; have $\frac{3}{4}$ of the parent of the teen manual completed
- h. Set up a billing structure to allow for billing as well as for tracking of the income from appointments related to the program
- i. Linked with case management department when child is uninsured and would qualify for state Medicaid program

Year One Barriers

- a. The program director responsibility changed hands 2 times due to time constraints of one employee and termination of another.
- b. We had difficult coordinating appointments with key providers so that all teens were evaluated. This was due to various factors in regards to families (transportation, vacations, activities, poor weather conditions)

Year Two Accomplishments:

- a. Developed policies to cover all aspects of the program, from structure of the advisory board, Interdisciplinary Team, processing of referrals, assessments, visit schedule, billing, and data collection
- b. Updated our brochure, which is available in all of our waiting rooms
- c. Advertised the program to our primary care providers as well as to the community,

which generated interest and referrals to the program

- d. Identified the process of how kids can be referred to the program utilizing our electronic medical record
- e. Developed documentation tools in our electronic medical record
- f. Developed a program outline and format
- g. Completed creation of the child manual.
- h. Set up a billing structure to allow for billing as well as for tracking of the income from appointments related to the program
- i. Linked with case management department when child is uninsured and would qualify for state Medicaid program
- j. We have had a total of 4 kids 7 teens in the Get in Shape program.
- k. We have identified some of the challenges and successes of the program as outlined in 2a. and will work on this in the ensuing year.
- l. We have collected data which has been evaluated by a professional evaluator. The result of which is that although our gains were relatively small, we have had some success in reducing obesity in our catchment area. We will have year-end statistics available for performance reporting.

Year Two Barriers

- a. Our psychiatric nurse practitioner left and it was a few months before we were able to replace her.
- b. In addition, our pediatric provider who was responsible as the Medical Director for the program left. This duty was given to our pediatric nurse practitioner.
- c. We experienced a lack of interest and commitment in the teen age group so focused our

attention on the 8-12 age group.

- d. We had a large number of referrals that involved children with multiple problems, requiring them to focus on mental health issues.

Year Three Accomplishments

- a. Restructured the program to concentrate our efforts on the 8-12 year olds due to our past experience with teens who showed a lack of commitment, due in part to other activities (i.e., sports, jobs, etc). We still enroll teens into our program but we make sure they understand the commitment required before joining.
- b. Implemented the requirement to sign a contract and charge a fee for participation in order to encourage commitment to the program and avoid participants exiting early from the program.
- c. Updated our brochure to reflect our structure changes and made these available in each office location as well as at various schools in our area.
- d. Advertised the program on our newly designed website, in school newspapers, posted flyers at area schools, and provided in-service to our primary care providers for the purpose of generating interest and referrals to the program.
- e. Attended various community functions via the Weeks on Wheels (WOW) van to promote the GIS program, providing brochures and small give-away items for incentives. Some of the events were the Lancaster Street Fair, Whitefield Community Day, and Lancaster Fair (county fair).
- f. Advertising was directed towards a positive image of health, nutrition and exercise instead of obesity being the focal point.
- g. Collaborated with school nurses to identify students in need who could be referred to

our program.

- h. Incorporated our home visiting program to conduct home visits to our participants for the purpose of helping children and parents stay on task with the Get in Shape goals.
- i. We refer patients to our office case manager, a new position developed in 2009 to identify and assist children who are uninsured or underinsured and would qualify for the state Medicaid program, NH Health Access, Weeks Health Access, WIC or any other resource available.
- j. Provided health education to parents and children as follows:
 - i. Providers educate patients at the time of the visit (i.e., immunizations, blood lead screenings, etc) and offer educational material.
 - ii. Various brochures are available to patients in the exam and waiting rooms.
 - iii. The office case manager provides information about services available.
 - iv. The home visitor provides books, puzzles, guides and works with the parent/child to develop teaching skills.
- k. Implemented time management assistance to patients as follows:
 - i. We Send forms and provide information about our practice and processes to new patients, allowing them more time to be with the provider.
 - ii. For existing patients we provided forms at the front desk to be completed in the waiting area prior to seeing the provider.
 - iii. Our goal is to check the patient in and have the provider available to see them within 5 minutes.
 - iv. The home visitor assists with time management skills in the home, helping families to prioritize.

- l. We had a total of 11 children ages 8-12 in the Get in Shape program last year.
- m. We have identified some of the challenges and successes of the program as outlined in 2a. and will work on this in the ensuing year.
- n. We have collected data which has been evaluated by a professional evaluator. The result of which is that although our gains were relatively small, we have had some success in reducing obesity in our catchment area. We will have year-end statistics available for performance reporting.

Year Three Barriers

- a. Although we continue to receive referrals from various sources, we still experience a lack of participation in the program. Patients who are referred seem to be reluctant in committing to the program, which is for an extensive 12 week period. In addition the program requires some homework assignments, nutritional and weight monitoring, appointments with various providers, activities with a certified trainer, plus a signed contract and nominal fee is required. These are a few of the barriers identified as reasons for lack of participation. Although these might be barriers, based on past history, the current program structure seems reasonable and necessary for the success of the program. In previous years we found that some of our participants dropped out of the program before completion because there is a lack of obligation to finish. With a signed contract and fee, we find that more participants remain in the program. As an incentive to participate, we inform them that there is a party at the end of the 12-week program with games and prizes.
- b. We are fortunate to have three providers directly involved in the Get in Shape program however it was recently identified at one of the interdisciplinary meetings that some of

the processes are not always being handled consistently, due in part to provider preference and not necessarily as the result of established policy. It was determined that in order to have the program function more effectively all of our providers had to coordinate services consistently. Our program medical director is in the process of scheduling informational meetings to discuss program protocol to improve consistency and coordination between providers directly associated with the program.

- c. Our program evaluator resigned in July 2009 and it was not until November 2009 that we were able to locate a new evaluator to provide us with statistical reporting. We are currently working with the new evaluator to obtain statistical information that will be of significance to us.
- d. We have experienced a lack of Advisory Board participation. We have always been proactive in notifying members a couple of weeks in advance of upcoming meetings, requesting an RSVP. We also send the meeting agenda and minutes of the prior meeting to board members about a week prior to the scheduled meeting as another reminder. In addition we made phone calls to members to encourage attendance however we have not been successful in our efforts to increase participation. We recognize that we are situated in a fairly remote location and many of our members find it difficult to travel the distance, especially in winter months so we provide a dial-up solution but only found that a few members utilize this option. At a recent advisory board meeting it was determined that quarterly meetings may be requiring too much of a commitment from individuals, especially for members who have other jobs. In December 2009 we requested and were approved a reduction to meeting on a semi-annually basis. We anticipate that members will be more receptive to attending when

we are meeting only twice a year. We will continue to monitor attendance and if no improvements are made our next step will be to review those members who routinely do not attend and replace them with another individual.

Year Four Accomplishments

- a. Continued to focus on the 8-12 age population, and interested 13-18 year olds who are able to make a commitment to the program. We were pleased to enroll 3 participants of adolescent age this past year.
- b. A new group is enrolled monthly, with a target group size of 1-6 attendees. When we have more than 1 enrollee, group meetings are scheduled at the fitness center; if only 1 enrollee, the sessions are held at the physician office. The Initial session is conducted by our program's RN Case Manager providing a program overview, reviewing expectations, reviewing and executing individual contracts. A nominal fee of \$40.00 is collected, and manuals distributed. Program consists of 4 group visits; the first month for the nutrition and emotional support sections of the program, 2-3 times per week fitness visits, and 2-3 one on one visits with the provider.
- c. We held a focus group on January 14, 2010 with 6 parents and 2 teens in attendance. Questions about the program were asked regarding likes and dislikes. Participants were enthusiastic about fitness, indicating they have more energy, however would like more flexible hours at the gym. Parents wanted to see more discussion around the manuals.
- d. There was a separate teen group meeting held with the mental health provider for the purpose of getting the teens to open up and feel comfortable with the MH provider. There were 7 adolescents who attended.
- e. Weeks Medical Center Practice Management Team has been working together to

coordinate services between Primary Care, Pediatrics, Case Management, Home Visiting, Family Planning and Mental Health Nurse Practitioner. Patients who are identified as needing other services are referred appropriately and documentation is maintained through the patient's electronic medical record. The participant's progress is evaluated, at a minimum, on a monthly basis to determine the participant's success and whether there are other resources needed.

- f. Participants who complete the program are rewarded with a party, games and prizes for their success.
- g. We have continued our partnership with a certified fitness trainer and reaching out to school administrators/teacher and other organizations.
- h. We collaborate with the State of NH, Coos Family Support Project, American Academy of Pediatrics and other agencies to advocate health issues.
- i. We contracted the services of a new program evaluator who has provided our program with more purposeful information, which has helped us better determine our successes. Reports are distributed to the advisory board on a semi-annual basis. The result of which is that although our gains were relatively small, we have had some success in reducing obesity in our catchment area. We will have year-end statistics available for performance reporting.
- j. We now monitor a child's success by looking back 2 years prior to joining the program. We found that some participants were gaining 10 to 50 pounds a year before joining the program, and the fact that a participant maintained weight is considered a success for that child.
- k. We are fortunate to have four providers directly involved in the Get in Shape program

and they have worked together over this past year to improve some of the processes that were not consistent. The Get in Shape Medical Director formed a sub-committee with other providers, including the Mental Health Provider to help coordinate services more consistently.

- l. We have promoted the program in the local and school newspapers as well as on our website, focusing on a more positive image. We have conducted in-service to our providers and clinical staff at office practice and clinical staff meetings. Our Get in Shape Medical Director wrote an article about our Get in Shape program that was published in our local newspaper.
- m. Our brochures were updated to correspond with program structure changes and we continue to make these available in all medical center locations.
- n. We provide multiple health information to parents and children regarding immunizations, blood lead screenings, services available at Weeks and in the area. This is conveyed through discussion with the provider, clinical staff, office case manager, home visitor or brochures.
- o. We had a total of 16 children ages 9-18 in the Get in Shape program last year.
- p. We have identified some of the challenges of the program as outlined in 2a. and will continue to work on these challenges in the ensuing year.

Year Four Barriers

- a. We are still receiving referrals from providers and other sources but are continuing to experience reluctance from participants to enroll in the program. This is particularly consistent with our adolescents who have other activities associated with school and sports with little time to commit to the Get in Shape program. Parents who are

interested in having their child enrolled seem to have much more influence over children ages 6-12 and less influence on adolescents. The commitment may seem overwhelming as the program requires some homework assignments, nutritional and weight monitoring, appointments with various providers, activities with a certified trainer, plus a signed contract and nominal fee is required. It was decided to use the current manuals as a resource instead of homework assignments in an effort to improve participation. In previous years we found that some of our participants dropped out of the program before completion because there was a lack of obligation to finish. Since we have implemented a required signed contract and \$40.00 nominal fee, participants who make the commitment are more apt to stay in the program.

- b. With a minimal number of participants, it has been difficult to utilize the current curriculum being used, which requires a participant to follow in sequential order and builds upon previous subjects learned. We identified that we needed a more flexible curriculum that allows participants to join the group at any time and then go back to prior subjects. Our interdisciplinary team found curriculum that provided us with this flexibility called "Trim Kids". We plan on implementing this in January 2011.
- c. In December 2009, we requested approval of reducing the number of Advisory Board meetings from quarterly to semi-annually. We did this with anticipation that members would be more receptive to attending twice a year. This helped a little, although we still lack the participation that we would like to see. We continue to be proactive in notifying members a couple of weeks in advance of upcoming meetings, requesting an RSVP. We also send the meeting agenda and minutes out about a week prior to the scheduled meeting as another reminder and have made phone calls to members to

encourage attendance. In addition, we offer a dial-up solution for those who have to travel. Our next step is to send a survey to advisory board members to determine what we can do to encourage attendance. The survey will include ideas such as day of week, time, location, refreshments, offering a presenter. We will also provide current advisory board members with the option to step down so that they might be replaced with another individual. We will continue to monitor attendance and our final step will be to terminate a member for non-attendance so that the position can be filled with a more active member.

Year 5 Accomplishments

- a. Continued to focus on the 8-12 age population, and interested 13-18 year olds who are able to make a commitment to the program. We were pleased to have 7 participants in our program this past year..
- b. Our goal is to enroll at least two participants up to 6. Group meetings are then scheduled at the fitness center. The Initial session is conducted by our program's RN Case Manager providing a program overview, reviewing expectations, reviewing and executing individual contracts. Program consists of 4 group visits; the first month for the nutrition and emotional support sections of the program, 2-3 times per week fitness visits, and 2-3 one on one visits with the provider.
- c. We implemented the "Trim Kids" curriculum in the past year and this has helped us to offer a more flexible program. It is easier for the providers to manager the program as the contents are not built on the previous section. This allows them to utilize any section during visits.
- d. Weeks Medical Center Practice Management Team has been working together to

coordinate services between Primary Care, Pediatrics, Case Management, Home Visiting, Family Planning and Mental Health Nurse Practitioner. Patients who are identified as needing other services are referred appropriately and documentation is maintained through the patient's electronic medical record. The participant's progress is evaluated, at a minimum, on a monthly basis to determine the participant's success and whether there are other resources needed.

- e. Participants who complete the program are rewarded with a party, games and prizes for their success.
- f. We have continued our partnership with a certified fitness trainer and reaching out to school administrators/teacher and other organizations.
- g. We collaborate with the State of NH, Coos Family Support Project, American Academy of Pediatrics and other agencies to advocate health issues.
- h. We have continued to measure results, which are provided to us by the program evaluator. Some of our success has been in helping those children who were gaining 10 to 50 pounds per year, maintain their current weight.
- i. We have promoted the program in the local and school newspapers as well as on our website, focusing on a more positive image. We have conducted in-service to our providers and clinical staff at office practice and clinical staff meetings.
- j. Our brochures continue to be updated to correspond with current program structure and are available in all medical center locations.
- k. We provide multiple health information to parents and children regarding immunizations, blood lead screenings, and other services available at Weeks and in the area. This is conveyed through discussion with the provider, clinical staff, office case

manager, home visitor or brochures.

- l. We had a total of 7 children ages 9-17 in the Get in Shape program last year.
- m. We have established a sustainability plan as outlined below under the Future Plans/Sustainability section of this report.

Year 5 Barriers

- a. We continue to experience reluctance from children and/or parents in regards to their participation in the program. We realize that some of the lack of participation is due to other activities that children are involved in such as school sports and other community activities. A few years ago we instituted a nominal fee of \$40.00 in an effort to encourage those that have enrolled, to continue their commitment to the program. It was thought that the fee would discourage participants from the dropping out of the program. However, we realized that this fee seemed to impact our enrollment so during 2011, we discontinued the fee. Feedback from the focus group held in 2010 indicated that participants were discouraged by the homework assignments so the assignments were eliminated. Although these adjustments were made to our program, we still have had difficulty increasing our enrollment.

We have also experienced lack of commitment from a few of our Advisory Board members. In December 2009, we requested approval of reducing the number of Advisory Board meetings from quarterly to semi-annually. We did this with anticipation that members would be more receptive to attending twice a year. We have provided the Advisory Board with meeting notifications and the capability of a dial-in solution. We received little response from a survey that was sent to our board last year regarding what would help encourage attendance and the option to step down. On a

positive note we have been able to maintain a core representation of board members who have actively participated and have been instrumental in our policies and structural changes.

6. PUBLICATIONS/PRODUCTS: List publications/products resulting from the project and the audiences for which each was designed. Products include but are not limited to: pamphlets, manuals, forms, surveys, questionnaires, CDs, DVDs, electronic educational products, slides, newsletters, training materials, web based training modules, protocols, standards, books, workbooks, brochures, articles, presentations, database formats. If the contact person for a particular publication/product is someone other than the Project Director, please provide their name, address, telephone number, and e-mail address.

NONE

7. DISSEMINATION/UTILIZATION OF RESULTS: Describe action taken to share information/findings/products/resources with others within and outside the State.

NONE

8. FUTURE PLANS/SUSTAINABILITY: Describe plans for continuing the activities initiated by the project and future funding. Include anticipated results and both the short and long term impact of the project.

At the last Advisory Board meeting in February 2012, the following decisions in regards to sustainability were made:

- a. The program will be held once a year during the months of March, April and May, which are slow months for school activities. It is anticipated that this may help draw interest to the program.
- b. We will utilize the services of the UNH Extension Coordinator who connects with the schools regularly and who will advocate our Get in Shape program to school officials
- c. Our current program is only for Weeks Medical Center patients; however we are extending this program to other health care facilities.
- d. In addition, we will not just focus on overweight and obese children. The Advisory Board felt that good nutrition and proper exercise should not just be associated with the

overweight and obese. There are problems with underweight children and those who do not eat a proper, healthy diet or exercise. The decision was to extend the program to any family in an effort to educate everyone on good nutrition and exercise.

- e. A new brochure has been designed, printed, and a mass mailing to non-weeks providers in the area and to include Dartmouth Hitchcock.
- f. The brochure will also be mail to all families with children ages 8-13. This age group seemed to have the highest success rate in maintaining interest in the program.
- g. The new program is expected to start mid March with a minimum enrollment of 6 participants
- h. Families will be charged \$5.00 per month per family, no limit of family members attending the three month program. We expect this will cover trainer's expense. The sessions will be held Mondays and Thursdays 3:30-5:00. Monday will be with the trainer where kids will learn fun exercising ideas which they can do at home. Thursday the parent or guardian is required to attend. These sessions will include cooking demonstrations and discussions of healthy eating.
- i. It is our intention to bill insurance plans as a group visit for the initial visit. What is not covered under an insurance plan will be covered under Weeks Medical Center's Busi Fund, which has been established specifically for "children services".
- j. The Advisory Board will contact The Lancaster Rotary Club for a contribution to help purchase additional "Trim Kids" books when they are needed.
- k. A fitness trainer has been contracted to provide physical fitness training.

On a separate page, please provide an annotation and key words list:

- ANNOTATION

Prepare a three to five sentence description of your project which identifies the projects purpose, needs and problems which were addressed, the goals of the project, the program activities used to attain the goals, the major results and materials developed.

- a. Provide education to school age children with BMI>25. to demonstrate effective and lasting therapy outcomes (10% or greater reduction in BMI). Modeled after the "Trim Kids" program.
- b. We have struggled with the lack of interest and commitment; however have continued to provide the best program to those who have enrolled and are committed.
- c. We also struggled with the participation of our advisory board; however the active board members were excellent resources for evaluating the current program and offering some structural changes the proved to be successful.
- d. We have identified many of the challenges that we experienced over the past 5 years and have developed a sustainability plan for the continuation of this program.

- KEY WORDS

- Adolescent health
- Adolescent nutrition
- Obesity

Select the most significant terms which describe the project, including health professions involved, population groups served and major issues addressed by the project.

4. ABSTRACT OF FINAL REPORT

An Abstract of the Final Report should accompany the Final Report. It should follow the topical outline prescribed previously, double-spaced and not exceed four pages.

- Please avoid formatting (do not underline, use bold type, or justify margins).
- Use a standard 12 pt font such as Courier, Times New Roman, or Arial.
- Capitalize only the first letter of principal words in the project identification section.

- Be sure to include an area code with the telephone number, full mailing address (including street and/or P.O. Box) with a zip code, e-mail address, and web site address, if available.
- Type section headings in all capital letters, followed by a colon and two spaces. Begin the narrative immediately after the two spaces.
- Please email one copy of your final report to Madhavi Reddy, MSPH, Program Director, Healthy Tomorrows Partnership for Children Program. Her e-mail address is mreddy@hrsa.gov. If you have any questions, you may also contact her at (301) 443-0754. A copy of your report will be e-mailed to the MCH Library to be included in the MCHB final reports available at <http://www.mchlibrary.info>.