Attendees: Prior to the start of the activity, please review the below information to ensure successful participation in this Enduring Activity

Accreditation and Designation Statements

• The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

• The AAP designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

• This activity is acceptable for a maximum of 1.0 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.

• The American Academy of Physician Assistants (AAPA) accepts certificates of participation for educational activities certified for AMA PRA Category 1 Credit™ from organizations accredited by ACCME. Physician assistants may receive a maximum of 1.0 hours of Category 1 credit for completing this program.

• This program is accredited for 1.0 NAPNAP CE contact hours of which 0 contain pharmacology (Rx), (0 related to psychopharmacology) (0 related to controlled substances), content per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.
Purpose of Course
The Childhood Obesity in Primary Care Modules are designed to provide evidence-based practice for obesity prevention and treatment and use of effective strategies with families. The modules also aim to create healthcare systems that better supports evidence-based practice, increasing the likelihood of effective and sustainable changes in practice. In addition, the modules also enhance collaboration of providers with other healthcare professional and with broader community initiatives.

Learning Objectives
Upon completion of this activity, participants will be able to:

- Explain the purpose and key components of a Key Driver Diagram
- Define the steps in PDSA cycles within the Model for Improvement and how cycles are used to change practice systems
- Identify the Global Aim and Key Drivers for the Childhood Obesity in Primary Care project
Disclosure of Commercial Support for AAP CME Activities

The AAP gratefully acknowledges support for Childhood Obesity in Primary Care Module 2 in the form of educational support from Nestlé Nutrition.

Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities Grid

The AAP CME/CPD program develops, maintains, and improves the competencies, skills, and professional performance of pediatricians and pediatric healthcare professionals by providing quality, relevant, accessible, and effective educational experiences that address gaps in professional practice. The AAP CME/CPD program strives to meet the educational needs of pediatricians and pediatric healthcare professionals and support their lifelong learning with a goal of improving care for children and families. (AAP CME/CPD Program Mission Statement, May 2015)

The AAP recognizes that there are a variety of financial relationships between individuals and commercial interests that require review to identify possible conflicts of interest in a CME activity. The “AAP Policy on Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities” is designed to ensure quality, objective, balanced, and scientifically rigorous AAP CME activities by identifying and resolving all potential conflicts of interest prior to the confirmation of service of those in a position to influence and/or control CME content. The AAP has taken steps to resolve any potential conflicts of interest.

All AAP CME activities will strictly adhere to the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support: Standards to Ensure the Independence of CME Activities. In accordance with these Standards, the following decisions will be made free of the control of a commercial interest: identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the CME activity.

The purpose of this policy is to ensure all potential conflicts of interest are identified and mechanisms to resolve them prior to the CME activity are implemented in ways that are consistent with the public good. The AAP is committed to providing learners with commercially unbiased CME activities.

Activity Title: Childhood Obesity in Primary Care Module 2: Building a System to Improve Primary Care
Activity Location: Online/Enduring Material
Activity Date: December 1, 2018- November 30, 2021

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<td>Alison Baker</td>
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## Disclosure of Financial Relationships

All individuals in a position to influence and/or control the content of AAP CME activities are required to disclose to the AAP and subsequently to learners that the individual either has no relevant financial relationships or any financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in CME activities. Listed below are the disclosures provided by individuals in a position to influence and/or control CME activity content.

A commercial interest is defined as any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by, or used on, patients.

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AAP gratefully acknowledges support for its Childhood Obesity in Primary Care Modules in the form of an educational grant provided by Nestlé.

Product-Specific Advertising / Links to Product Websites
No product-specific advertising of any type appears in this activity. No links to product websites appear in this activity.

List of Principal Faculty and Credentials
• Janice Liebhart, MS

Method of Participation
Participants will participate in the module online. Upon completion of the webinar, participants will complete an assessment in order to receive CME credit.

Minimum Performance Level
Per the 2010 revision of the American Medical Association (AMA) Physician’s Recognition Award (PRA) and credit system, a minimum performance level must be established on enduring material and journal-based CME activities that are certified for *AMA PRA Category 1 Credit™*. In order to successfully complete this Ambulance Safety for the 21st Century Webinar CME activity for *AMA PRA Category 1 Credit™*, learners must demonstrate a minimum performance level of 70% or higher on the post-activity assessment, which measures achievement of the educational purpose and objectives of the activity.
Medium or Combination of Media Used
Enduring Material

List of hardware/software requirements
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If you are unable to open and play the presentation, the test has failed. In this case, you may either need to try another computer or consult with your network administrator to obtain privileges required to view streaming media. This process could take some time, so please conduct this test as soon as possible.

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• For Firefox and Chrome, Silverlight 1.0 or later
• Windows Media Player 9.0 or later
• Broadband Internet connection (256 Kbps & above)
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Privacy and Confidentiality Statement
Childhood Obesity in Primary Care
Building a System to Improve Primary Care

Janice Liebhart, MS
AAP Institute for Healthy Childhood Weight
About Janice

- Institute for Healthy Childhood Weight Evaluation Manager
- Key staff member for quality improvement initiatives
Janice Liebhart, MS

✓ I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.

✓ I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
Learning Objectives

- Explain the purpose and components of a key driver diagram
- Define the steps in PDSA (Plan-Do-Study-Act) cycles within the Model for Improvement and how cycles are used to change practice systems
- Identify the global aim and key drivers for the Childhood Obesity in Primary Care project
Today’s Presentation

- Definition of quality improvement (QI)
- Rationale for QI in obesity prevention and treatment
- Common model for facilitating QI
- Structure of the Childhood Obesity in Primary Care project
Definition of Quality

“The degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge”

\(^1\) Institute of Medicine (IOM), 2001
AAP Quality Agenda

“Every Child Gets the Right Care Every Time”

IOM Six Quality Aims

- Safe
- Effective
- Efficient
- Timely
- Equitable
- Patient-Centered

Outcomes

- Patient Safety
- Professionalism
- Access
- Business Operations - Finance
- Health Care Equity

"Every Child Gets the Right Care Every Time"
Why is Quality Improvement (QI) Needed?

- Lag between new knowledge and routine practice
- Multiple quality aims
- Complexity of practice system environments
- Differences across practice systems
“Every system is perfectly designed to get the results it gets.”

~ Paul Batalden, MD
Standards for Obesity Prevention and Treatment

- Expert committee recommendations (ECR) regarding prevention, assessment, and treatment
- US Preventive Services Task Force Statement: Screening for Obesity in Children and Adolescents
- Expert panel on integrated guidelines for cardiovascular health and risk reduction
- Children’s Hospital Association consensus statements
  - Comorbidities of childhood obesity
  - Addressing prediabetes in childhood obesity treatment programs

Quality Gap in Obesity Prevention and Treatment

- Nearly all pediatricians now report calculating/plotting BMI at all well child visits for children 2 and older.

- About 2/3 discuss healthy behaviors at every well child visit.

7 Frintner, et al., 2018; 8 AAP, 2017
Quality Gap in Obesity Prevention and Treatment

- A modest majority or minority of pediatricians:
  - Consider their prevention counseling to be somewhat or very effective
  - Report very good or excellent ability to conduct several key assessments for children with overweight or obesity

\(^8\) AAP, 2017
Model for Improvement

- Common framework used to accelerate QI process
- Endorsed by Institute for Healthcare Improvement (IHI)
- Used by hundreds of healthcare organizations, including:
  - American Board of Pediatrics
  - American Academy of Pediatrics
  - National Institute for Children’s Health Quality (NICHQ)
  - Cincinnati Children’s Hospital Medical Center

9 Langley, et al., 2009; 10 Institute for Healthcare Improvement (IHI), 2018
Model for Improvement

Three questions

One process

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?
A Good Aim Statement is SMART

S → Specific
M → Measureable
A → Actionable
R → Realistic
T → Time-bound
Example Aim Statements

Between October and next March, participating practice teams will enhance access to care by:

- Identifying the primary care pediatrician or physician-led care team for 90% or more of all patients
- Ensuring that 90% or more of all patients receive their health supervision visits from their primary care pediatrician or physician-led team members

Adapted from: Florida Medical Home Demonstration Project, 2018
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

ACT

PLAN

STUDY

DO
Measures

- Link directly to stated aims and numeric goals
  - Use of data to take action
  - Common frame of reference

- Provide ongoing feedback about change processes
  - Learning, not judgment
  - “You can’t improve what you don’t measure.”
Common Measurement Strategy

- “Vital few” (e.g., 6-10)
- Reported monthly
- Relatively easy to collect
- Submitted with qualitative reports

Different types:
- **Outcome**: Impact on patients
- **Process**: Changes in practice system
- **Balancing**: Unintended changes
Example Measure #1

Numerator: Total number of patients with an identified primary care pediatrician or physician-led care team

Denominator: Total number of patients in monthly chart review
Example Measure #2

Numerator: Total number of patients whose primary care pediatrician or physician-led care team member provided the most recent health supervision visit

Denominator: Total number of patients with an identified primary care pediatrician or physician-led care team
Plotting Measures Over Time

Most Recent Health-Supervision Visit by Primary Care Pediatrician (Process)

- **Goal** (red dotted line)
- **Group** (blue line)

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Cycle

Percent
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

ACT
PLAN
STUDY
DO

Childhood Obesity in Primary Care
Components for Tests of Change

1. “Change concepts”: Interventions or strategies for change that can be adapted to your unique environment

2. PDSA test method
Change Package

- Primary content for a collaborative
- Often presented as a Key Driver Diagram
- Typically organized from general strategies to very small, specific changes
Key Driver Diagram

Global Aim

Specific Aims

Key Drivers
System factors that directly contribute to achieving the aim

Interventions
Actions and interventions necessary to achieve primary drivers

Tools & Resources
Resources to enact interventions

Childhood Obesity in Primary Care
Key Driver Diagram

Global Aim

To assess the effectiveness of systems of care and implement tools, strategies and measures designed to improve medical “homeness”, including enhancing access to care and providing family-centered care.
Specific Aim(s)

Between October and March, the participating practice teams will enhance access to care by:

- Identifying the primary care pediatrician or physician-led care team for 90% or more of all patients
- Ensuring that 90% or more of all patients receive their health supervision visits from their primary care pediatrician or physician-led team member
Interventions

- Identify primary care pediatrician or physician-led care team
- Ensure patients receive health supervision visits from primary care pediatrician or physician-led team members
Key Driver Diagram

**Key Driver**

- Ensure patients receive health supervision visits from primary care pediatrician or physician-led team members

**Interventions**

- Expand or tailor appointment hours to better accommodate practice population
- Offer alternative ways for providers/teams to interact with patients

**Tools & Resources**

- Consumer Assessment of Healthcare Provider and Systems (CAHPS) Survey
- Appointment tally sheet (calculates supply vs. demand)
- AAP Practice Management Online (change ideas & resources)
- Consider nurse triage services to help families determine if in-person visit is needed
- Develop multiple access points for communication, including visits, phone, e-mail, and Internet

Childhood Obesity in Primary Care
PDSA Cycle

ACT

PLAN

STUDY

DO
Why Test?

- Increase your belief that the change will result in improvement
- Predict how much improvement can be expected
- Learn how to adapt the change to local conditions
- Evaluate costs and side-effects
- Minimize resistance to implementation
PDSA Cycle

**PLAN**
- Formulate an objective and **prediction**
- Plan to carry out the test (who, what, where, when)
- Plan for data collection

**DO**

**STUDY**

**ACT**
Medical Summary/Care Plan Reviewed With & Offered to Patient

1. Clinical Support Staff
   - Review scheduled well-child visit charts
   - Pull out existing medical summary/care plan or template to chart

2. Pediatrician
   - Review existing medical summary/care plan
   - Conduct exam
   - Discuss medical summary/care plan with patient

3. Patient/Family
   - Provide feedback and share concerns

4. Front Office Staff
   - Load updated medical summary/care plan into patient portal

Time Stages:
- Before Appointment
- During Appointment
- After Appointment
PDSA Cycle

**ACT**
- Carry out the plan
- Document what happens
- Begin data analysis

**PLAN**

**STUDY**
# QI Teams: Common roles

<table>
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<th>Role</th>
<th>Description</th>
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<tbody>
<tr>
<td>Clinical Leader</td>
<td>Has authority to make clinical changes and solve problems</td>
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<tr>
<td>Technical Expert</td>
<td>Knows one or more key processes extensively</td>
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<tr>
<td>Day-to-Day Leader</td>
<td>Leads team; ensures completion of all tasks</td>
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<tr>
<td>Project Sponsor</td>
<td>Links team to senior management</td>
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PDSA Cycle

ACT

PLAN

DO

STUDY

Complete data analysis
Compare to predictions
Summarize what was learned
PDSA Measures ≠ Project Measures

- More frequent
- Less formal
- Small scale (e.g., 1 patient, 1 provider)
- Quick indicator of whether a change is working
- Goal is to ultimately improve project-level measures
PDSA Cycle

ACT

Select one action based on results:
- Adopt?
- Adapt?
- Abandon?
Plan next test

PLAN

STUDY

DO
Does Your Prediction Match Results?

No:
- ✓ Did your method of testing fail?
- ✓ Is the change ineffective?

Yes: Expand the test
- ✓ Scale: More units
- ✓ Scope: Different conditions
Expanding the Test

Scale: Rule of 5

- Start with 1 patient (or MD or day)
- If successful, increase to 5

Scope:

- Spread change to different team roles, patient groups, sites, etc.
Scaling & Implementing Change

- Evidence
- Best Practice
- Testable Ideas

P/D/S/A  P/D/S/A  P/D/S/A  P/D/S/A

- Small Scale Test
- Follow-up Tests
- Wide-scale Tests
- Implementation of Change

Changes that result in improvement
Flag template prior to visit

Integrate template into patient portal

Medical Summaries or Care Plans Reviewed with & Offered to Patient

Childhood Obesity in Primary Care
Sustainability

✓ “Locking in progress”

✓ “Capacity to continue to deliver intended benefits” (particularly after a program period has ended)

✓ “Integration of a new program within an organization”
Summary: Process to achieve aims

- Plan and implement small tests of change
- Scale up successful changes
- Combine various strategies for change
- Measure changes over time
- Consider sustainability throughout
Childhood Obesity in Primary Care Project
Global Aim

“To improve evidence-based primary care practice surrounding healthy weight assessment for pediatric patients, from birth to 21 years of age.”
Specific Aims

- By the end of the 19-week MOC participation period, during well child visits, the practice will appropriately assess obesity risk, for all children, including an assessment of growth:
  - 50% of the time for patients < 2 years of age
  - 85% of the time for patients from 2 through 21 years of age

- For patients from 2 through 21 years of age, the practice will appropriately assess and counsel on healthy active living behaviors 50% of the time.
Specific Aims

For patients with overweight or obesity, they will:

- Appropriately assess medical risk (through family history, obesity review-of-systems, and physical exam) 50% of the time
- Provide appropriate follow-up through lab orders and, when indicated, work-ups, 50% of the time.
Basics

- Brief (19 week) collaborative
- Team (practice level) implementation of changes and measurement
- Targets National Academy of Medicine (*formerly IOM*) dimensions of effectiveness, patient-centeredness, and timeliness
- Individual-level opportunities
  - 25 Part 4 Maintenance of Certification credits (pediatricians and qualifying residents)
  - Up to 9 Continuing Medical Education credits (clinical staff)
    - 4 required and 2 optional modules
    - 3 Action Period webinars
Core QI Team

- 2-4 individuals, depending on practice

Roles

- **Lead Clinician** (MD, DO, NP, or PA site champion)
- **Clinical Support Staff** (e.g., RN, LPN, MA, CNA)
- **Office Manager** (i.e., staff with knowledge of clinic flow & authority to facilitate practice-level changes)
- **Front Office Staff** (i.e., staff knowledgeable about patient scheduling & billing)
Collaborative Supports

- Key Driver Diagram and Change Package
  - Algorithm
  - CME modules
  - Other tools/strategies
- 1 Kick-off & 3 Action Period webinars
- Coaching
  - Ongoing access to faculty/staff, other teams
Key Driver Diagram

Outcomes

Global Aim: To improve evidence-based primary care practice surrounding healthy weight assessment for pediatric patients, from birth to 21 years of age.

Key Drivers

1. Accurately weigh, measure and chart growth, based on age and sex
2. Assess behavioral risk associated with overweight/obesity
3. Appropriately assess medical risk related to overweight/obesity
2. Assess behavioral risk associated with overweight/obesity

1. Accurately weigh, measure, and chart growth, based on age and sex

**Key Drivers**

**Interventions**

**For all patients:**
- Assess weight for length percentile by age and sex for children < 2 years of age
- Calculate BMI percentile by age and sex for youth ≥ 2 years of age

**For patients ≥ 2 years of age:**
- Assess healthy active living behaviors, including nutrition, physical activity, and sleep behaviors.
- Conduct patient-centered counseling, relevant to assessed healthy active living behaviors.
3. Appropriately assess medical risk related to overweight/obesity

**For all patients ≥ 2 years of age:**
- Conduct an obesity-specific Family History

**For all patients ≥ 2 years of age with a BMI ≥ 85th percentile:**
- Conduct an obesity-specific Review of Systems
- Conduct an obesity-specific Physical Exam

**For patients ≥ 2 years of age with a BMI ≥ 85th percentile and assessed health risk:**
- Order appropriate labs
- Order other work-up tests, as appropriate, to assess potential comorbidities
Key Driver Diagram

Assess weight for length percentile by age and sex for children < 2 years of age

Tools & Resources

- World Health Organization (WHO) weight-for-length percentile growth charts for infants and children 0-2 years of age
- Online training for using the WHO growth charts to assess growth
Continuing Medical Education Modules

Required
1. The Childhood Obesity Epidemic and the Role of the Healthcare Provider
2. Building a System to Improve Primary Care
3. Introduction to the New Childhood Obesity Algorithm
4. Childhood Obesity and the Primary Care Practice Team: Setting your Office Up for Success

Optional
5. Management and Treatment of Comorbidities of Obesity
6. Motivational Interviewing: A Strategy to Stimulate Change Talk
Clinical Quality Measures

Children < 2 years:

- Weight-for-length percentile

Children ages 2 through 21 years:

- BMI percentile
- Healthy eating and active living behaviors
- Obesity-specific family history
Clinical Quality Measures

Children with BMI percentile ≥ 85:
- Obesity-specific review of systems
- Obesity-specific physical exam
- Assessment of medical risk

Children with BMI percentile ≥ 85, assessed with health risk:
- Obesity-specific labs ordered
- Other obesity-specific work-up tests ordered (if appropriate)

**Balancing measure:** Staff satisfaction
MOC Requirements: All participating pediatricians

- Provide direct or consultative care to patients (or supervise care by other providers) as part of the QI project
- Implement the project’s interventions
- Collect, submit, and review data
  - Every pediatrician (involved in direct patient care) must have a minimum of 5 charts included in each data cycle.
- Complete and pass four required CME modules
  - Modules 1 & 2 are due prior to the Kickoff webinar
  - Modules 3 & 4 are due prior to the first Action Period webinar.
- Participate in the QI project for its duration of 19 weeks
- Complete participation under their current ABP certificate or MOC cycle
MOC Requirements—Local Pediatricians

- Attend at least 4 local-level meetings hosted by the project’s Lead Clinician or collaborative webinars (other than the Kickoff), at which data are reviewed and strategies are discussed.
MOC Requirements—Lead Clinicians

- Ensure that a core Quality Improvement (QI) Team is assembled
- Support local participating pediatricians in implementing the project’s interventions
- Attend all four webinars (kickoff + 3 action period webinars).
- Lead at least four substantive local meetings at which data are reviewed and plans are made
- Ensure that data is submitted and reviewed each cycle
- Ensure that three PDSA forms are submitted
## MOC Tracking

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Prior to the collaborative

Lead Clinician

- Submits team roster & list of pediatricians participating locally for MOC credit
- Begins tracking participation for local pediatricians

All team members

- Sign consent form
- Take pre-project survey

Pediatricians (required) and clinical staff (optional)

- Must complete first 2 (of 4) required CME modules before the Kickoff webinar
- Are strongly encouraged to complete 3rd CME module
- May complete all 4 required (and 2 optional) CME modules
“Kicking off” the Collaborative—Weeks 1-3

Week 1
- Teams participate in Kickoff webinar
  - Data Coordinators (1 per team) participate in data submission training
  - Teams meet (weeks 1 or 2)

Week 2
- Teams submit cycle 1 (baseline) data, using the Quality Improvement Data Aggregator (QIDA)

Week 3
- Data reports from QIDA are generated for practices
The Project Home page is used for data submission:

- Data Collection Tools
- Project Surveys
The Workspace area contains project headers where relevant project documents and resources are housed.
Medical Record Data can be entered **by chart** or **in aggregate**.

Data collection forms pose a series of questions to calculate measures.

### Pediatric Practice Individual Chart Review Tool

**Sample:**
- Include medical records for 20 most recent eligible *well-child* visits for patients from birth through 21.
- Records should only be from pediatricians participating for Part 4 MOC or other participating primary care providers. Submitted records should include at least 5 charts from the Lead Clinician and each pediatrician participating for MOC.
- Exclude patients who are pregnant (or were pregnant during the past 12 months)
- Sampling periods for each data cycle are as follows:
  1. Data submission #1 (Jan. 9th-13th) should be based on the most recent eligible charts from October, 2016. (Include September charts if 20 charts are not available from October.)
  2. Data submission #2 (Feb. 27th-March 3rd) should be based on the most recent eligible charts from Action Period #1 (Jan. 23rd-Feb. 26th)
  3. Data submission #3 (April 17th-21st) should be based on the most recent eligible charts from Action Period #2 (March 13th-April 16th).

Questions refer to [documentation in the medical record for this particular visit](#).

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the patient &lt; 24 months of age on the date of the visit?</td>
<td>□ Yes (If Yes, continue to #2)</td>
</tr>
<tr>
<td></td>
<td>□ No (If No, skip to #3)</td>
</tr>
<tr>
<td>2. Is there documentation that weight-for-length percentile was assessed?</td>
<td>□ Yes (No additional data will be collected for this patient.)</td>
</tr>
<tr>
<td></td>
<td>□ No (No additional data will be collected for this patient.)</td>
</tr>
<tr>
<td>3. Is there documentation that a family history was conducted related to obesity, type 2 diabetes, and cardiovascular disease?</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
</tr>
</tbody>
</table>
Medical Record Data can be entered by chart or in aggregate.

PDFs of forms can be downloaded.

QIDA Data Entry

Pediatric Practice Aggregate Chart Review Tool

Sample:
- Include medical records for all eligible well-child visits for patients from birth through 21.
- Records should only be from pediatricians participating for Part 4 MOC or other participating primary care providers. Submitted records should include at least 5 charts from the Lead Clinician and each pediatrician participating for MOC.
- Exclude patients who are pregnant (or were pregnant during the past 12 months)
- Sampling periods for each data cycle are as follows:
  1. Data submission #1 (Jan. 9th-13th) should be based all eligible charts from October, 2016. (Include September charts if 20 charts are not available from October.)
  2. Data submission #2 (Feb. 27th-March 3rd) should be based on all eligible charts from Action Period #1 (Jan. 23rd-Feb. 26th)
  3. Data submission #3 (April 17th-21st) should be based on all eligible charts from Action Period #2 (March 13th-April 16th).

Questions refer to documentation in the medical record for this particular visit.

What is the total number of eligible patients seen by the pediatric practice during the sampling period ______ patients

1. From the total number of eligible patients, how many patients were less than 24 months of age on the date of the visit? _______ patients

2. Of the charts entered in #1 (<24 months of age), for how many patients is there documentation that weight-for-length was assessed? _______ patients

3. From the total number of eligible patients, how many patients were 24 months of age or older on the date of the visit? (Note: The number of patients in #1 and #3 should sum to the total number of eligible patients.) _______ patients
PDSA Forms/Progress Reports

- What meetings did you hold; who led/attended?
- What change(s) did you test?
- What did you predict?
  - How did your results compare with predictions?
- What did you learn?
- Please describe your next test of change.
Action Period #1: Weeks 4 - 10

Week 4
- Teams meet, review data reports, plan changes
- Teams submit PDSA form/Progress report using QIDA

Weeks 5-8
- Teams test changes

Week 6
- Teams participate in Action Period webinar #1
- Pediatricians must have completed CME modules 3 & 4

Week 9
- Teams submit cycle 2 data

Week 10
- Data reports from QIDA are generated for practices
Week 11
- Teams meet, review data reports, plan changes
- Teams submit PDSA form/progress report using QIDA

Weeks 12-15
- Teams test changes

Week 13
- Teams participate in Action Period webinar #2

Week 16
- Teams submit cycle 3 data
Finishing the collaborative

Week 17
- Data reports from QIDA are generated for practices

Week 18
- Teams meet, review data reports, plan changes
- Teams submit PDSA form/progress report

Week 19
- Teams participate in Action Period webinar #3
- MOC participants submit attestation forms to Lead Pediatricians
- Lead Pediatricians submit signed attestation forms to AAP

Wrap-up
- Team members participate in post-project surveys/interviews
Questions?

Please contact:
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References


