Childhood Obesity in Primary Care
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 competence, 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.

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**Activity Title:** Childhood Obesity in Primary Care Module 2: Building a System to Improve Primary Care  
**Activity Location:** Online/Enduring Material  
**Activity Date:** November 1, 2015 – November 1, 2018

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<td>Victoria Rogers, MD, FAAAP</td>
<td>Faculty</td>
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<tr>
<td>Jeanne Lindros, MPH</td>
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<tr>
<td>Corrie Pierce</td>
<td>Disclosure Admin</td>
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<td>Do not intend to discuss</td>
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* 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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**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 in a subsequent manner 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.
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<td>AAP Reviewer</td>
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<tr>
<td>Zoe Gooe, MD</td>
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<tr>
<td>Ivor Hill, MD</td>
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<td>Robert Wiebe, MD</td>
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<tr>
<td>Rickey Williams, MD</td>
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<tr>
<td>D. Corey Lachman, MD</td>
<td>AAP Reviewer</td>
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<td>None</td>
<td>Do not intend to discuss</td>
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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.
Enduring Material

List of hardware/software requirements
Our Technical Support team would like to ensure that you have a great experience with our streaming media services. Due to variations in PC and network security configurations, we recommend that you test the ability to receive streaming media before the day of this event on the computer you will be using to view the event. To do this, click the "Test Your Computer Now" button below. You will hear a short announcement and see slide information.

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.

System requirements
The system requirements for viewing a streaming media event are:

Windows
• Windows XP, Windows 2003 or Windows Vista
• Display resolution of 800x600 pixels or greater
• Microsoft Internet Explorer 6.0 SP1 or later, Firefox 2.0 or later, or Google Chrome 1.0
• For Firefox and Chrome, Silverlight 1.0 or later
• Windows Media Player 9.0 or later
• Broadband Internet connection (256 Kbps & above)
• No network blocks or filters that disable streaming media

Mac
• Mac OS X 10.4.8 or later
• Safari 2.0.4 or later (or Firefox 2.0 or later)
• Silverlight 1.0
• Broadband Internet connection (256 Kbps & above)
• No network blocks or filters that disable streaming media

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If you need further assistance, please call KRM Customer Service Monday–Friday at 800.775.7654 or 715.833.5426 between 7:00 am and 5:00 pm CT, or email us at support@krm.com.

Provider Contact Information
If you have questions about this course or encounter technical problems, please contact Nikki Berry at nberry@aap.org

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
Disclosure Statement

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

Business Operations - Finance

Health Care Equity

Access

Professionalism

Patient Safety
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
- 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

- 60% average adherence level to ECR in sample of 211 Midwestern pediatricians and family physicians
- 88% of children 10-18 years of age with overweight or obesity in MA primary care sample (n>3400) did not have any recommended labs ordered

9 Harkins, et al., 2012; 10 Sharifi, et al., 2013
Quality Gap in Obesity Prevention and Treatment

- 76% of general pediatricians calculate BMI at every well child visit; 69% plot BMI on a growth curve
- 26% of graduating pediatric residents consider their counseling on obesity prevention to be very effective

6 Klein, et al., 2011; 7 AAP, 2010; 8 Frintner, et al., 2014
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

\(^{11}\) Langley, et al., 2009; \(^{12}\) Institute for Healthcare Improvement (IHI), 2015
Model for Improvement

Three questions

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?

One process

ACT

PLAN

STUDY

DO
A Good Aim Statement is SMART

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

What? For whom? By when? How much?
Example Aim Statements

Between October 2013 and March 2014, 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, 2015
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)

Cycle
- Cycle 1
- Cycle 2
- Cycle 3
- Cycle 4
- Cycle 5
- Cycle 6
- Cycle 7

Percent
- 0.0
- 10.0
- 20.0
- 30.0
- 40.0
- 50.0
- 60.0
- 70.0
- 80.0
- 90.0
- 100.0

Goal
Group
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
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
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.
Key Driver Diagram

Specific Aim(s)

Between October 2013 and March 2014, 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

Global Aims

Specific Aim(s)

Key Drivers

Interventions
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
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

ACT

STUDY

DO
Medical Summary/Care Plan Reviewed With & Offered to Patient

**Clinical Support Staff**
- Review scheduled well-child visit charts

**Pediatrician**
- Review existing medical summary/care plan
- Conduct exam

**Patient/Family**
- Discuss medical summary/care plan with patient
- Provide feedback and share concerns

**Front Office Staff**
- Update medical summary/care plan
- Load updated medical summary/care plan into patient portal

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**Before Appointment**

**During Appointment**

**After Appointment**

Childhood Obesity in Primary Care
PDSA Cycle

Plan
- Carry out the plan
- Document what happens
- Begin data analysis
**QI Teams: Common roles**

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

STUDY
Complete data analysis
Compare to predictions
Summarize what was learned

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

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

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:
• Asses 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

**Key Drivers**

**Interventions**

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

- 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 as part of the QI project
- Implement the project’s interventions
- Collect, submit, and review data
  - Every pediatrician participating for MOC credit must have a minimum of 5 charts included in each data cycle.
- Complete and pass four required CME modules
- 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
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<th>January</th>
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<td>New Childhood Obesity Algorithm</td>
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Prior to the collaborative

Lead Clinician
- Submits 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 end of Month 1
- Are strongly encouraged to complete 3\textsuperscript{rd} 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 Collections 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

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**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.

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1. Was the patient < 24 months of age on the date of the visit?
   - Yes (If Yes, continue to #2)
   - No [If No, skip to #3]

2. Is there documentation that weight-for-length percentile was assessed?
   - Yes (No additional data will be collected for this patient.)
   - No (No additional data will be collected for this patient.)

3. Is there documentation that a family history was conducted related to obesity, type 2 diabetes, and cardiovascular disease?
   - Yes
   - No
Medical Record Data can be entered by chart or in aggregate.

PDFs of forms can be downloaded.

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**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.

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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

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*Childhood Obesity in Primary Care*
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
- Pediatricians must have completed first 2 CME modules

Weeks 5-8
- Teams test changes

Week 6
- Teams participate in Webinar #2

Week 9
- Teams submit cycle 2 data

Week 10
- Data reports from QIDA are generated for practices
Action Period #2: Weeks 11 - 16

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 Webinar #3

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 Webinar #4
- Team members **must** have completed all 4 required CME modules
- 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


6. Klein JD, Cull WL, O'Connor KG, Hassink SG. Trends in BMI Screening in Pediatric Primary Care. Pediatric Academic Societies annual conference; 2011; Denver, CO.


