Many thanks are due to our 11 Round 1 and 23 Round 2 practices for their tireless work to improve obesity-related risk assessment at well-child visits. Clinical data were submitted at 3 time points (T1, T2, and T3) during both rounds, most providers tried new tools related to assessing behavioral and medical risks, as well as the comprehensiveness of care algorithms.

**Objective:** To examine the feasibility and effectiveness of COPC, a brief, all-virtual, team-based QI collaborative to improve obesity-related risk assessment at well-child visits.

**Design and Methods**

**COPC Project Design**
- A 19-week, virtual collaborative was piloted in January-May, 2016 and repeated in January-May, 2017.
- All teams included 4 roles: Lead Clinician, Clinical Staff, Office Manager, and Front Office Staff.
- All practices provided additional staff as desired.
- Inclusion criteria: At least 90% of the visits were conducted by the practice in the community for children ages 1-18 years.
- In the second round, additional team members included CME Facilitators, coaches, and facilitators.
- The virtual collaborative began with an initial pilot phase, followed by a 17-week intervention.
- During both rounds, the majority of users rated all resources as both easy to use and valuable.

**Participation**
- Round 1 included 11 teams, 35 providers, and 37 staff.
- Round 2 included 23 teams, 110 providers, and 64 staff.
- Teams were diverse with respect to geographic location, urban/suburban/rural location, size/type of practice, and medical home status (i.e., NCQA PCMH recognition).

**Key Data Sources**
- Clinical data were submitted at 3 time points (T1, T2, and T3) during both rounds (n=98; 88; 95) (for MOC).
- All available risk assessment measures were compared during both rounds (T1, T2, and T3).

**Analysis**
- Overall clinical measures were constructed by aggregating results across all submitted charts. Fisher’s exact test was used to compare clinical measures at baseline (T1) with values at T2 and T3. Hypotheses were one-sided improvements (improvement with significance set at p < .025 due to 2 comparisons).
- Post survey results are presented as descriptive statistics and common themes (if open ended).

**Key Driver Diagram**

**Background & Objective**
- A gap remains between the primary care provided to pediatric patients and present standards for obesity prevention and treatment. Systems-level quality improvement (QI) processes are likely needed.
- However, because relevant QI projects are often time- and resource-intensive or focused on the level of individual providers, a novel approach appears needed.
- Childhood Obesity in Primary Care (COPC) was designed to facilitate the conduct of comprehensive obesity-related risk assessment during well-child visits, including growth, behavioral, and medical risks, while enhancing the feasibility of practice team participation.
- Objective: To examine the feasibility and effectiveness of COPC, a brief, all-virtual, team-based QI collaborative to improve obesity-related risk assessment at well-child visits.

**Table 1: Provider Resource Use During COPC**

<table>
<thead>
<tr>
<th>Resource Type</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Assistance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>T1</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>T2</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>T3</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Most Common Task/Resource</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Risk Tools</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Behavioral Risk Tools</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Follow-up Tests</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Family History</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Changes in Aggregate Clinical Measures**

- During both rounds, most providers tried new tools related to assessing behavioral and medical risks, as well as the comprehensiveness of care algorithms.
- Users rated resources from "extremely difficult to use" to "extremely easy" and perceived value from "not at all to extremely valuable," with further validated scales for each.
- During both rounds, the majority of users rated all resources as both easy to use and valuable.

**Sustainability Assessment**

**Summary**
- The support the feasibility and effectiveness of participation in a brief, virtual QI collaborative to facilitate the implementation of a comprehensive obesity-related risk assessment during well-child visits.
- Findings were generally consistent across rounds and supported by both clinical and survey data.
- Improvements occurred for growth and behavioral risk assessments but were particularly apparent for medical risk assessments, specific to children with overweight or obesity.
- A team approach to brief QI projects is feasible and may enhance performance.
- Improvements occurred without apparent disruption to other aspects of practice.

**Next Steps**
- Willing Round 2 teams will submit clinical data in October 2017, to assess sustainability.
- Round 3 of COPC is scheduled to begin in January 2018.

**Conclusions**

**Acknowledgements**

- Many thanks are due to our 11 Round 1 and 23 Round 2 practices for their tireless work to improve pediatric care during and after the project and their assistance with evaluation efforts.
- Funding for this project was provided by the American Academy of Pediatrics Institute for Healthy Childhood Weight, made possible by its founding sponsor, Nestle.