The Maine Youth Overweight Collaborative

Final Report

July, 2006

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Maine Harvard Prevention Research Center
Maine Center for Public Health
Maine Chapter of the American Academy of Pediatrics

With Funding From the ***Maine Health Access Foundation***

Practice Sites	
Ambulatory Care Center – The Barbara Bush Children's Hospital at Maine Medical Center	Portland
Bridgton Pediatrics	Bridgton
Central Maine Medical Center Family Practice Residency Clinic	Lewiston
Dover-Foxcroft Family Medicine	Dover-Foxcroft
Kennebec Pediatrics	Augusta
Maine Coast Pediatrics	Ellsworth
Martins Point Brunswick Pediatrics	Brunswick
Norumbega Pediatrics	Bangor
PrimeCare Pediatrics	Kennebunk
Waterville Pediatrics	Waterville
Western Maine Pediatrics	Norway
Winthrop Family Pediatrics Center	Winthrop

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Executive Summary

Need

The epidemic increases in overweight among children, adolescents and adults in the United States demands that intervention strategies to counter these trends be broad-based, including multiple sectors of society. The health care setting, where providers already see almost all children and youth in the United States may be opportune for creating awareness and motivating change to reduce overweight risk. Although there is limited evidence for effective clinical interventions to prevent overweight in children, or to improve diet, physical activity levels or to reduce television viewing in primary care settings, successful Collaborative models have been developed for asthma and diabetes. Based on the overwhelming need to address the challenge of youth overweight, and the success of the Collaborative model, we apply this model to the problem of youth overweight in Maine.

The Intervention

In partnership with the Maine Harvard Prevention Research Center (MHPRC), the Maine Center for Public Health (MCPH) established the *Maine Youth Overweight Collaborative* (MYOC) in collaboration with the Maine Chapter of the American Academy of Pediatrics to improve care and outcomes for youth who are at risk for overweight (85-94th percentile for age and gender) and those already overweight (>= 95th percentile for age and gender) [6]. The project was funded by a two-year grant from the Maine Health Access Foundation. The Collaborative focused on improving systems in primary care practices to assess the problem of youth overweight; improving control of key behavioral and clinical risk factors; and improving use of self-management support strategies by clinician teams and patients. We recruited 12 practices throughout Maine and followed the Care Model and Institute for Healthcare Improvement Breakthrough Collaborative frameworks to implement MYOC.

Evaluation Methodology

We designed and implemented an evaluation process to measure implementation of the framework and MYOC outcomes. We developed process and outcome data collection instruments to measure implementation success; as well as provider, practice team, patient, and office system outcomes. Provider and parent caretaker surveys were completed both pre and post intervention. Charts were also reviewed pre and post intervention as well as throughout MYOC. In addition, process data was collected throughout implementation in order to improve MYOC staff support to practice teams.

Impact

Data demonstrate MYOC strategies were successful in attaining many desired initial and intermediate outcomes as well as improving clinical practice and office systems. We also learned how to make MYOC implementation a success through extensive data collection on satisfaction with specific activities. Some of the largest improvements were seen in the areas of goal setting, brief focused negotiation, and tracking BMI percentile for age and gender. *Provider surveys* demonstrated improved knowledge of weight classification categories and of how to address lifestyle issues with their patients. From baseline to post-test:

- 43% and 71% knew the correct BMI percentile range for *ideal* weight ;
- 64% and 94% knew the correct BMI percentile range for *at risk for overweight*;;
- 93% and 100% knew the correct BMI percentile range for *overweight*

Providers' efficacy and practice addressing lifestyle issues also improved. Results indicate that at post-test providers were doing the most lifestyle-related work with their patients at highest risk. The following results indicate the number of providers who strongly agreed with a statement indicating they were comfortable (from baseline to post-test respectively):

- 14% and 76%; addressing weight with all patients;
- 7% and 76%; addressing nutrition;
- 21% and 82%; addressing physical activity;
- 29% and 82%; addressing screen time;
- 29% and 82%; addressing sugar-sweetened beverages;
- 7% and 59%; doing behavioral goal setting;
- 7% and 53%; doing brief focused negotiation.

Measures of provider behaviors also showed large shifts from pretest to post-test as follow. Providers strongly agreed with statements they were currently:

- 21% and 71%; tracking BMI for age and gender annually on all patients;
- 21% and 76%; tracking BMI for age and gender annually on overweight patients;
- 14% and 59%; treating based on weight classification;
- 21% and 41%; medically evaluating based on weight classification;
- 7% and 35%; doing behavioral goal-setting with overweight patients;
- 0% and 29%; using brief focused negotiation.

From *parent caretaker surveys*, we learned that as compared to baseline, families heard substantially more messages about nutrition, television or screen time, physical activity and sugar-sweetened beverages at post-test.

Lifestyle factor	Baseline-all patients (N=346)	Post-overweight patients only (N=40)	Post-all patients (N=386)
Nutrition	73%	100%	90%
Television or Screen Time	58%	88%	78%
Physical Activity or Exercise	77%	100%	87%
Sugar-Sweetened Drinks	54%	93%	80%

Overweight patients and families heard even more messages than the overall patient population. Families reported setting goals with their providers and making changes. *Chart reviews* revealed the greatest office system improvements were for tracking BMI, BMI percentile for age and gender, and weight classification. Teams also made substantial progress in working as a team and clarifying roles; tracking; patient classification, and; providing patients with 5210 educational messages.

	Baseline	Post-Test
BMI	40%	94%
BMI percentile for age/gender	28%	89%
Weight Classification	22%	74%
5210 Patient Survey	0%	82%

Every team made connections with a community coalition. Clearly, significant work was accomplished through practice/community partnerships during MYOC. Teams reported high levels of satisfaction, overall, with collaborative implementation.

Our results also demonstrate room for improvement. Recommendations for a future collaborative effort could include continuation and reinforcement of previous efforts as well as:

- Improving identification of community resources and patient services (e.g. nutrition and psychological)
- Increased efforts to train providers in motivational interviewing and goal setting
- Providing more technical assistance with patient registries
- Clarifying recommendations and expectations around attaining patient labs
- Providing improved support for patient follow-up
- Providing more patient education materials
- Improving involvement from senior leaders in practice organizations
- Working with payers around reimbursement
- Improving support for connecting with communities and helping to define practice community partnership work

Introduction

Need

The prevalence of childhood risk for overweight and overweight is increasing at an alarming rate in the United States. Prevalence of overweight among children and adolescents has doubled in the past two decades. Currently, 16.3% of 6- to 11-year-olds and 15.5% of 12- to 19-year-olds are at or above the 95th percentile for Body Mass Index (BMI)[1], with even higher rates among subpopulations of minority and economically disadvantaged children[2,3,4]. Overweight is associated with significant health problems in the pediatric age group and is an important early risk factor for much of adult morbidity and mortality.

The epidemic increases in overweight among children, adolescents and adults in the United States demands that intervention strategies to counter these trends be broad-based, including multiple sectors of society [7, 8,9,10]. One important focus for intervention is the health care setting, where providers already see almost all children and youth in the United States. This setting may be opportune for creating awareness and motivating change to reduce overweight risk [9].

Current gaps in both care and provider attitudes highlight the opportunities that exist in this area. Providers are not widely measuring BMI for kids, are not delivering preventive healthy weight messages, or providing appropriate medical evaluation for overweight. There is also a documented lack of provider confidence or self-efficacy for addressing BMI in children, and addressing lifestyle issues with kids and their families[11,12,13,14,15].

Unfortunately, there is very limited evidence for effective clinical interventions to prevent overweight in children, or to improve diet, physical activity levels or to reduce television viewing in primary care settings[16, 8]. The Guide to Clinical Preventive Services notes no trials with children and adolescents in primary care settings of intensive counseling on diet or to promote physical activity [17].

Basis for Intervention

Successful Collaborative models have been developed for asthma, diabetes and other chronic diseases [22,23,24,25]. Based on the overwhelming need to address the challenge of youth overweight, and the success of the Collaborative model, we apply this model to the problem of youth overweight in Maine. We use the American Academy of Pediatrics Policy Statement for Prevention of Pediatric Overweight and Obesity[6] as a guide for our Collaborative framework. We also utilize the expertise gained from research conducted by the Harvard Prevention Research Center (HPRC), the National Initiative for Children's Healthcare Quality (NICHQ), the Centers for Disease Control and Prevention (CDC), and others documenting effective strategies to reduce obesity among youth in the development of our Collaborative [26].

In developing our interventions, we followed the approach of Rollnick et al in adapting elements of motivational interviewing for brief interventions [18,19] to promote health behavior change that considers the time constraints of busy primary care settings[18]. Materials were developed or adopted to enhance maintenance of behavior change, using learning theory[20]. Evidence from randomized trials are lacking to support any particular

strategy over others to prevent or treat the development of overweight among children and youth[21,29]. However, some have advocated for primary care providers to talk with families about a few specific behaviors (e.g. television viewing reduction, encouraging outdoor play, limiting consumption of sugar-sweetened beverages, and encouraging breastfeeding)[30]. Several strategies were found useful in the management of overweight patients in primary care settings, and have potential for the prevention of overweight as well. These include the routine assessment of BMI and communication strategies that avoid blame and encourage concern and interest in change on the part of overweight patients and their families. Strategies identified include control of the environment, monitoring behavior, goal setting, rewarding successful behavior change, problem solving and parenting skills[21].

Overview of the Maine Youth Overweight Collaborative (MYOC)

In partnership with the Maine Harvard Prevention Research Center (MHPRC), the Maine Center for Public Health (MCPH) established the *Maine Youth Overweight Collaborative* (MYOC) in collaboration with the Maine Chapter of the American Academy of Pediatrics to improve care and outcomes for youth who are at risk for overweight (85-94th percentile for age and gender) and those already overweight (>= 95th percentile for age and gender)[6]. The project was funded by a two-year grant from the Maine Health Access Foundation.

MYOC focused on improving systems in primary care practices to assess the problem of youth overweight; improving control of key behavioral and clinical risk factors; and improving use of self-management support strategies by clinician teams and patients. Our model worked to improve healthcare through the application of evidence based interventions, tailored to individuals, utilizing community, family and other system resources to accomplish health outcomes. With its emphasis on system change, MYOC can serve as a model for all disease prevention and treatment, where healthcare systems foster improved outcomes for populations, eliminating disparities and improving health for all.

Our model specifically offers support to provider teams within primary care practices throughout Maine to improve prevention and treatment of youth overweight. Using the "Breakthrough Series Collaborative" model developed by the Institute for Healthcare Improvement (IHI), we brought together clinical experts, primary care practices, and community partners to develop local expertise and shared goals among clinical practice teams in order to improve patient management and decrease youth overweight in Maine.

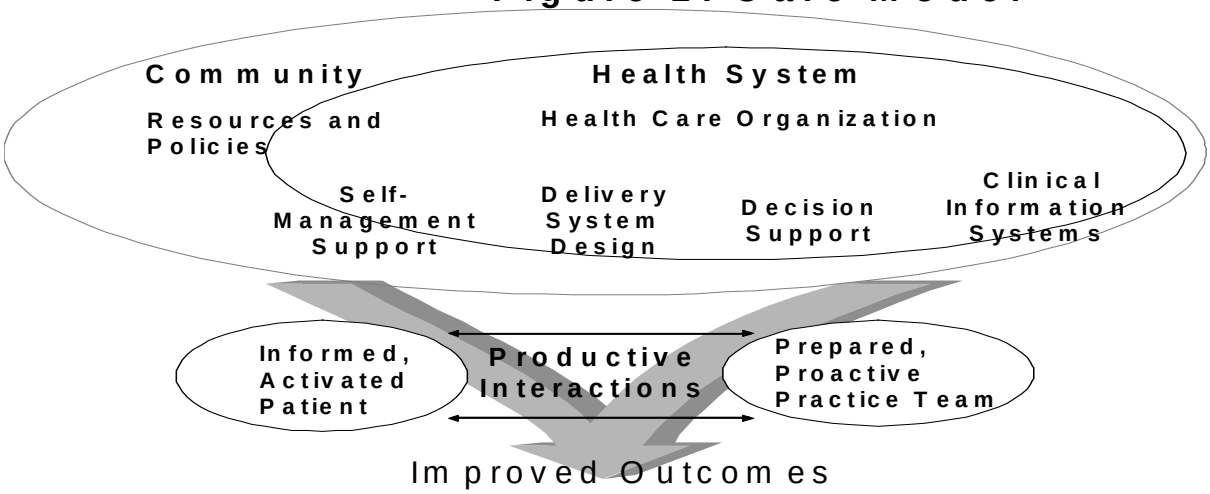
Given that some have advocated for primary care providers to talk with families about a few specific behaviors, MYOC adopted, as a framework for intervention, four key messages consisting of encouraging five (5) or more servings of fruits and vegetables on most days; limiting screen time to two (2) hours or less daily; participating in at least one (1) hour or more of physical activity daily, and; avoiding (0) sugar-sweetened beverages, limiting fruit juice to one-half cup or less per day and encouraging water and 3-4 servings of fat free milk daily. This framework came to be known as "5-2-1-0" on which the patient assessment as well as other patient materials, such as posters, were built.

The 12 practice teams participating in MYOC represent a geographically diverse group and emphasize care for the underserved. Interested practices were self-selected and completed an application form which was used to facilitate decision-making for which practice teams would ultimately comprise the Collaborative. Every practice applying to enroll in MYOC was able to participate. In the end, practice sites included one pediatric residency program; one family practice residency program; nine primary care pediatric practices, and; one family practice.

A steering committee was formed early in the MYOC planning process and met seven times (once before MYOC started and quarterly thereafter) throughout MYOC implementation. Steering committee members represented providers; provider organizations; specialists and other clinical experts; community organizations; payers; academic partners; Maine state organizations such as the Maine Center for Disease Control; and the National Initiative of Children's Health care Quality. The steering committee convened an expert panel to review existing literature and protocols and to develop state of the art protocols where none existed. Provider tools, including the flip chart (see Appendix B) were thus developed. The steering committee also worked on MYOC goals and strategies to attain them. All MYOC work was guided by the steering committee.

The *specific* changes in office practice being promoted by the Collaborative are based on the framework of the Care Model (CM) [22,27,28] depicted below in Figure 1.

Figure 1: Care Model



The six key changes that practices were asked to put into place were:

1) *Health care system support*, or the promotion of leadership on youth overweight among healthcare system leaders, including public and private payers. Participating practice teams were asked to include senior leaders at learning sessions and at the final celebration. They were also asked to keep senior leaders within their respective organizations informed about MYOC activities and progress towards MYOC goals.

2) *Self-management support*, or educating families and patients about the risks and complications of youth overweight, and providing compassionate support for behavior change that promotes healthy lifestyles. Practice teams were encouraged and supported (through learning sessions, bimonthly calls, other communications and tools provided such as the flip-chart) to routinely deliver "5210" healthy lifestyle messages to patients on annual preventive care visits; to assess patient readiness to change and self-efficacy for making change; to promote self-management skills with patients; and to assist patients with setting self-management goals for behavior change.

3) *Healthcare system redesign*, or identifying the care team in the practice, and clarifying roles for each team member. Care teams consisted of at least three persons from each practice and were required to include a physician, a nurse or PA and other administrative or staff person. The concept of the team approach is central to the Care model and is an important premise underlying MYOC office changes. Team members were asked to make joint decisions about patient tracking, assessment, education and follow-up. Decisions about how to carry out these activities are unique in each practice site and are therefore tailored to the needs, context and skills of each of the individual teams. Prior to the first learning session, practice teams were asked to identify and clarify roles and expectations for each practice team member. Teams were also asked to set up a regular meeting schedule to assess team functioning and to plan improvements. Teams were asked to provide care for overweight patients using planned care follow-up visits, and were asked to use alternative models of care to support overweight patients (e.g. telephone follow-up or group visits).

4) *Clinical decision support*, or assessing BMI% for age and gender on all children 5-18 years old annually, and following recommendations for medical assessment of overweight patients. Participating provider teams were provided with tools such as a "5210" healthy lifestyle assessment, and a provider flip chart with guidelines for the medical assessment of overweight, and other resources in order to support measurement and tracking of BMI percentile for age and gender on all children at the annual well-child visit; appropriate patient classification into weight categories at the annual visit; appropriate medical assessment of overweight patients; routine incorporation of specialty expertise into care; and regular follow-up care for overweight patients.

5) *Clinical Information Systems*, or using a registry to track outcomes and improve care. Practice teams were provided an Excel or Access-based population registry developed by MYOC and NICHQ, respectively, to identify and track overweight patients. If practices had an electronic medical record system, they were provided technical support in order to develop a registry; track key clinical metrics for overweight patients (e.g. BMI, BP, goal setting, follow-up); and identify patients who would benefit from proactive care (e.g. patients who have not been seen in >6 months or needing referral to a specialist).

6) *Community*, or partner with one or more community organizations that have the potential to impact healthy lifestyles for children. As part of this community outreach, practices were encouraged to reach out to form alliances and partnerships with state programs, local agencies, schools, faith organizations, businesses and others, in order to inform and support individuals and their treatment plans. Because of the importance of

linking clinical teams with community partners, the Maine Youth Overweight Collaborative has actively partnered with Healthy Maine Partnership sites in the areas appropriate to the chosen practice teams. Healthy Maine Partnerships have been established to improve physical activity, nutrition and decrease tobacco use in 31 Maine communities. These partnerships are themselves comprised of individuals, organizations, service providers and practitioners working together to reduce the burden of chronic diseases in local communities. These partnerships are therefore ideally suited to partner with local practice teams to achieve their common outcomes. Practice teams were asked to link with their local Healthy Maine Partnership sites in order to familiarize themselves with local community resources that promote physical activity and good nutrition for patient referrals; and to create links with local schools (e.g. school nurse, coordinated school health program, PTO, school board) in order to address issues of physical activity and healthy eating in schools.

Methods

Study design

Setting and Intervention

Twelve practices participated in a learning collaborative project for 18 months. The 12 participating practice teams represented a diverse group widely dispersed throughout Maine. Practices include one pediatric residency program, one family practice residency program, nine primary care pediatric practices and one family practice. A relatively high percentage of Medicaid and underinsured patients are represented in Maine's population and the 12 MYOC practice sites (overall, approximately 58% of Maine children are eligible for MaineCare and approximately 10% are under or uninsured: Maine Kids Count Data Book, 2006). Table 1 depicts each MYOC practice with its respective number of providers and patients.

Table 1: MYOC Practice Team Characteristics

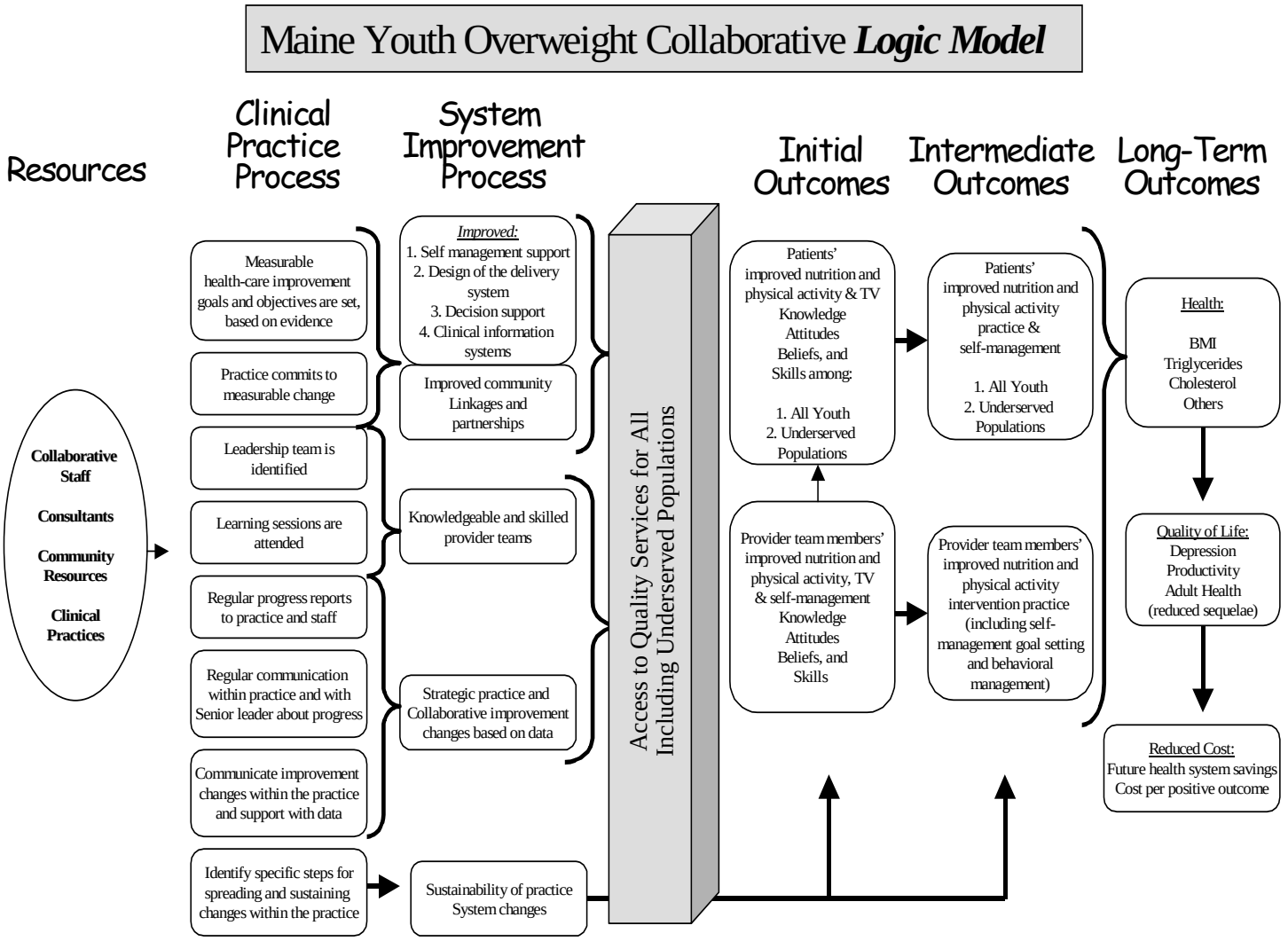
Practice	Number of providers in practice	Total Number of Pediatric Patients in Practice
1	4	10,000
2	16	5200
3	3	3,000
4	7	8,200
5	6	6,000
6	3	3,500
7	23	18,000
8	3	4,100
9	7	7,000
10	8	11,000
11	5	4,100
12	3	6,000

Each site was requested to send a three-member multidisciplinary team (composed of a provider leader/champion, another medical staff person and an administrator) to three 1.5 day learning sessions during the course of MYOC. In November 2004, participating practices were asked to collect baseline data to identify performance gaps (the difference between current and desired performance) in their practice. At the first learning session in November, 2004, teams were taught a comprehensive method to proactively care for patients with overweight using the care model and concepts of quality improvement including the Model for Improvement (a specific approach to quality improvement that emphasizes the use of small, incremental tests of change). They were provided materials and information based on the guidelines developed from a childhood overweight expert panel (convened June 2004) and tools to support clinical decision making and behavior modification (e.g. MYOC Flip Chart-in Appendix B)

During the next 18 months, coaching and support was provided through two additional learning sessions; bimonthly conference calls used to bolster best practice around

medical evaluation and follow-up and to engage practice teams in discussion; site visits; an active email list providing the latest news and literature on relevant topics to practice teams; and periodic performance feedback based on expert faculty review of bimonthly project team reports. The first two learning sessions focused extensively on brief focused negotiation and patient goal setting while the third provided extensive information on shared medical appointments and group visits.

The logic model in Figure 2 depicts the expected process and outcomes for the MYOC.



Data collection, Measures, and Data Management

(See Appendix A for data collection instruments)

The following table summarizes the data collection instruments and type of data collected to evaluate MYOC process and outcomes.

Table 2: Overview of Data Collection Sources with Data Elements

Data Source	Data elements
Initial and Intermediate Outcomes	
Provider Survey Baseline: *November, 2004* Post-test: *March, 2006*	Knowledge of BMI classification percentiles
	Knowledge of how to address lifestyle with patients
	Beliefs about the importance of tracking BMI and addressing weight and lifestyle with patients
	Perceived Efficacy to address weight and lifestyle with patients
	Current practice regarding BMI tracking and addressing weight and lifestyle
	Knowledge of and practices regarding community resources
Parent/Caretaker Survey Baseline: *December, 2004* Post-test: *March 2006*	Awareness of messages from provider about nutrition
	Awareness of messages from provider about physical activity
	Awareness of messages from provider about television or screen time
	Awareness of messages from provider about sugar sweetened drinks
	Perceived helpfulness of message(s)
Clinical Practice and System Improvement Process	
Chart Review Data Baseline: most recent well-child visit *prior to* MYOC (Jan 2005) Post-test: 70 most recent well-child visits as of March 2006	Patient nutrition/physical activity assessment
	BMI measurement and classification
	Blood Pressure
	Diagnosis of overweight
	Labs
	Physician advice/goal setting
	Follow-up for overweight
	Referral
Practice Team Implementation Survey *May, 2005*	Team member role
	Awareness of toolkit and resources provided
	Use of toolkit and resources provided
	Satisfaction with toolkit and resources provided
	Improvement suggestions
Practice Team Bimonthly Summary Report *Bimonthly, throughout MYOC*	BMI %'ile for age and gender measurement
	Weight Classification
	5210 assessment and messaging
	Blood Pressure performed
	Goal setting
	Follow-up appointments made for overweight
Practice Team Experience Highlights *May, 2005 and Sept 2006*	Anecdotal experiences, successes, challenges and lesson learned
Post-Test Practice Team Survey	Impact of participation in the collaborative
	Team plans after the collaborative

Data Source	Data elements
April, 2006	Support after the collaborative
	Satisfaction with the collaborative
	Next steps
Post-Test Provider "scripts" telephone Interviews *April, 2006*	Process of using Brief Focused Negotiation (BFN)
	How encounter is opened using BFN
	When use BFN
	Comfort using BFN
	Perceived success using BFN
	Words used when using BFN
	Words used to keep conversation going
	Words used when barriers encountered
	Words that don't work
	Language used to talk about BMI
	Language used re weight
	Language used with sub-populations
	Difficult behaviors to address using BFN
Healthy Maine Partnership Director Interviews *March, 2006*	Contact with local MYOC practice
	Plans and accomplishments with MYOC practice
	Barriers and Needs for improvement
	Key lessons learned
MYOC Learning Session Evaluations *Nov, 2004; May 2005; Sept 2006.*	Satisfaction with Learning Session Presentations
	Overall satisfaction with the experience
	Attainment of specific learning objectives
	Satisfaction with the facility
Resources	
Steering Committee Evaluation	Satisfaction with the steering committee process

The following section of the report describes each data collection instrument and the type of data it collected.

Initial and Intermediate outcomes

Provider Survey

A paper and pencil provider survey, consisting of 40 items, was developed to measure providers' knowledge, attitudes and practices around key collaborative change objectives, including measurement and tracking of height, weight, and BMI calculation and classification, behavioral goal setting, motivational interviewing, and working with local community organizations to support patients. Survey respondents were asked how strongly they agreed or disagreed with a particular statement on a Likert-type scale from 1-5. We attempted to attain a census of MYOC providers to complete the provider survey. At pretest, providers were asked to complete the provider survey before learning Session #1 in November, 2004. Teams were given the learning session materials only after team providers completed and returned a survey.

In early March, 2006, MYOC providers were asked to complete a post-test provider survey including additional questions exploring providers' experiences with specific aspects of the collaborative such as trainings, administering the 5210 survey, keeping a registry, doing labs, positive effects of the collaborative, as well as providers' greatest challenges.

Parent/ Caretaker Survey

A parent/Caretaker survey was developed, consisting of five items to assess parents' awareness of *ever* having heard lifestyle messages (around 5-2-1-0) from their child's provider or nurse in the office, and the perceived helpfulness of those messages. At pretest, these items were:

- Has a doctor, nurse, or anyone else in this office, ever talked to you about nutrition? (Yes/No)
- Has a doctor, nurse, or anyone else in this office, ever talked to you about physical activity or exercise? (Yes/No)
- Has a doctor, nurse, or anyone else in this office, ever talked to you about television viewing or other screen time? (Yes/No)
- Has a doctor, nurse, or anyone else in this office, ever talked to you about sugar-sweetened drinks? (Yes/No)
- If you heard advice on any of the above, was it helpful? (Yes/No/I did not hear advice on any of the above)

In early October, 2004, MYOC practices were mailed the parent caretaker survey forms with a return envelope and a protocol to have the parents/caretakers of children in for well-child visits to be given the surveys, while in the waiting area, as part of their pre-visit paperwork. Practices were asked to obtain 50 by the end of November. The surveys were distributed to the first 50 parents/caretakers of well-child patients. Practices were also asked to keep a tally of non-responders by including any incomplete surveys in the return envelope. One family practice site, because of the lower numbers of well-child visits seen over any period of time, used both acute visit and well-child visits as prompts for survey administration. Surveys were marked as to whether they were acute or well-child.

At post-test, additional questions were added to the parent caretaker survey. Added were questions about their child's last well-child visit. More specifically, these questions included goals setting and attainment, as well as perceived quality of the advice they received around the 5-2-1-0 messages. Practices were mailed the surveys in mid-February and were asked to mail back completed surveys by the end of March. At post-test, practices were asked to obtain surveys from the next 70 parent caretakers coming in to the practice for well-child and other acute visits. We requested a larger number of surveys at post-test because of our desire to analyze the parent caretaker information for patients who were told they were overweight, separately, requiring a larger sample size given the relatively few expected number of overweight patients in the sample. We also included a question which asked when their last well-child visit was so we could exclude those visits that occurred prior to MYOC.

Clinical Practice and System Improvement Process

Chart Reviews

Baseline chart reviews were conducted by each practice team in November, 2004. Practice teams were asked to review the last 30-50 well-child visit charts, including at least 10 charts per provider with the exception of practices with more then 5 providers where less than 10 charts per provider were reviewed. These reviews included assessment of BMI calculation; weight classification; blood pressure; diagnosis of overweight; appropriate medical evaluation; any goal setting; and follow-up. Only aggregate data were reported.

At post-test, we asked practices to review charts from the last 70 well-child visits completed for patients aged 5 to 18 including at least 10 charts per provider, or less than 10 spread equally among a number of providers equaling less than 7. At post-test, two reviews were completed per patient. The first review was for the last well-child visit and the second review was for the last visit PRIOR to January 2005---when MYOC practice-based interventions began. This effectively allowed us to sample the same population for pretest and post-test.

Practice Team Implementations Survey

We developed a Practice Team Implementation Survey, consisting of 15 items, to assess the practice process around BMI calculation and classification; patient assessment; behavioral goal setting; and follow-up. We also obtained information on practice teams' awareness of resources provided by project staff, as well as practice team use and satisfaction of resources and tools. Practice Team Surveys were mailed to practice teams in April of 2005 and were distributed to practice teams again in September 2005 at Learning Session #3, several months after a revised toolkit was distributed to practice teams.

Practice Team Bimonthly Summary Reports

Practice teams were asked to report progress on six required basic measures. This was done on a bimonthly basis until May 2005 and at learning sessions thereafter. The six basic measures were:

- BMI % for age measurement: percent of patients seen for an annual preventive care visit who have had BMI% for age and gender documented
- Weight Classification: Percent of patients seen for an annual preventive care visit whose BMI is appropriately classified by weight category (e.g. underweight, healthy weight, at risk for overweight and overweight)
- 5-2-1-0: Percent of patients seen for annual preventive care visit who receives 5-2-1-0 (Healthy Weight) messages (e.g. received 5-2-1-0 survey)
- BP: Percent of overweight patients with Blood Pressure performed
- Goal Setting: Percent of overweight patients with self-management goal established
- Follow-up appointment: Percent of overweight patients with a follow-up appointment for overweight scheduled.

Practice teams performed chart reviews to ascertain % compliance with the measures. Results were reported to and compiled by MYOC staff.

Practice Team Experience Highlights from Learning Sessions 2 and 3

Practice Teams were asked to share experiences related to the implementation of MYOC and talk about some of their successes and lessons learned. These shared experiences were recorded and summarized, in a qualitative fashion.

Post-Test Practice Team Survey

An online practice team survey was developed and posted on the Survey Monkey website to assess the impact of participation in MYOC on the practice team. The survey consisted of 16 questions consisting of mostly Likert-type response questions. We used a survey from a MaineHealth Diabetes Collaborative and adapted the question to fit MYOC process and goals. The survey queried respondents on their perceived impact of participation; team plans after the collaborative; support needed after the collaborative to sustain changes; satisfaction with the collaborative; and possible next steps.

Post-Test Provider "Scripts" Telephone Interviews

A semi-structured telephone interview was developed to learn about the process of using Brief Focused Negotiation (BFN) in the practice setting. Providers were asked questions pertaining to the process of using BFN; opening the encounter using BFN; comfort using BFN; perceived success using BFN; what made it successful: words to use to engage patients; words that don't work; and language used when discussing weight and/or BMI.

Healthy Maine Partnership Director Telephone Interviews

A semi-structured telephone interview guide was developed to interview the Healthy Maine Partnership directors with MYOC practices in their catchment areas. The twelve survey questions included:

- When did you make contact with your local MYOC practice?
- How often have you been in contact since?
- Where did/do you meet with your local MYOC practice members
- Who did you meet with?
- Did you make any plans to work together?
- If yes, what were those plans?
- If yes, were you able to accomplish what you'd planned to do?
- Did you encounter any barriers to working with your local MYOC practice?
- Is there anything that might enhance your work with your local MYOC practice?
- Has this relationship helped you with any other work that you are doing?
- Has your interaction with your local MYOC practice enhanced your work in any other way?
- Any key lessons you want to share?

MYOC Learning Session Evaluations

Learning session evaluations were developed and distributed at each of the three MYOC learning sessions. Questions included perceived satisfaction with each presentation or section of the learning session; satisfaction with the experience as a whole; and attainment of learning objectives specific for each learning session; evaluation of the facilities; and any other comments participants wanted to make.

Resources

Steering Committee Evaluation

We assessed the quality of the MYOC steering committee process by developing and administering a steering committee evaluation form which measured, satisfaction with the steering committee process, attendance, interest in participating in the future, and any additional comments respondents had. Respondents were asked to agree or disagree with a number of statements by circling a response category from 1-5, where 5 was *strongly agree*. The number of steering committee meetings attended, and whether the respondent had interest in participating in MYOC 2 was also captured. There was also a space for any additional comments at the end.

Data Analysis

We used descriptive analyses of MYOC survey responses and chart review findings to assess office system, provider, patient, and practice team changes.

Results

Initial and Intermediate Outcomes

Provider Survey

Fourteen providers (representing 88% of MYOC team providers at baseline) completed the baseline provider survey while 17 providers (representing 100% of MYOC team providers at post-test) completed the survey at post-test. All providers were aware of the American Academy of Pediatrics recommendation to track BMI % for age and gender annually for all children and adolescents at baseline and at post.

- Forty-three percent (43%) and seventy one percent (71%) knew the correct BMI percentile range for *ideal* weight ;
- Sixty four percent (64%) and ninety-four percent (94%) knew the correct BMI percentile range for *at risk for overweight* and;
- Ninety three percent (93%) and one hundred percent (100%) knew the correct BMI percentile range for *overweight* at baseline and post-test respectively.

Positive trends were apparent from baseline to post-test on measures of providers' knowledge, attitudes, efficacy and practice. Not surprisingly, some of the largest positive shifts occurred among measures of provider efficacy. Providers average efficacy Likert scores, on a scale from 1-5, where 5 was *very comfortable* were:

- 3.9-4.5 comfortable addressing weight with all patients;
- 3.7-4.8 nutrition;
- 4.1-4.8 physical activity;
- 4.2-4.8 screen time;
- 4.4-4.8 sugar-sweetened beverages;
- 3.2-4.4 behavioral goal setting;
- 2.8-4.1 brief focused negotiation; from pretest to post-test, respectively.

Measures of provider behaviors also showed large shifts from pretest to posttest as follows:

- 3.8-4.47 track BMI for age and gender annually on all patients;
- 3.4-4.77 track BMI for age and gender annually on overweight patients;
- 3.6-4.6 treat based on weight classification;
- 4.3-4.8; 3.5-4.3 medically evaluate based on weight classification;
- 3.2-4.2 medically evaluate based on weight classification;
- 2.9-4.1 do behavioral goal-setting with overweight patients;
- 2.4-3.8 use motivational interviewing.

Awareness of specific community resources increased from 50% to 88%, yet perception of adequacy of community resources decreased from 30% feeling there were adequate resources at pretest to 24% at posttest. At post-test 87% of providers reported the 5210 survey as useful or very useful with all patients while 93% of providers considered the survey useful or very useful for use with overweight patients. Only 40% of providers considered keeping a registry and doing labs on overweight patients useful or very useful. Table 3 presents a complete compilation of baseline and post-test provider survey results.

Table 3: Provider Survey: Baseline and Post-Test Results
* SA= Strongly Agree

Survey Item	Baseline		Post	
	% SA*	Average Score	% SA*	Average Score
Number of MYOC provider respondents	14		17	
Correct definition of Ideal Weight-Correct	43%		71%	
Correct definition of At Risk for Overweight	64%		94%	
Correct definition of Overweight	93%		100%	
Have good understanding of medical evaluation	14%	3.7	65%	4.7
Know how to address nutrition	7%	2.9	41%	4.4
Know how to address physical activity	7%	3.3	53%	4.5
Know how to address screen time	14%	3.6	65%	4.7
Know how to address sugar-sweetened beverages	21%	4.1	76%	4.7
Know what behavioral goal setting is	7%	3.4	65%	4.5
Familiar with brief focused negotiation	0%	3.0	59%	4.4
Tracking BMI age/gender for overweight patients is important	64%	4.8	82%	4.8
Tracking BMI age/gender for all is important	50%	4.5	76%	4.8
Medical evaluation for overweight is important	50%	4.5	76%	4.7
Important to address nutrition with all patients	50%	4.6	82%	4.8
Important to address physical activity with all patients	50%	4.6	88%	4.8
Important to address screen time with all patients	50%	4.6	88%	4.8
Important to address sugar-sweetened beverages	50%	4.6	82%	4.8
Important to do behavioral goal setting with overweight patients	43%	4.4	65%	4.5
Motivational Interviewing can be a powerful tool	29%	3.9	65%	4.5
Am comfortable addressing weight with all patients	14%	3.9	76%	4,5
Am comfortable addressing nutrition with all patients	7%	3.7	76%	4.8
Am comfortable addressing physical activity with all patients	21%	4.1	82%	4.8

Survey Item	Baseline		Post	
	% SA*	Average Score	% SA*	Average Score
Am comfortable addressing screen time with all patients	29%	4.2	82%	4.8
Am comfortable addressing sugar sweetened beverages with all patients	29%	4.4	82%	4.8
Am comfortable doing behavioral goal setting with all patients	7%	3.2	59%	4.4
Am comfortable using brief focused negotiation with all patients	7%	2.8	53%	4.1
Track BMI for age/gender annually on all patients	21%	3.8	71%-Always;	4.5
Track BMI for age/gender annually on overweight patients	21%	3.4	76%-Always;	4.8
Treat based on weight classification	14%	3.6	59%-Always;	4.6
When overweight patients identified, I address	21%	4.3	82%	4.8
Medically evaluate based on weight classification	21%	3.5	41%	4.3
Schedule follow-up for weight	7%	3.2	35%	4.2
Address nutrition with overweight patients	21%	4.1	53%	4.5
Address physical activity with overweight patients	21%	4.1	59%	4.7
Address screen time with overweight patients	38%	4.3	71%	4.7
Address sugar-sweetened beverages with overweight patients	43%	4.5	65%	4.7
Do behavioral goal setting with overweight patients/families	7%	2.9	35%	4.1
Use motivational interviewing with overweight patients/families	0%	2.4	29%	3.8
Aware of specific community resources	50% Yes		88% Yes	
Have list of community resources available	30% Yes		71% Yes	
Adequate community resources for physical activity	30% Yes		24% Yes	
Adequate community resources for nutrition	30% Yes		24% Yes	
Refer overweight patients to community resources for physical activity	71% Yes		47% Yes	
Questions added at Post-Test				
Usefulness of 5210 Survey	N/A		87% useful or very useful	
Usefulness of 5210 survey with overweight patients only	N/A		93% useful or very useful	
Usefulness of motivational interviewing training	N/A		78% useful or very useful	
Usefulness of motivational interview training for use with overweight patients only	N/A		82% useful or very useful	

Survey Item	Baseline		Post	
	% SA*	Average Score	% SA*	Average Score
Usefulness of keeping a registry for overweight patients	N/A		40% useful or very useful	
Doing labs on overweight patients	N/A		40% useful or very useful	

Five open-ended questions were asked on the provider survey at post-test. Verbatim responses to these questions are in Appendix C. Providers clearly felt they were doing more positive things for their patients as compared to before MYOC. Providers also elaborated on challenges they face. These included patients' lack of motivation; patients' time constraints; culture around food and physical activity; television viewing; lack of reimbursement for weight-related services; and inadequate community resources. Providers shared many successes and elucidated that they needed more community support/resources; more training opportunities; more support for patient follow-up; use of registries; and patient education materials, among others.

Parent/caretaker survey

Three hundred and forty six (346) parent caretakers completed surveys at baseline and three hundred and eighty six (386) parent caretaker surveys from patients who had been seen within the past year for a well-child visit were completed at post-test. From baseline to post-test there were clear indications of improvement in parents/caretakers having ever heard messages from their provider office about lifestyle issues. Tables 4 and 5 provide these data and also show the rates for patients whose parent or caretaker had been told at the last visit that the patient was overweight.

Table 4: Parent Caretaker Survey: Has Doctor, Nurse or Anyone Else in this office EVER talked with you about….

Lifestyle factor	Baseline-all patients (N=346)	Post-overweight patients only (N=40)	Post-all patients (N=386)
Nutrition	73%	100%	90%
Television or Screen Time	58%	88%	78%
Physical Activity or Exercise	77%	100%	87%
Sugar-Sweetened Drinks	54%	93%	80%
Was advice helpful?	80% Yes	83% Yes	64% Yes

At post-test, questions about the last well-child visit were added. Table 5 includes the results from the questions asked at post-test. These results indicate that all patients and overweight patients, respectively, heard messages from their MYOC providers about nutrition (69% and 95%); physical activity (65% and 90%); screen time (57% and 78%); and sugar-sweetened drinks (55% and 83%) at the last well-child visit (within the timeframe of MYOC). Patients also reported setting goals with their providers, making

behavioral changes, and perceived the advice they were getting as high quality. Overweight patients heard more messages from their providers.

Table 5: Parent Caretaker Survey: Post-Test Last well Child Visit (within the last year) Overweight, and All Kids

Survey Item	Overweight Patients, (N=40)	ALL Patients (N=386)
Did a doctor or nurse talk with you about nutrition at last well-child visit?	95% Yes	69% Yes
Set a goal of 5 fruits and vegetables	65% Yes	49% Yes
Set another nutrition goal	28% Yes	11% Yes
Able to reach nutrition goal	23% Yes	25% Yes
Made nutrition changes	55% Yes	26% Yes
Quality of nutrition advice	93% good, very good, or excellent	66% good, very good or excellent
Did a doctor or nurse talk with you about physical activity at last well-child visit?	90% Yes	65% Yes
Set a goal of at least 1 hour of physical activity	55% Yes	40% Yes
Set another physical activity goal	35% Yes	14% Yes
Able to reach physical activity goal	28% Yes	26% Yes
Made physical activity changes	48% Yes	15% Yes
Quality of physical activity advice	85% good, very good, or excellent	61% good, very good or excellent
Did a doctor or nurse talk with you about television viewing or screen time at last well-child visit?	78% Yes	57% Yes
Set a goal of two hours or less of television or screen time	43% Yes	38% Yes
Set another TV/screen time goal	18% Yes	7% Yes
Able to reach TV/screen time goal	38% Yes	25% Yes
Made TV/screen time changes	20% Yes	12% Yes
Quality of TV/screen time advice	76% good, very good, or excellent	54% good, very good or excellent
Did a doctor or nurse talk with you about sugar-sweetened drinks at your last well-child visit?	83% Yes	55% Yes

Survey Item	Overweight Patients, (N=40)	ALL Patients (N=386)
Set a goal of no sugar-sweetened drinks	50% Yes	32% Yes
Set another drink goal	33% Yes	12% yes
Able to reach drink goal	43% Yes	24% Yes
Made drink changes	45% Yes	17% Yes
Quality of drink advice	61% good, very good, or excellent	53% good, very good, or excellent

Table 6: Parent Caretaker Survey: Post-Test Last Well-Child Visit (within the last year) Questions Related to Office Systems Improvement
Overweight and All Patients

Questions related to Office System Improvements	Overweight Patients (N=40)	All Patients (N=386)
Given a written list of things to do	25% Yes	22% Yes
Doctor or nurse thought about your values, beliefs	85% Yes	69% Yes
Asked questions about lifestyle	70% Yes	59% Yes
Asked to schedule a follow-up visit to talk about lifestyle	43% Yes	13% Yes
Know what 5-2-1-0 stands for	65% Yes	47% Yes
Told your child was overweight	100% Yes	10% Yes

Clinical Practice and System Improvement Process

Chart Reviews

Eight hundred and ninety-six (896) charts were reviewed at post-test. Eighty two percent (82%) of charts reviewed indicated that the 5210 survey had been done at post. This was a new tool introduced to the practices through MYOC. The data indicate large shifts in BMI and BMI percentile for age and gender documentation from before MYOC to post MYOC. Weight classification increased from 22% to 74%; blood pressure from 85% to 96%; height from 90% to 99%; and weight from 91% to 100%. Table 7 below gives the percentage of charts at baseline and post-test with specific information related to office system improvements and provider behavior.

Table 7: Chart Review Data: Assessment and Classification at Baseline and Post-Test

	Baseline	Post-Test
Number of Charts	896	
Gender	51% Male; 48% Female	
Height	90%	99%
Weight	91%	100%
BMI	40%	94%
BMI percentile for age/gender	28%	89%

	Baseline	Post-Test
Weight Classification	22%	74%
Blood Pressure	85%	96%
5210 Patient Survey	0%	82%

Table 8: Chart Review Data: Labs if Overweight at Baseline and Post-Test

LABS	Baseline	Post-Test
If Classified as Overweight	**N=66 (7%)**	**N=144 (16%)**
Lipid panel	11%	19%
Tot Cholesterol	9%	14%
LDL	8%	11%
HDL	8%	14%
Triglycerides	6%	10%
Fasting BS	11%	15%
Glucose Tolerance	0%	1%
Liver function panel	5%	10%
ALT	5%	9%
AST	5%	10%
Advice	26%	62%
Goals set	48%	64%
Follow-up visit recommended	14%	42%
Referral	14%	10%

Table 9: Chart Review Data: Type of Goals Set If Overweight at Baseline and Post-Test

	Baseline N=*32*	**Post-Test N=*92***
Nutrition	97%	79%
Screen Time	19%	39%
Physical Activity, if goal set	47%	59%
Soda/Sugar drinks, if goal set	25%	47%

Practice Team Implementation Survey

Thirty seven (37) practice team surveys were completed by MYOC practice team members in April of 2005, and forty (40) in September, 2005 at Learning Session #3. Respondents were primary care providers (35%), nurses (30%), medical assistants (15%) and other office staff (20%). Several teams filled out the survey together, as a team. Table 10 below depicts the practice team implementation survey data from Learning Session #3. These results are used because a new and improved toolkit was provided to practice teams at Learning Session 2 and by Learning Session 3 teams had had an opportunity to use these materials.

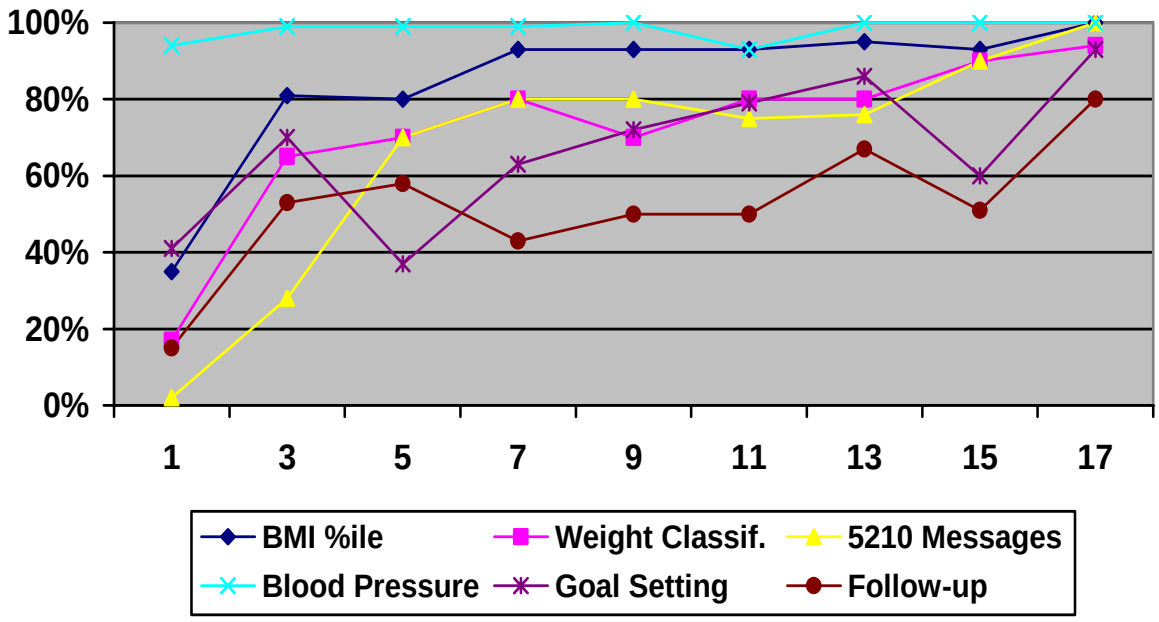
Table 10: Practice Team Implementation Survey Results

Survey Category	Results
Team member role: "Please indicate who performs each of the following tasks by checking the appropriate box" (response options: PCP, Nurse, MA, Other staff)	• Nurses, then primary care providers followed closely by medical assistants most often calculated and classified BMI (34%, 30% and 27% respectively). • Nurses most often administered the 5-2-1-0 assessment, followed by primary care providers and medical assistants (30%, 26% and 22% respectively). • Behavioral Goal setting was done by primary care providers 79% of the time while only four nurses, three medical assistants and three other office staff persons ever reported performing this task. • Setting up follow-up care for *at risk* or *overweight* patients was most often done by a primary care provider (63% of the time) and also by other office staff (excluding nurses and medical assistants) about 25% of the time.
Awareness of toolkit and resources provided:	• Only one respondent reported being unaware of the resources provided. • 40% of respondents reported using the toolbox often; 41% occasionally and 19% rarely.
Use of toolkit and resources provided:	• Primary care providers, nurses and medical assistants reported using the toolkit (49%, 30% and 15% of the time, respectively). About 5% of other office staff ever used them. • The flip chart (containing guidelines, reference labs, communication tools, co-morbidity and treatment interventions, brief negotiation, BMI charts, and more) and patient education materials (such as patient handouts) were used most often by respondents.
Satisfaction with toolkit and resources provided:	• Respondents were most satisfied with the flip chart scoring 4.21 on a scale from 1-5, where 5 was very satisfied) and the goal-setting worksheet (scoring 4.00) and the patient education materials (scoring 3.88). • Practice team members were somewhat less satisfied with the physical activity survey (scoring 3.61), and the in-depth nutrition survey (scoring 3.59).
Improvement suggestions:	Comments included : o wanting more examples and more detail on portion size o decrease the number of resources o simplify handouts to be more like the 5210 sheet o an area to list current fruits and vegetables on goal sheet o goal sheet may be too formal o provide more dietary handouts o more flip charts, please o a food guide pyramid for adolescents o quick and healthy meal ideas o goal charts with stickers for children

Practice Team Bimonthly Summary Reports

Practice Teams submitted summary information based on chart reviews on a bimonthly basis. Figure 3 shows the bimonthly reporting data for the six required measures, averaged across all the practice sites. Upward trends can be observed for all the bimonthly measures. Most notable gains are for the 5210 messages, weight classification, and BMI percentile for age and gender.

Figure 3: Average Bimonthly Required Measures From Summary Team Reports Graph



Practice Team Experience Highlights

Qualitative information from teams' experiences shared at each of two learning sessions was captured and summarized in the tables in Appendix E. This information highlights the unique process and progress that each practice team was engaged in.

Post-Test Practice Team Survey

All participating practice sites except two participated in this online survey. About one third of respondents were primary care providers, one third were nurses, and the remainder were medical assistants and other office staff. The total number of respondents was 24. Survey questions and responses are summarized in Appendix F. Teams rated using the 5210 messages; BMI percentile for age and gender; meeting with other teams; and the learning sessions the most useful aspects of MYOC. Teams expressed needing more help with registries and wanted more age appropriate educational materials for patients. Overall, teams were satisfied with the collaborative process and felt they had made substantial improvements in patient care because of it. Many team members expressed the desire to sustain changes, continue improvements and work with MYOC in the future.

Post-Test Provider "Scripts" Telephone Interviews

Five (5) interviews were conducted with self-selected MYOC providers between March 30 and May 9, 2006. Appendix G summarizes responses to survey questions from the 5 interviews. The providers interviewed discussed their experience using brief focused negotiation and discussing lifestyle and weight with their patients. Providers highlighted what works for them and what didn't work for them at different points within the patient encounter. Providers were asked to provide examples of specific language they used. All providers interviewed used brief focused negotiation and felt it was a success. These results will be used to help create more detailed tools for providers for future MYOC work.

Healthy Maine Partnership Director Telephone Interviews

Telephone interviews using semi-structured interview guides were completed with all 11 Healthy Maine Partnership Directors with MYOC practice sites within their catchment area. See Appendix H for the telephone survey responses. One Healthy Maine Partnership director had two MYOC practice sites in her area. Clearly, practice site/community connections were made and significant work was accomplished (see Appendix H) Most MYOC practice teams had made contact with their Healthy Maine Partnership by the second learning session. How often they met and who met varied from site to site. Work accomplished consisted of working with local schools on wellness policies or giving joint presentations promoting the 5210 messages; working with local grocery stores to add signage to encourage healthy eating; developing referral lists for practices; developing specific referrals mechanisms to local resources such as YMCA's; developing list of local resources for physical activity for practice sites; and developing specialty clinics, for example.

Interview data also suggests room for improvement around role clarification, direction, models, connecting more formally and earlier, and the need to be realistic about what can be accomplished.

MYOC Learning Session Evaluations

The learning session evaluations demonstrated a high level of satisfaction with the learning sessions as well as high levels of participant attainment of course objectives. These results were used in developing subsequent learning sessions and the final celebration. See learning session evaluation results in detail, in Appendix I.

Resources

Steering Committee Evaluation

(see list of steering committee members Appendix J)
The MYOC steering committee met seven (7) times throughout MYOC implementation. Steering committee members were asked to complete a steering committee evaluation form after the last steering committee meeting. Ten (10) of thirty nine (39), or 26% of steering committee members, completed evaluation forms. Members were generally satisfied with the steering committee process. One member suggested that the role of the steering committee be clarified. Appendix J shows responses to steering committee evaluation questions.

Discussion

Evaluation results show clear improvement in all six Care Model key change areas from baseline to post-test. Results also show that there are still many opportunities for improvement in each area. Limitations in our ability to draw conclusions from our evaluation efforts include, most importantly, the fact that we did not use comparison data. Therefore changes we observe may, in some part, have been observed by other practice sites. Secondly, our data gathering instruments were, for the most part, designed or modified by us without extensive pilot testing; nor did we have the resources to assess validity and reliability.

At post-test, MYOC practice team providers demonstrated improved knowledge of weight classification categories and of how to address lifestyle issues with patients. Providers' efficacy and practice addressing lifestyle issues also improved. Some of the largest improvements were seen in the areas of goal setting, brief focused negotiation and tracking BMI percentile for age and gender. These findings were supported by findings from other data sources as well. Providers already seemed to hold strong beliefs about the importance of addressing lifestyle issues with their patients at pretest. Therefore, these variables did not show much improvement. Providers' awareness of specific community resources improved. However, perception of the adequacy of these resources decreased slightly, perhaps due to a greater appreciation of the need for resources as they improved identifying and addressing lifestyle with their patients throughout MYOC. Provider survey open-ended question responses reinforced the quantitative findings. Clearly, providers felt more comfortable addressing lifestyle at post-test and felt that they could have a positive impact. Some of the greatest challenges providers mentioned included patients' lack of motivation and family constraints (e.g. lack of time, inconsistent parenting/households because of divorce); our culture which seems to promote unhealthy lifestyle; patients' discomfort associated with discussing weight issues; the lack of adequate community resources; third party payer issues; time involved in lifestyle intervention; and the challenges of Maine winter and environment (rural). Providers cited many successes; among these were multiple examples of patient weight loss using the 5210 message. It seems that for some patients, minimal effort afforded positive results.

Reported support needed to continue MYOC improvement included community nutrition services; psychological support services; continued provider training; and more help with registries.

Even with these positive findings, providers' scores leave room for improvement. More practice and training addressing lifestyle, especially around brief focused negotiation and goal setting is warranted. Community connections and help identifying more patient resources is also clearly an area of need.

Parent Caretaker survey results demonstrate that patients and families had (ever) heard substantially more messages about nutrition, television or screen time, physical activity and sugar-sweetened beverages at post-test than at pretest. Overweight patients and families heard even more messages than the overall patient population. These results reinforce providers' reports of improved practice around lifestyle.

When asked about the last well-child visit, again, overweight patients and families heard more messages and talked more with their providers about lifestyle. If patients talked with their providers about a specific lifestyle issue (e.g. 5-2-1 or 0) at their last well-child visit, they were likely to set a goal around that issue. And, if they set a goal around that issue, some reported being able to reach their goal (up to about 30% in some cases). Overweight patients reported reaching sugar-sweetened beverage and TV or screen time goals more often than did all patients. Overweight patients reported the quality of advice they received around lifestyle issues higher, overall, than did all patients. These results indicate that at post-test providers were doing the most lifestyle work with their patients at highest risk.

Chart reviews represent the most robust MYOC results and demonstrated findings consistent with provider and parent caretaker surveys. Height, weight, and blood pressure measurement and tracking showed modest improvement, not surprising given their high rates at pretest. The greatest improvements were seen for BMI, BMI percentile for age and gender, weight classification, and performing the 5210 patient assessment (introduced through MYOC). Chart reviews also demonstrated that providers diversified goal setting from mostly nutrition goals at baseline to a more equal number of goals for each of the 5-2-1-0 areas. These changes are substantial and represent monumental office system improvements. Modest changes in recommended labs were observed perhaps partly due to inconsistencies among MYOC teams' perceptions about the usefulness of obtaining labs consistently on overweight patients. The system improvements observed will need to be reinforced over time and recommendations around attaining labs will need to be clarified for future efforts.

From practice team implementation surveys, we learned that nurses, providers and medical assistants worked together to implement MYOC strategies. Nurses as well as providers most often calculated BMI, classified patients and administered the 5210 survey to patients while primary care providers overwhelmingly did behavioral goal setting, and set follow-up care with their patients. Among the tools provided to teams, flip charts and patient educational materials were most popular. Teams also requested additional patient education materials.

Reinforcing chart review data, summary team reports on required bimonthly measures indicate substantial changes in the areas of BMI percentile for age and gender tracking; patient classification; providing patients with 5210 messages; goal setting; and follow-up. Among the six required measures, goal setting and follow-up leave the most room for improvement.

The post-test practice team survey revealed team members' perception that office systems improved significantly; that patients were receiving better care and were more aware and knowledgeable about lifestyle at post-test. Teams perceived having worked well together yet there may not always have been adequate time to perform collaborative tasks. Almost half of respondents said they spent more than four (4) hours monthly on collaborative tasks while almost one third reported spending more than six (6) hours monthly. Teams reported that they would be most likely to use the well-child visit to routinely review the needs of overweight patients and continue to spread improvements to other providers within their organizations now that MYOC was

finished. Teams also mentioned other plans to continue improvement such as developing group visits and specialty clinics. Reported team needs around sustaining change included more support from senior leaders; more dedicated office time for collaborative activities; and increased efforts to work with payers on issues of reimbursement. Components of the collaborative that teams found most useful were meeting with other teams; the learning sessions; using BMI percentile for age and gender to asses and track patients; using the 5210 messages for assessment and intervention; provider tools; and support from MYOC staff. Perceived as least useful were storyboards and bimonthly reporting. All MYOC components were rated useful, overall.

The Healthy Maine Partnership director telephone survey responses reinforced team self-assessment progress reports of community connections being made. Clearly significant work was accomplished through practice/community partnerships during MYOC. The interview data suggest room for improvement around role clarification, direction for providers and community groups with models and examples for work. The work accomplished with communities over MYOC will be able to serve as a model and will provide examples for future community/practice partnerships. Interview data also suggests the need to connect with community groups earlier, and perhaps more formally, as well as to be realistic about what can be accomplished.

The steering committee evaluation revealed a high level of satisfaction with the steering committee process and members' participation. There was some indication that in the future it would benefit such a committee to have a more clearly defined role.

Conclusion

We recruited 12 practices throughout Maine to MYOC. We followed the Care Model and IHI Breakthrough Collaborative frameworks to implement our collaborative and designed and implemented an evaluation process to measure implementation of the framework and MYOC outcomes. MYOC strategies were apparently successful in attaining many desired initial and intermediate outcomes as well as improving clinical practice and office systems. Results also demonstrate room for improvement. Recommendations for a future collaborative effort could include continuation and reinforcement of previous efforts as well as:

- Improving identification of community resources and patient services (e.g. nutrition and psychological)
- Increased efforts to train providers in motivational interviewing and goal setting
- Providing more technical assistance with patient registries
- Clarifying recommendations and expectations around attaining patient labs
- Providing improved support for patient follow-up
- Providing more patient education materials
- Improving involvement from senior leaders in practice organizations
- Working with payers around reimbursement
- Improving support for connecting with communities and helping to define practice community partnership work

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Appendix A:
Data Collection Instruments

POST SITE: 1

Provider Survey

You are invited to take part in the Maine Youth Overweight Collaborative evaluation by answering the following questions. Your participation is voluntary. We are trying to learn how your practice's involvement in the Maine Youth Overweight Collaborative is helping you to change the way you think and work. You will be asked to answer a similar set of questions, in about a year and a half, near the end of the Maine Youth Overweight Collaborative funding. If you have any questions about this survey or other aspects of the Maine Youth Overweight Collaborative, please contact Joan Orr, the MYOC coordinator, at 207 629-9272.

Are you a member of the Maine Youth Overweight Collaborative three-person "TEAM" from your practice site? ☐ Yes ☐ No

Please answer the following questions with respect to the care of patients 5-18 years old

Knowledge

1. The American Academy of Pediatrics recommends tracking BMI% for age and gender annually for all children and adolescents
   ☐ True
   ☐ False

2. The CDC definition of ideal weight is:
   ☐ 10-90th BMI %ile for age and gender
   ☐ 5-94th BMI %ile for age and gender
   ☐ 5-84th BMI %ile for age and gender
   ☐ 10-84th BMI %ile for age and gender
   ☐ None of the above

3. The CDC definition of at risk for overweight is:
   ☐ 91st -95th BMI %ile for age and gender
   ☐ 95th -99th
   ☐ 85th-94th
   ☐ 85th-95th
   ☐ None of the above

4. The CDC definition of overweight is:
   ☐ ≥94th BMI %ile for age and gender
   ☐ ≥95th BMI %ile for age and gender
   ☐ ≥96th BMI %ile for age and gender
   ☐ ≥99th BMI %ile for age and gender

Please circle the number that corresponds with your answer:

		Strongly disagree				***strongly agree***
5.	I have a good understanding of medical evaluation (lab tests) for pediatric patients who are overweight.	1	2	3	4	5
6.	I know how to address nutrition with pediatric patients and/or their families.	1	2	3	4	5

POST 2

		Strongly disagree				*strongly agree*
7.	I know how to address physical activity with my patients and/or their families.	1	2	3	4	5
8.	I know how to address screen time (time watching television or playing computer games) with my pediatric patients and/or their families.	1	2	3	4	5
9.	I know how to address consumption of soda or sugar-sweetened beverages with my pediatric patients and/or families.	1	2	3	4	5
10.	I know what behavioral goal-setting is.	1	2	3	4	5
11.	I am familiar with brief motivational interviewing (Provider/patient counseling techniques presuming the patient's autonomy, capacity, and expertise).	1	2	3	4	5
Beliefs						
12.	Tracking BMI % for age and gender annually is important for my overweight patients.	1	2	3	4	5
13.	Tracking BMI % for age and gender annually is important for all my pediatric patients.	1	2	3	4	5
14.	It is important to medically evaluate pediatric patients for possible complications of weight related issues.	1	2	3	4	5
15.	I believe it is important to address nutrition with all of my pediatric patients and/or families.	1	2	3	4	5
16.	It is important to address physical activity with all of my pediatric patients and/or families.	1	2	3	4	5
17.	It is important to address screen time (TV/Video) with all of my pediatric patients and/or families.	1	2	3	4	5
18.	It is important to address consumption of soda or sugar-sweetened beverages with all of my pediatric patients and/or their families.	1	2	3	4	5

POST 3

		Strongly disagree				*strongly agree*
19.	It is important to do behavioral goal setting with overweight pediatric patients and/or families.	1	2	3	4	5
20.	Motivational interviewing can be a powerful tool to help change behavior.	1	2	3	4	5
	Perceived Efficacy					
21.	I am comfortable addressing weight with my pediatric patients and/or families.	1	2	3	4	5
22.	I am comfortable addressing nutritional issues with my pediatric patients and/or families.	1	2	3	4	5
23.	I am comfortable addressing physical activity with pediatric patients and/or families.	1	2	3	4	5
24.	I am comfortable addressing screen time (TV/Video) with pediatric patients and/or families.	1	2	3	4	5
25.	I am comfortable addressing consumption of soda or sugar-sweetened beverages with pediatric patients and/or families.	1	2	3	4	5
26.	I am comfortable doing behavioral goal setting with pediatric patients and/or families.	1	2	3	4	5
27.	I am comfortable using brief motivational interviewing techniques with my pediatric patients and/or families.	1	2	3	4	5
	Practice					
		Never				*Always*
28.	I/my practice tracks BMI% for age and gender annually on all overweight pediatric patients.	1	2	3	4	5
29.	I/my practice tracks BMI% for age and gender annually on all pediatric patients.	1	2	3	4	5
30.	I currently treat my pediatric patients based on the CDC weight classifications (ideal, at risk for overweight, and overweight).	1	2	3	4	5

POST 4

		Strongly disagree				*strongly agree*
31.	When I identify a pediatric patient as overweight, I address the issues with the patient and/or family.	1	2	3	4	5
32.	I currently medically evaluate pediatric patients based on the CDC weight classification of overweight.	1	2	3	4	5
33.	I/my practice currently schedules a visit to specifically follow-up when a weight issue is identified.	1	2	3	4	5
34.	I currently address nutrition with my overweight patients and/or families.	1	2	3	4	5
35.	I currently address physical activity with my overweight pediatric patients and/or families.	1	2	3	4	5
36.	I currently address screen time (TV/Video) with my overweight pediatric patients and/or families.	1	2	3	4	5
37.	I currently address consumption of soda or sugar-sweetened beverages with my overweight pediatric patients.	1	2	3	4	5
38.	I currently do behavioral goal setting with my overweight pediatric patients and/or families.	1	2	3	4	5
39.	I use motivational interviewing techniques with my overweight pediatric patients and/or families.	1	2	3	4	5

Community Resources

40. I am aware of specific resources in my practice community to support pediatric patients and/or families with physical activity and/or nutritional behavior change
☐ Yes ☐ No

a. If yes, I have a list of community resources available to me ☐ Yes ☐ No
b. If yes, There are adequate community resources to support patients' physical activity changes in my practice area ☐ Yes ☐ No
c. If yes, There are adequate resources for patient nutritional support, education, or counseling in my practice area ☐ Yes ☐ No
d. If yes, I currently refer my overweight pediatric patients and/or families to community resources for physical activity or nutrition behavior support/change ☐ Yes ☐ No

POST 5

41. Now, Please tell us about your experience with MYOC over the last 12-15 months. How useful did you find the following? Please circle the number that corresponds with your best answer or check the "I did not use" box. Please add any comments you may have.

	WITH ALL PATIENTS Not Useful 1 2 3 4 5 Very Useful	WITH OVERWEIGHT (>95th) PATIENTS ONLY Not Useful 1 2 3 4 5 Very Useful
5210 Patient survey	1 2 3 4 5 ☐ I did not use this	1 2 3 4 5 ☐ I did not use this
Comments:		
Training on Motivational Interviewing	1 2 3 4 5 ☐ I did not use this	1 2 3 4 5 ☐ I did not use this
Comments:		
Keeping a registry		1 2 3 4 5 ☐ I did not do this
Comments:		
Doing labs		1 2 3 4 5 ☐ I did not routinely do this
Comments:		

42. Please tell us one of the most positive things you are doing now for overweight patients as compared to before MYOC.

43. What were your greatest challenges addressing Physical activity and Nutrition with all your patients/families?

POST 6

44. What were your greatest challenges addressing Physical Activity and Nutrition with you OVERWEIGHT Patients/families ONLY?

45. Tell us about your successes with regard to addressing physical activity and nutrition with your patients/families. Please include any successes with your overweight patients/families as well.

46. What, if any, support would you like now?

47. Do you believe any of your 5-18 year-old patients had any of the following conditions such as anorexia, bulimia, or other eating disorders?

- ☐ none
- ☐ 0-5
- ☐ 6-10
- ☐ 11-20
- ☐ 20 or more

48. During the Collaborative, did you identify overweight patients aged 5-18 who also had type 2 Diabetes?

- ☐ none
- ☐ 0-5
- ☐ 6-10
- ☐ 11 or more
- ☐ 20 or more

49. During the Collaborative, did you identify overweight patients aged 5-18 who also had Asthma?

- ☐ none
- ☐ 0-5
- ☐ 6-10
- ☐ 11 or more
- ☐ 20 or more

Parent/Caretaker Survey

You are invited to take part in a study to help your child's provider and other provider offices learn more about how to promote a healthy lifestyle for their patients. Your participation in this study is voluntary. To take part in the study, all you have to do is answer the following questions. We are not asking for your name. And, your child's provider will NOT know how you answered these questions. We are interested in your ideas about any healthy lifestyle messages you may have heard while in this office. You may be asked to answer a similar set of questions, in about a year and a half, near the end of our study. If you have any questions about this survey, please contact Joan Orr, at the Maine Center for Public Health, at 207 629-9272.

1. Has a doctor, nurse, or anyone else in this office, ever talked to you about nutrition?

   ☐ YES ☐ NO

2. Has a doctor, nurse, or anyone else in this office, ever talked to you about physical activity or exercise?

   ☐ YES ☐ NO

3. Has a doctor, nurse, or anyone else in this office, ever talked to you about television viewing or other screen time?

   ☐ YES ☐ NO

4. Has a doctor, nurse, or anyone else in this office, ever talked to you about sugar-sweetened drinks?

   ☐ YES ☐ NO

5. If you heard advice on any of the above, was it helpful?

   ☐ YES ☐ NO ☐ I did not hear advice on any of the above

Thank You!

Site:

Parent/Caretaker Survey

You are invited to take part in a study to help your child's provider and other provider offices learn more about how to promote a healthy lifestyle for their patients. Your participation in this study is voluntary. To take part in the study, all you have to do is answer the following questions. We are not asking for your name. And, your child's provider will NOT know how you answered these questions. We are interested in your ideas about any healthy lifestyle messages you may have heard while in this office. You may be asked to answer a similar set of questions, in about a year and a half, near the end of our study. If you have any questions about this survey, please contact Joan Orr, at the Maine Center for Public Health, at 207 629-9272.

1. When was the last time your child was seen in this office for a well-child visit?

☐ within the last year ☐ greater than one year ago ☐ never

	YES	NO
2. *Has a doctor, nurse, or anyone else in this office, ever* talked to you about nutrition?	☐	☐
3. .....*ever* talked to you about physical activity or exercise?	☐	☐
4..... *ever* talked to you about television viewing or other screen time?	☐	☐
5. .....*ever* talked to you about sugar-sweetened drinks?	☐	☐
Now, please tell us about your child's last well-child visit		
6. Did a doctor, nurse or anyone talk with you about nutrition *at your child's last visit*?	☐	☐
If YES, did you and your child set a goal of 5 servings of fruits and vegetables daily?	☐	☐
Did you and your child set another nutrition goal with your provider?	☐	☐
If you set another goal, what was it? _____		
If you and your child set a nutrition goal, were you able to reach it?	☐	☐
Did you and your child make any nutrition related changes?	☐	☐
If you made nutrition changes, what were they? _____		
How would you rate the quality of advice you received about nutrition at that last visit? ☐ poor ☐ fair ☐ good ☐ very good ☐ excellent		
7. Did a doctor, nurse or anyone talk with you about physical activity or exercise *at your child's last visit*?	☐	☐
If YES, did you and your child set a goal of doing at least one hour of physical activity?	☐	☐
Did you and your child set another physical activity or exercise goal?	☐	☐
If you set another goal, what was it? _____		
If you and your child set a physical activity goal, were you able to reach it?	☐	☐
Did you and your child make any physical activity related changes?	☐	☐
If you made physical activity changes, what were they? _____		
How would you rate the quality of advice you received about physical activity at that visit? ☐ poor ☐ fair ☐ good ☐ very good ☐ excellent		

	YES	NO
8. Did a doctor, nurse or anyone talk with you about television viewing or screen time *at your child's last visit*?	☐	☐
If YES, did you and your child set a goal of no more than two (2) hours of television or screen time for your child?	☐	☐
Did you and your child set another television or screen time goal with your provider?	☐	☐
If you set another goal, what was it? _____		
If you and your child set a television or screen time goal, were you able to reach it?	☐	☐
Did you and your child make any television or screen time related changes?	☐	☐
If you made any changes, what were they? _____		
How would you rate the quality of advice you received about television or screen time at that visit? ☐ poor ☐ fair ☐ good ☐ very good ☐ excellent		
9. Did a doctor, nurse or anyone talk with you about sugar sweetened drinks *at your child's last visit*?	☐	☐
If YES, did you and your child set a goal of no sugar sweetened drinks for your child?	☐	☐
If YES, did you and your child set another sugar sweetened drink goal?	☐	☐
If you set another goal, what was it? _____		
If you set a sugar sweetened drink goal, were you able to reach it?	☐	☐
Did you and your child make any sugar sweetened drink related changes?	☐	☐
If you made any drink changes, what were they? _____		
How would you rate the quality of advice you received about sugar sweetened drinks at that visit? ☐ poor ☐ fair ☐ good ☐ very good ☐ excellent		
10. If you heard advice on any of the above, at your last visit, was it helpful? ☐ YES ☐ NO ☐ I did not hear any advice on any of these		
11. At your last well child visit, were you given a written list of things you and/or your child should do to improve his/her health?	☐	☐
12. At your last well child visit, did you feel that your doctor or nurse thought about your values, beliefs, and traditions when they talked to you and your child about his/her physical activity and nutrition?	☐	☐
13. At your last visit did anyone in the office ask you or your child questions either directly or on a written survey about his/her physical activity and nutrition habits?	☐	☐
14. Were you and/or your child advised by your doctor or nurse to schedule a follow-up visit to talk about physical activity or nutrition?	☐	☐
15. Do you know what 5-2-1-0 stands for?	☐	☐
16. At your child's last visit, were you or your child told that he/she was overweight?	☐	☐

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MOST RECENT WELL-CHILD VISIT: Chart Review Data Form

Please review data from patient's most recent annual "well child" check!

Reviewer_____ Today's Date_____ Practice_____ Provider_____

Date of most recent well-child visit _____ Number of providers in practice_____

Patient date of birth (MM/YY): _____ ☐ Male ☐ Female

5-2-1-0 Survey completed?	☐No	☐Yes	
Blood Pressure recorded?	☐No	☐Yes	(please circle)
Height recorded?	☐No	☐Yes Value:_____	in or cm
Weight recorded?	☐No	☐Yes Value:_____	lbs or kg
BMI calculated?	☐No	☐Yes Value:_____	
BMI% for Age/Gender recorded?	☐No	☐Yes Value:_____	
Weight classification done?	☐No	☐Yes…	
If yes….	☐ Underweight (<5th %'ile for age/gender)		
	☐ Healthy Weight (5 – 84th %'ile age/gender)		
	☐ At Risk for Overweight (85 – 94%'ile for age/gender)		
	☐ Overweight (≥95 %'ile for age/gender)		

For patients classified as overweight—was there evidence in the chart that a clinical diagnosis of "overweight" was made? ☐No ☐ Yes

Was there evidence in the chart that the issue was discussed with the family and/or patient? ☐No ☐ Yes

IF child is "overweight" **(Check the BMI %--**Patient MUST be >95th % for age and gender to answer below)

➢ ***Were any of following LAB TESTS done?*** ***Note N/I=Not indicated, check if abnormally elevated value***

Lipid panel, *OR…*	☐No	☐Yes (If lipid panel done, please also check individual lipid tests)	☐N/I	
Total Cholesterol	☐No	☐Yes	☐N/I	☐ abnormally elevated value
LDL	☐No	☐Yes	☐N/I	☐ abnormally elevated value
HDL	☐No	☐Yes	☐N/I	☐ abnormally elevated value
Triglycerides	☐No	☐Yes	☐N/I	☐ abnormally elevated value
Fasting Blood Sugar	☐No	☐Yes (If FBS normal, don't need to check Gluc Tol Test)	☐N/I	
IF FBS elevated…	☐ abnormally elevated value			
Gluc Tolerance Test done?	☐No	☐Yes	☐N/I	☐ abnormally elevated value
Liver function panel, *OR…*	☐No	☐Yes (If liver panel done, please also check individual liver tests)	☐N/I	
ALT	☐No	☐Yes	☐N/I	☐ abnormally elevated value
AST	☐No	☐Yes	☐N/I	☐ abnormally elevated value

Physician Advice / Goal Setting:

Were any recommendations made regarding weight loss? ☐No ☐Yes

Were any behavioral goals set with patient/ family? ☐No ☐Yes

If yes, goal(s) set, please check all that apply:

☐ Nutritional ☐ Screen Time ☐ Physical Activity ☐ Soda/sugar drinks

Follow up:

Was a follow up office visit for overweight with this PCP recommended? ☐No ☐Yes

If yes, did patient keep the recommended follow-up appointment? ☐No ☐Yes

Was patient referred for follow up to specialty care or other services? ☐No ☐Yes

Referred to: _____

NOTES:

February 16, 2006

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VISIT PRIOR TO MYOC: Chart Review Data Form

*Please review data from patient's **most recent annual "well child" check prior to January 2005.***

Provider_____ Date of most recent well-child visit prior to January 2005_____

				(please circle)
Blood Pressure recorded?	☐No	☐Yes		
Height recorded?	☐No	☐Yes	Value:_____	in or cm
Weight recorded?	☐No	☐Yes	Value:_____	lbs or kg
BMI calculated?	☐No	☐Yes	Value:_____	
BMI% for Age/Gender recorded?	☐No	☐Yes	Value:_____	
Weight classification done?	☐No	☐Yes...		

If yes ....
- ☐ Underweight (<5th %'ile for age/gender)
- ☐ Healthy Weight (5 – 84th %'ile age/gender)
- ☐ At Risk for Overweight (85 – 94%'ile for age/gender)
- ☐ Overweight (≥95 %'ile for age/gender)

For patients classified as overweight—was there evidence in the chart that a clinical diagnosis o "overweight" was made? ☐No ☐ Yes

Was there evidence in the chart that the issue was discussed with the family and/or patient? ☐No ☐ Yes

➢ ***Were any of following LAB TESTS done?*** *Note N/I=Not indicated, check if abnormally elevated value*

Lipid panel, *OR*...	☐No	☐Yes (If lipid panel done, please also check individual lipid tests)		☐N/I
Total Cholesterol	☐No	☐Yes	☐N/I	☐ abnormally elevated value
LDL	☐No	☐Yes	☐N/I	☐ abnormally elevated value
HDL	☐No	☐Yes	☐N/I	☐ abnormally elevated value
Triglycerides	☐No	☐Yes	☐N/I	☐ abnormally elevated value
Fasting Blood Sugar	☐No	☐Yes (If FBS normal, don't need to check Gluc Tol Test)		☐N/I
IF FBS elevated...	☐ abnormally elevated value			
Gluc Tolerance Test done?	☐No	☐Yes	☐N/I	☐ abnormally elevated value
Liver function panel, *OR*...	☐No	☐Yes (If liver panel done, please also check individual liver tests)		☐N/I
ALT	☐No	☐Yes	☐N/I	☐ abnormally elevated value
AST	☐No	☐Yes	☐N/I	☐ abnormally elevated value

➢ ***Physician Advice / Goal Setting:***

Were any recommendations made regarding weight loss? ☐No ☐Yes

Were any behavioral goals set with patient/ family? ☐No ☐Yes

If yes, goal(s) set, please check all that apply:

☐ Nutritional ☐ Screen Time ☐ Physical Activity ☐ Soda/sugar drinks

➢ ***Follow up:***

Was a follow up office visit for overweight with this PCP recommended? ☐No ☐Yes

If yes, did patient keep the recommended follow-up appointment? ☐No ☐Yes

Was patient referred for follow up to specialty care or other services? ☐No ☐Yes

Referred to: _____

NOTES:

February 16, 2006

Maine Youth Overweight Collaborative
Practice Team Survey

1. Today's Date _____

2. Name of practice_____

We would like to learn more about how you're making changes to improve the prevention and management of overweight youth within your practice. Please indicate who performs each of the following tasks by checking the appropriate box (please check *all* that apply):

3. BMI calculation and classification	4. "5-2-1-0" (Healthy Weight) Survey	5. Behavioral Goal Setting (for patients at risk for overweight or overweight)	6. Setting up follow-up care for patients at risk for overweight or overweight
☐ primary care provider ☐ Nurse ☐ Medical Assistant ☐ Other office staff	☐ primary care provider ☐ Nurse ☐ Medical Assistant ☐ Other office staff ☐ Not doing this	☐ primary care provider ☐ Nurse ☐ Medical Assistant ☐ Other office staff ☐ Not doing this	☐ primary care provider ☐ Nurse ☐ Medical Assistant ☐ Other office staff ☐ Not doing this

7. As part of the Maine Youth Overweight Collaborative, we supplied a "toolbox" of patient and provider educational materials and resources to use with your patients and families who are dealing with weight issues. Please tell us how often your practice uses this toolbox.

- ☐ Often
- ☐ Occasionally
- ☐ Rarely
- ☐ Never

8. If the toolbox is used, who uses it in your practice?

Please check all that apply:

- ☐ Primary care provider
- ☐ Nurse
- ☐ Medical Assistant
- ☐ Other office staff

9. I am a ☐ primary care provider
☐ Nurse
☐ Medical Assistant
☐ Other office staff

For each item listed in the chart, please indicate how often you use the item(s). If you use the item(s), please tell us how satisfied you are with them, your favorite one or two tools under this heading (if there are several), and whether you have any improvements you'd like to share with us.

MYOC Materials	1 *How often do you use this (these)?* Not Often — Very Often	2 *How satisfied are you with this (these)?* Not Satisfied — Very Satisfied	3 *What are your favorite tools under this category (if there is more than one)?*	4 *Do you have any recommendations for improving this (these)?*
10. **Flip Chart-** Containing "Overweight Clinical Guidelines" In the Provider Tools Section of the Toolkit	1 2 3 4 5	1 2 3 4 5		
11. Patient Education Materials (throughout the Toolkit)	1 2 3 4 5	1 2 3 4 5		

MYOC Materials	1 *How often do you use this?* Not Often — Very Often	2 *How satisfied are you with this?* Not Satisfied — Very Satisfied	*3* ***Do you have any recommendations for improving this?***
12. **Physical Activity Survey** In the Physical Activity section of the Toolkit	1 2 3 4 5	1 2 3 4 5	
13. **In depth nutrition survey** (Not the Food Diary!) In the Food Diary section of the Toolkit	1 2 3 4 5	1 2 3 4 5	
14. **Goal Setting Worksheet** in the Goal Setting section of the Toolkit	1 2 3 4 5	1 2 3 4 5	

15. Are there any tools or supporting materials that you do not have available and wish you had?

Thank You!!

Draft 2/13/06 1

Online Practice Team Survey

Please provide the following background information

1. Please check your organization
List sites here with check boxes

2. Please indicate your role on the Collaborative Team

- ☐ Physician, PA or NP
- ☐ Medical Assistant
- ☐ Nurse
- ☐ Office Manager
- ☐ Other

Impact of Participation in the Collaborative

3. As a result of our participation in the Collaborative, I feel that our team…

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Put systems in place to screen all children aged 5-18 for overweight annually using BMI % for age	☐	☐	☐	☐	☐
Has improved our clinical management of overweight patients	☐	☐	☐	☐	☐
Put systems in place to track overweight children aged 5-18	☐	☐	☐	☐	☐
Is better able to set self-management goals with our patients	☐	☐	☐	☐	☐
Has the information they need to provide care to overweight patients	☐	☐	☐	☐	☐
Put systems in place to routinely deliver healthy weight messages using the 5-2-1-0 message	☐	☐	☐	☐	☐
Put systems in place to routinely run appropriate labs on obese patients	☐	☐	☐	☐	☐
Experiences higher staff satisfaction with the process of caring for overweight patients	☐	☐	☐	☐	☐

4. As a result of our participation in the Collaborative, I feel that our patients…

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Are better able to self-manage their risk factors for overweight	☐	☐	☐	☐	☐
Are more willing to set self management goals with providers in our practice	☐	☐	☐	☐	☐
Are more aware of long-term complications if they do not	☐	☐	☐	☐	☐

address their overweight

5. Please indicate the following percentages

	0-25%	26%-50%	51%-75%	76%-100%
What percentage of overweight PATIENTS cared for by the clinician(s) on your Collaborative TEAM has been impacted in care?	☐	☐	☐	☐
What percentage of PROVIDERS in your practice SITE has made changes to improve care as a result of the Collaborative?	☐	☐	☐	☐
What percentage of ALL the PATIENTS in your PRACTICE SITE has been impacted by improvements as a result of the Collaborative?	☐	☐	☐	☐

6. During our participation in the Collaborative, I feel our team…

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Functioned well, with clearly assigned roles and responsibilities	☐	☐	☐	☐	☐
Had clear support from the senior leader(s) of our organization	☐	☐	☐	☐	☐
Had dedicated and/or structured time to perform Collaborative related tasks	☐	☐	☐	☐	☐
Had enough time to perform Collaborative related tasks	☐	☐	☐	☐	☐

7. Please estimate the overall amount of time YOU spent per MONTH on Collaborative activities (excluding time spent to attend Learning Sessions)

☐ <1 hour
☐ 1-2 hrs
☐ 2-4 hrs
☐ 4-6 hrs
☐ >6 hrs
☐ Other (please specify)

Team plans after the Collaborative

8. After the Collaborative, as a team we plan to continue to…

	N/A-aren't currently doing this	Disagree	Undecided	Agree	Strongly Agree
Use a registry (or our electronic medical record) to identify and help manage the population of overweight patients in our practice	☐	☐	☐	☐	☐
Use a registry to offer proactive care to our overweight patients (e.g. identify patients with	☐	☐	☐	☐	☐

abnormal labs)					
Use planned care ("well") visits to routinely review needs of overweight patients	☐	☐	☐	☐	☐
Collect clinical measures of care and share them with organization's senior leaders (e.g. BMI %'iles or abnormal labs)	☐	☐	☐	☐	☐
Spread improvements and tracking of data to other providers in our organization	☐	☐	☐	☐	☐

9. Please list any other plans you have to continue overweight improvement that are not listed above in question #8.

Support after the Collaborative

10. In order to sustain the changes our team made during the Collaborative, we need...

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Better systems to collect and share data within our own organization	☐	☐	☐	☐	☐
More support from senior leaders to support this work	☐	☐	☐	☐	☐
Dedicated office time for teams to meet and plan changes	☐	☐	☐	☐	☐
Better delineation of roles and responsibilities within practice to support improvement efforts	☐	☐	☐	☐	☐
Efforts to work with payors to better align payment systems to reward improved outcomes	☐	☐	☐	☐	☐

11. If you have ideas for additional support or resources, please write them in the following box.

Satisfaction with Collaborative

12. Please indicate the components of the Collaborative your team found most or least useful for each...

	Not Useful				Very Useful
Meeting with, sharing information from other teams	☐	☐	☐	☐	☐
Learning sessions	☐	☐	☐	☐	☐
Creating storyboards	☐	☐	☐	☐	☐

Learning from the storyboards of other teams	☐	☐	☐	☐	☐
Bimonthly team conference calls	☐	☐	☐	☐	☐
Bimonthly reports (reporting of data)	☐	☐	☐	☐	☐
Support from Collaborative staff/faculty	☐	☐	☐	☐	☐
Site visits by Collaborative staff	☐	☐	☐	☐	☐
Using Chronic Care Model as a framework for improvement	☐	☐	☐	☐	☐
Using "rapid cycle change" (PDSA!) as a model for change	☐	☐	☐	☐	☐
Using BMI% for age consistently as a patient screening tool	☐	☐	☐	☐	☐
Using the 5-2-1-0 messages	☐	☐	☐	☐	☐
Provider tools from the MYOC program (e.g. flowsheets, algorithms, etc.)	☐	☐	☐	☐	☐
Patient tools from the MYOC program (e.g. patient handouts) Other (please specify)	☐	☐	☐	☐	☐

13. Please suggest other ways we could better support teams participating in a Collaborative.

14. Please indicate anything you felt was a particular weakness of the Collaborative model, or the support you received (e.g. learning sessions).

Next Steps...

15. Our team...

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Feels that our time as a team involved in the Collaborative was worth the effort	☐	☐	☐	☐	☐
Would recommend participating in a collaborative to a colleague	☐	☐	☐	☐	☐
Will CONSIDER participating in a possible phase 2 of this Collaborative	☐	☐	☐	☐	☐
DEFINITELY PLAN to participate in a phase 2 of this Collaborative	☐	☐	☐	☐	☐

16. Please feel free to write any additional comments or suggestions below.

Thank you so much for your assistance in improving the Collaborative process.

Appendix B:
Provider Flip Chart

Overweight Clinical Guidelines
(2005)

5 - Eat at least 5 servings of fruits and vegtables on most days
2 - Limit screen time to 2 hours or less daily
1 - Participate in at least 1 hour or more of physical activity every day
0 - Avoid soda and sugar-sweetened drinks; limit fruit juice to half cup or less per day. Instead, encourage water and 3-4 servings/day of fat-free milk.

This flipchart was developed by the Maine Youth Overweight Collaborative (MYOC), a joint initiative of the Maine Center for Public Health, the Maine-Harvard Prevention Research Center, and the Maine Chapter of the American Academy of Pediatrics. We particularly want to acknowledge the Kids COOP at The Barbara Bush Children's Hospital at Maine Medical Center, Maine Medical Center & MaineHealth. By providing the tools and resources included, the Collaborative seeks to provide practical support and guidance to health care practices across the state to help improve care and outcomes for overweight youth. These tools are a result of the hardwork and support of many individuals associated with the Collaborative who are dedicated to promoting healthy lifestyles for Maine families, with special thanks to the Kaiser Permanente Medical Group for sharing their tools.

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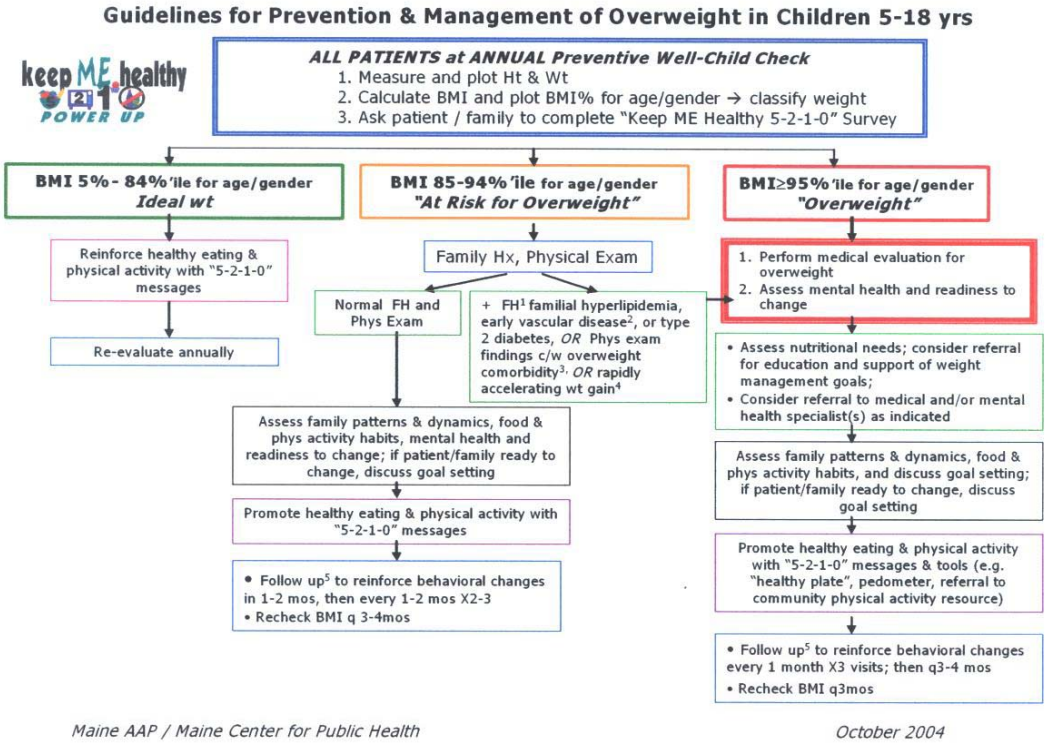
Disclaimer Statement:
The materials included here are for use in the pilot "Maine Youth Overweight Collaborative" program by participating clinicians in the diagnosis and management of youth at-risk for overweight and overweight. The information has been gathered from a variety of sources, and reflects a synthesis of current clinical consensus and expert opinion from Maine & around the nation. Please be advised that these tools collectively represent a body of work that is in progress, and may be revised in the future as guidelines and standards of care evolve. These tools are not intended to replace clinical judgment, or to promote specific care recommendations for providers outside of our pilot initiative.



Guidelines for Prevention & Management of Overweight in Children 5-18 yrs (Notes over)

Guidelines for Prevention & Management of Overweight in Children 5-18 yrs

NOTES:

(1) +FH = Family Hx of condition in parents, siblings, aunts/uncles, or grandparent

(2) Early vascular disease = Parent or grandparent with coronary atherosclerois, MI, angina, PVD, CVD or sudden cardiac death at ≤ 55 years (men) or ≤ 65 years (women)

(3) Overweight comorbidities include HTN, metabolic syndrome, PCOS, liver disease, depression, sleep apnea, asthma, mental health, orthopedic problems. Metabolic syndrome def'd as 3 or more risk factors: TG's≥110; HDL≤ 40; SBP or DBP>90th %ile; abd girth >90th %ile; impaired fasting glucose (≥100)

(4) Rapidly accelerating weight gain = annual increase in BMI or ≥3-4 units/year

(5) Follow up: Initial follow-up visit recommended to be face-to-face visit to reinforce behavioral changes; may be appropriate to utilize range of clinical staff (e.g. nurse, dietician, health educator) for visit

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Notes to Guidelines for Prevention & Management of Overweight in Children 5-18 yrs

Guidelines for the Medical Evaluation of Overweight Child 5-18yrs[1]

keep ME healthy 2 1 POWER UP

BMI ≥95%'ile for age/gender *Or...*

BMI 85-94%'ile for age/gender AND one or more risk factors:
- Fam Hx of familial hyperlipidemia, early CAD, or type 2 diabetes, OR
- Clinical signs of overweight comorbidity[2]
- Rapidly accelerating weight gain (annual increase in BMI of ≥3-4 units/yr)

Recommended Steps

All ages:	Assess BP (use largest cuff that fits comfortably around arm; cuff should cover at least 2/3's arm elbow -> shoulder)	Dx HTN if SBP or DBP >95%ile for age/gender/ht on 3 visits If HTN, assess for secondary causes HTN; obtain echocardiogrm to assess for LVH[3]; consider specialist referral. If BP90-94th % (pre-HTN), follow closely
	Assess growth velocity, predicted height (consider parental height)	
	Physical exam, including abd girth	NOTE: Abd girth >90%'ile for age may indicate increased risk for *metabolic syndrome* [*Metabolic syndrome* defined by 3 or more risk factors: TG's ≥ 110; HDL≤ 40; BP>90th %ile; abd girth>90%ile; impaired fasting glucose ≥100]
AND, IF poor growth velocity or abnormal physical findings	Assess for potential *syndromes / causes of endogenous obesity*	If poor linear growth velocity and otherwise nl exam, consider *hypothyroidism*; assess with TSH, fT4; consider specialty referral
		If abnormal facies, developmental delays, abnormal genitalia, digital abnormalities, consider *Prader-Willi, Turners, Laurence-Moon-Badet-Biedle*; consider specialty referral
		If hirsutism, moon facies, violaceous striae, HTN, consider *Cushing's*; assess with 24hr urine free cortisol/creatinine; consider specialty referral
AND, If 10+ yrs or pubertal	1) Assess for *hyperlipidemia*	Check fasting lipid profile (check once during adolescence; consider screen at younger age if +FH familial dyslipidemia)
	2) Assess for *liver disease* (steatohepatitis)	Check ALT/AST → if elevated (>1.5X nl), continue wgt mngmnt interventions X3mos, then recheck; if still elevated, check abd US and consider med rx and/or GI consult Check annually if pt continues rapid rate of wt gain; if rate of wt gain returns to normal, check q2yrs
	3) Assess *risk factors for type 2 diabetes* – i.e. • FH type 2 diabetes • Ethnicity with high prevalence type 2 diabetes (African American, Hispanic, Native American) • Signs of insulin resistance (acanthosis nigrans, HTN, dyslipidemia, abd girth>90%ile age; PCOS)	IF ≥2 risk factors for type 2 diabetes, screen for diabetes with FBS *Interpretation of FBS results:* • <100: Normal; re-evaluate every 2 yrs • 100-125: Impaired Fasting Glucose → perform 2hr Modified OGTT • ≥ 126 (X2 occasions) → type 2 diabetes mellitus
AND, for all ages	Use directed hx & phys exam to assess for *comorbidities of overweight*[2], including mental health issues; refer for specialty evaluation as indicated	IF pubertal and evidence of PCOS (oligo/amenorrhea, hirsutism), consider DHEAS, free testosterone, FBS, fasting insulin (if FBS elevated, do 2hr mod OGTT)and/or endo consult
		Mental Health: consider screening with Pediatric Symptom Checklist; depression screening (Child Depression Inventory), assessment of self esteem
		Resp: assess for dyspnea, asthma, sleep apnea, daytime sleepiness (consider sleep stdy)
		Musculoskeletal: assess for spinal asymmetry, flat feet, genu varus/valgus, bowed legs (Blount's disease), slipped capital epiphysis, tibia vara

(1) Based on "Obesity Eval & Treatment: Expert Comm Rec's", *Peds*, 102(2), Sept98 and expert opinion
(2) Also see Comorbidity Quick Reference Guide, ME Youth Overwgt Collab
(3) See "4th Report on Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents," *Peds*, 114(2), Aug2004

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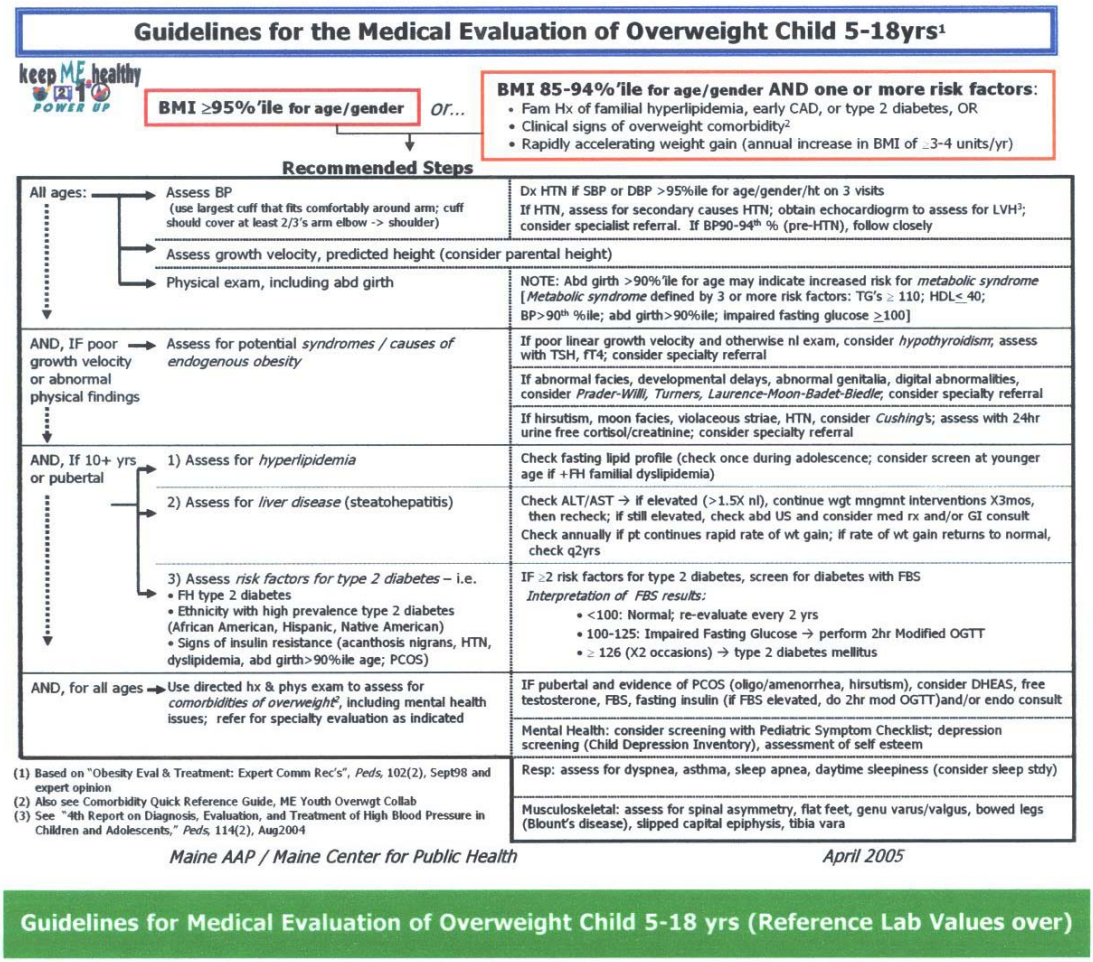
Guidelines for Medical Evaluation of Overweight Child 5-18 yrs (Reference Lab Values over)



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Maine AAP / Maine Center for Public Health *April 2005*

Guidelines for Medical Evaluation of Overweight Child 5-18 yrs (Reference Lab Values over)

Reference Lab Values

Glucose testing	Normal	Impaired	Diabetes	Reference values from American Diabetes Association 2005 Standards of Care
FBS	<100	≥100-125 (Impaired Fasting Glucose)	≥126 (repeat X2)	
2 hr Modified OGTT*	<140	140-199 (Impaired Glucose Tolerance)	>200 (repeat X2)	(*use 1.75gm/kg Glucola, to max 75gms)
Fasting glucose/insulin		<4.4 (MAY indicate insulin resistance)		

Lipids	Acceptable	"Borderline"	Abnormal
Total cholesterol	<170 mg/dl	170-199	≥200
LDL	<110	110-129	≥130
HDL	>40		(<40 is Low)

Triglycerides	Normal Male	Normal Female	Lipid Ref values from Pediatrics Vol.101(1) pg 145 Jan. 1998
8-9 yrs	25-90 mg/dl	30-115 mg/dl	
10-11 yrs	30-105	35-130	
12-15 yrs	35-130	40-125	Trig. Ref values from NHANES III (1988-1994)
16-19 yrs	40-145	40-145	

DHEAS	Male		Female	
Tanner Stage	Age	DHEAS	Age	DHEAS
1	<9.8yr	13-83 ug/dL	<9.2 yr	19-114 ug/dl
2	9.8-14.5	42-109	9.2-13.7	34-129
3	10.7-15.4	48-200	10.0-14.4	32-326
4	11.8-16.2	102-385	10.7-15.6	58-260
5	12.8-17.3	120-370	11.8-18.6	44-248
	Adult	180-450	Adult	60-255

Reference values from Esoterix Labs (Calabassas, CA)

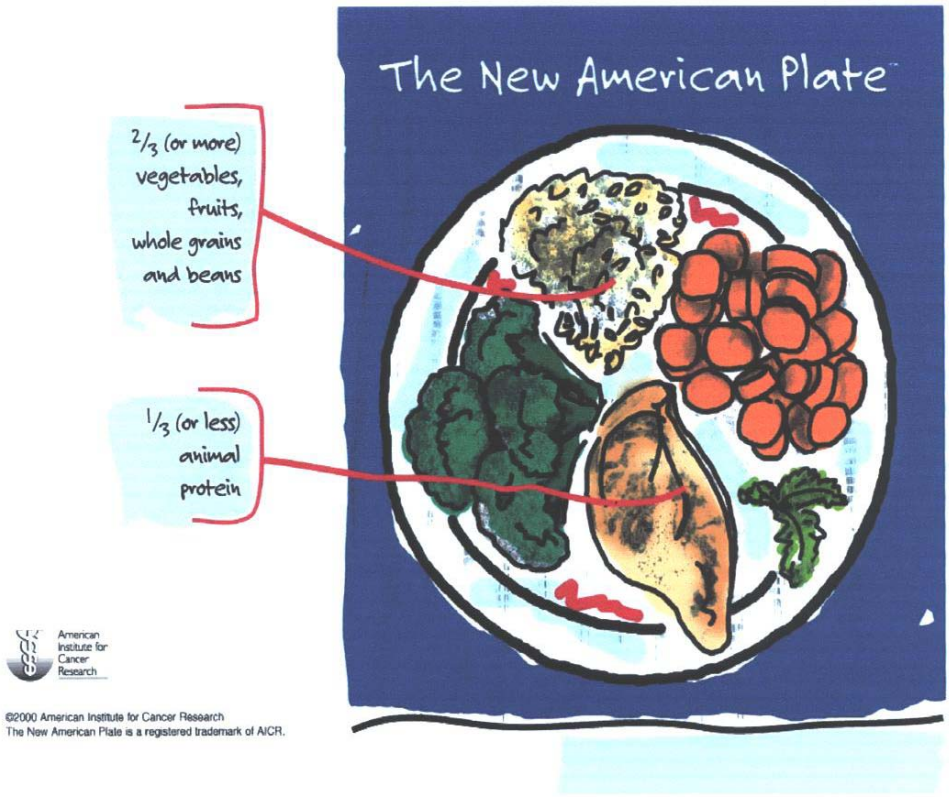
Thyroid Fxn	Pre-pubertal	Pubertal
TSH (2-20yo)	0.6-5.5 mIU/L	0.5-4.8 mIU/L
Free T4 (2yrs- adult)	0.8-2.3 ng/dL	

Reference values from Esoterix Labs (Calabassas, CA)

Abd Girth 90%'ile	8yrs	12 yrs	15 yrs	Adult	Reference values from Fernandez et al. J Pediatrics 2004;145:439-44
Male	71 cm	85 cm	94 cm	102 cm	
Female	70 cm	82 cm	90 cm	89 cm	

Maine AAP / Maine Center for Public Health *April 2005*

Reference - Lab Values



The New American Plate (Effective Communication with Families over)

Effective Communication with Families

Scott Gee, MD, Jodi Ravel, MPH, Sandra Roberts, RN, Amanda Wylie

Regional Health Education – Kaiser Permanente Northern California

Communication Techniques

Lifestyle Advice – Well Child or Urgent Visit

- < 1 minute
- Children not currently at risk for overweight

Brief Focused Advice – Well Child Visit

- < 3 minutes
- Children who are overweight or at risk for overweight

Brief Negotiation & Cognitive Behavioral Skills - Follow up Visit or Weight Management Intervention

- 10 + minutes: single or multiple sessions
- Children who are overweight or at risk for overweight

Who Do You Communicate With?

2 - 5 Years Old

- Communicate with Parent
- Child in Room

6 - 12 Years Old

- Communicate with Parent or Both
- The First Encounter Consider Taking Parent to Your Office to Discuss in Private First

Over 12Years Old

- Communicate with Teen or Both
- The First Encounter Consider Having Parent Leave Exam Room First

Brief Negotiation Skills – Particularly Effective for Contemplative/Ambivalent Patients

- Asking open ended questions
- Listening
- Summarizing
- Clinician Style: empathetic, accepting, collaborative

Cognitive Behavior Skills – For Patients Ready and Willing to Make Changes

- Develop awareness of eating habits, activity and parenting behavior
- Identification of problem behaviors
- Problem solving and modification of problem behaviors
- Weekly goal setting for children and parents on dietary, activity and self-esteem/parenting goals
- Positive reward systems
- Record keeping
- Weight checks

Stages of Behavior Change

Prochaska & Di Clemente: *Transtheoretical Model of Behavior Change*

Effective Communication with Families

REVIEW OF SYSTEMS		
✓ Developmental delay (genetic disorder) ✓ Poor linear growth ➢ Hypothyroidism ➢ Cushing's syndrome ➢ Prader-Willi syndrome ✓ Headaches ➢ Pseudotumor cerebri	✓ Nighttime breathing difficulty ✓ Daytime somnolence ➢ Sleep apnea ➢ Obesity hypoventilation syndrome ✓ Abdominal pain ➢ Gall bladder disease	✓ Hip or knee pain ➢ Slipped capital femoral epiphysis ✓ Oligomenorrhea or amenorrhea ➢ Polyscystic ovary syndrome ✓ Psycho-Social ➢ Family behavior ➢ Self-esteem ➢ Depression
PHYSICAL EXAM		
✓ Height, weight, blood pressure, and BMI ✓ Truncal obesity ➢ Risk of cardiovascular disease ➢ Cushing's syndrome ✓ Dysmorphic features ➢ Genetic disorders ➢ Prader-Willi syndrome ✓ Acanthosis nigricans ➢ Diabetes ➢ Insulin resistance	✓ Hirsutism ➢ Polycystic ovary syndrome ➢ Cushing's syndrome ✓ Violaceous striae ➢ Cushing's syndrome ✓ Optic disks Pseudotumor cerebri ✓ Tonsils ➢ Sleep apnea ✓ Abdominal tenderness ➢ Gall bladder disease	✓ Undescended testicle ➢ Prader-Willi syndrome ✓ Limited hip range of motion ➢ Slipped capital femoral epiphysis ✓ Lower leg bowing ➢ Blount's disease

Adapted from Wellpoint.com Patient Counseling Guidelines for Families with Overweight Children and Adolescents

Co Morbidity Quick Reference (Treatment Interventions for the Overweight Child over)

TREATMENT INTERVENTIONS FOR THE OVERWEIGHT CHILD
(BMI ≥95%'ile for age/gender)

1) **Choose and/or tailor interventions** to ensure they are appropriate for patient's age, and to meet patient and family's readiness to change. **Keys: start early/aim long term behavioral change; small steps/gradual change; family support/praise; measurable.**

2) **Use Motivational interviewing with brief negotiation and brief focused advice** to engage patient and family in goal setting for specific behaviors. Patient chooses option; scale motivation; co-sign contract; measurable goals with specific lifestyle/behavior change. **Keys to Motivation: fun; challenge ("ask for less; they'll give you more"); responsive to peer/social approval; sensitive to appearance; simple/ explicit steps; set goals that are measurable ("if you can't count it you can't change it"); empathize don't criticize.**

3) **Consider mental health consult** (e.g. child psychology) to evaluate family stressors and co-morbidities (e.g. depression, anxiety, PTSD, etc) and need for mental health intervention (e.g. family counseling, individual, medications.)

4) **Promote healthy eating and nutritional education:**
   a) Assess patient and family's dietary habits using MYOC "Provider Tool for Diet Assessment"
   b) Facilitate child/family nutritional consult, to include appropriate interventions – e.g.
      - Provide practical advice and visual portion size education using "healthy plate" method
      - Advise balanced age-appropriate diet emphasizing 5 fruits/vegetables each day; lower carbohydrates/refined sugars; healthy fats and proteins; and skim or 1%lowfat milk (versus whole milk, or juice and soda)
      - Encourage healthy family food behaviors – e.g. regular breakfasts, structured family suppers, limited fast food restaurants, "parent provides/child decides", not using food as bribe or reward.
      - Aim for reasonable daily target for calorie reduction (e.g. 200-300 calories less daily).

5) **Promote increased physical activity:**
   a) Assess patient and family's physical activity habits, using MYOC "Physical Activity Survey"
   b) Advise physical activity of 60 minutes or more daily (including walking), and 20 minutes vigorous aerobic activity at least 3 days week. Emphasize OUTDOOR physical activity.
   c) Encourage a decrease in physical inactivity: advise family to limit *total* screen time to 2 hours or less per day (TV, computer, video games, etc)
   d) Advise no TV in bedroom! (and/or remove TV from bedroom)
   e) Refer to specific community physical activity program (e.g. local YMCA/YWCA; Boys/Girls Club; before/after school physical activity program)
   f) Encourage development of family physical activity plan (e.g. "Move and Improve")
   g) Provide free pedometers with age appropriate goal of daily steps for BOTH patient and parent.

6) **Sub-specialist Referral** with persisting co-morbidities despite 4-6 months intensive, focused healthy lifestyle interventions above: nutritionist; peds endocrinology with persisting metabolic syndrome/ Type 2 Diabetes; peds GI with progressive ALT elevation; polysomnography with persistent sleep disorder/ daytime fatigue; orthopedics with hip/ knee pain; neurology with headaches/ pseudo-tumor cerebri; psychology with persistent depression, etc.

Treatment Interventions for the Overweight Child - Maine AAP WorkPlan

Lifestyle Advice

To stay healthy and energized:

5 Eat at least 5 servings of fruits & vegetables on most days
2 Limit screen time to 2 hours or less daily
1 Participate in at least 1 hour or more of physical activity every day
0 Avoid soda & sugar-sweetened drinks; limit fruit juice to half cup or less per day. Instead, encourage water and 3-4 servings/day of fat-free milk.

Brief Focused Advice

Step #1: Engage the Patient / Parent	**Step #2: Share Information (optional)**
• Can we take a few minutes together to discuss your health and weight? • What do you think of your health and weight?	• Your current weight puts you at risk for developing heart disease and diabetes. • What do you make of this? • Some ideas for staying healthy include...(see tool kit) • What are your ideas for working toward a healthy weight?
Step #3: Make a Key Advice Statement	**Step #4: Arrange for Follow Up**
• I strongly encourage you to... ✓ Eat at least 5 servings of fruits & vegetables on most days ✓ Limit screen time to 2 hours or less daily ✓ Participate in at least 1 hour or more of physical activity every day ✓ Avoid soda & sugar-sweetened drinks; limit fruit juice to half cup or less per day. Instead, encourage water and 3-4 servings/day of fat-free milk. • Use patient ideas from step #2	• Would you be interested in more information on ways to reach a healthier weight? AND / OR • Let's set up an appointment in ___ weeks to discuss this further.

Adapted from the Permanente Medical Group, Inc. Northern California Regional Health Education

ABCs of Counseling and Motivating Overweight Children and Families

Ask Open-Ended Questions
- ✓ How do you feel about us talking about your physical activity, TV watching, and eating today?
- ✓ Assess what the patient knows
- ✓ How concerned are you about the patient's weight?
- ✓ What practices need to be changed?

Body Language
- ✓ Put patient at ease
- ✓ Use eye contact without barriers
- ✓ Convey respect
- ✓ Counsel in a private setting

Care and Empathy
- ✓ Do not criticize
- ✓ Acknowledge patient's feelings
- ✓ Answer questions without sign of judgment
- ✓ Use language that is nonjudgmental:
  - Healthier food vs. bad food
  - Healthier weight vs. ideal weight
  - Overweight vs. obese

Lifestyle Advice (Brief Negotiation over)

Brief Negotiation

Overweight Sensitivity
"Do no harm"

INSTEAD OF...	USE...
• Obesity	• Overweight
• Ideal Weight	• Healthier Weight
• Personal Improvement	• Family Improvement
• Focus on Weight	• Focus on Lifestyle
• Diets or "Bad Foods"	• Healthier Food Choices
• Exercise	• Physical Activity

Open the Encounter

Ask Permission
- *Would you be willing to spend a few minutes discussing your weight? / Are you interested in discussing ways to stay healthy and energized?*

Ask an Open-Ended Question – Listen – Summarize
- *What do you think/How do you feel about your weight? / What have you tried so far to work toward a healthier weight?*

Share BMI / Weight (optional)
- *Your current weight puts you at risk for developing heart disease and diabetes. / Your BMI is at the 92nd percentile. The recommended level for your age is 85 or below.*
- Ask for the patient's interpretation: *"What do make of this?"*
- Add your own interpretation or advice as needed AFTER eliciting the patient's / parent's response.

Negotiate the Agenda

5 Eat at least 5 servings of fruits and vegetables on most days.

2 Limit screen time to 2 hours or less daily.

1 Participate in at least 1 hour or more of physical activity every day.

0 Avoid soda and sugar-sweetened drinks; limit fruit juice to half cup or less per day.
Instead, encourage water and 3-4 servings/day of fat-free milk.

- *Is there one of these you'd like to discuss further today? Or perhaps you have another idea that isn't listed here?*

Assess Readiness
- *On a scale from 0 to 10, how ready are you to consider [option chosen above]?*
- Straight question: *Why a 5?*
- Backward question: *Why a 5 and not a 3?*
- Forward question: *What would it take to move you from a 5 to a 7?*

0 1 2 3 4 5 6 7 8 9 10

Explore Ambivalence

Step 1: Ask a pair of questions to help the patient explore the pros and cons of the issue.
- *What are the things you like about _____?* **AND** *What are the things you don't like about_____?* **OR**
- *What are the advantages of keeping things the same?* **AND** *What are the advantages of making a change?*

Step 2:
- Summarize ambivalence: *Let me see if I understand what you've told me so far....* (begin with reasons for maintaining the status quo, end with reasons for making a change)
- Ask: *Did I get it all? / Did I get it right?*

Tailor the Invention

Stage of Readiness	Key Questions
Not Ready 0 - 3 • Raise Awareness • Elicit Change Talk • Advise and Encourage	• *Would you be interested in knowing more about reaching a healthy weight?* • *How can I help?* • *What might need to be different for you to consider a change in the future?*
Unsure 4 – 6 • Evaluate Ambivalence • Elicit Change Talk • Build Readiness	• *Where does that leave you now?* • *What do you see as your next steps?* • *What are you thinking / feeling at this point?* • *Where does _____ fit into your future?*
Ready 7 – 10 • Strengthen Commitment • Elicit Change Talk • Facilitate Action Planning	• *Why is this important to you now?* • *What are your ideas for making this work?* • *What might get in the way? How might you work around the barriers?* • *How might you reward yourself along the way?*

Close the Encounter
- Summarize: *Our time is almost up. Let's take a look at what you've worked through today...*
- Show Appreciation / Acknowledge willingness to discuss change: *Thank you for being willing to discuss your weight.*
- Offer advice, emphasize choice, express confidence: *I strongly encourage you to be more physically active. The choice to increase your activity, or course, is entirely yours. I am confident that if you decide to be more active you can be successful.*
- Confirm next steps and arrange for follow up: *Are you able to come back in 1 month so we can continue to work together?*

Adapted from the Permanente Medical Group, Inc. Northern California Regional Health Education

Brief Negotiation

Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Girls Age 1 to 17 Years by Percentiles of Height

Age	Height Percentiles* → / BP† ↓	Systolic BP (mm Hg) 5%	10%	25%	50%	75%	90%	95%	Diastolic BP (mm Hg) 5%	10%	25%	50%	75%	90%	95%
1	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	105	107	107	57	57	57	58	59	60	60
2	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15	90th	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

*Height percentile determined by standard growth curves.
†Blood pressure percentile determined by a single measurement.

Blood Pressure Reference - 90% Girls (Boys over)

Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Boys Age 1 to 17 Years by Percentiles of Height

Age	Height Percentiles* → / BP† ↓	Systolic BP (mm Hg) 5%	10%	25%	50%	75%	90%	95%	Diastolic BP (mm Hg) 5%	10%	25%	50%	75%	90%	95%
1	90th	94	95	97	98	100	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	104	106	106	55	55	56	57	58	59	59
2	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15	90th	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89

*Height percentile determined by standard growth curves.
†Blood pressure percentile determined by a single measurement.

Blood Pressure Reference - 90% Boys

Selected excerpts from "The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents," Pediatrics, Vol. 114, No. 2, August 2004

Definition of Hypertension

- **Hypertension** is defined as average SBP and/or diastolic BP (DBP) that 95th percentile for gender, age, and height on ≥3 occasions.
- **Prehypertension** in children is defined as average SBP or DBP levels that are ≥90th percentile but <95th percentile; as with adults, adolescents with BP levels ≥120/80 mm Hg should also be considered prehypertensive.
- A patient with BP levels >95th percentile in a physician's office or clinic, who is normotensive outside a clinical setting, has "white-coat hypertension." Ambulatory BP monitoring (ABPM) is usually required to make this diagnosis.

Table 7: Clinical Evaluation of Confirmed Hypertension

Study or Procedure	Purpose	Target Population
Evaluation for identifiable causes		
History, including sleep history, family history, risk factors, diet, and habits such as smoking and drinking alcohol; physical examination	History and physical examination help focus subsequent evaluation	All children with persistent BP ≥95th percentile
BUN, creatinine, electrolytes, urinalysis, and urine culture	R/O renal disease and chronic pyelonephritis	All children with persistent BP ≥95th percentile
CBC	R/O anemia, consistent with chronic renal disease	All children with persistent BP ≥95th percentile
Renal U/S	R/O renal scar, congenital anomaly, or disparate renal size	All children with persistent BP ≥95th percentile
Evaluation for comorbidity		
Fasting lipid panel, fasting glucose	Identify hyperlipidemia, identify metabolic abnormalities	Overweight patients with BP at 90th–94th percentile; all patients with BP ≥95th percentile; family history of hypertension or CVD; child with chronic renal disease
Drug screen	Identify substances that might cause hypertension	History suggestive of possible contribution by substances or drugs.
Polysomnography	Identify sleep disorder in association with hypertension	History of loud, frequent snoring
Evaluation for target-organ damage		
Echocardiogram	Identify LVH and other indications of cardiac involvement	Patients with comorbid risk factors* and BP 90th–94th percentile; all patients with BP ≥95th percentile
Retinal exam	Identify retinal vascular changes	Patients with comorbid risk factors and BP 90th–94th percentile; all patients with BP ≥95th percentile
Additional evaluation as indicated		
ABPM	Identify white-coat hypertension, abnormal diurnal BP pattern, BP load	Patients in whom white-coat hypertension is suspected, and when other information on BP pattern is needed
Plasma renin determination	Identify low renin, suggesting mineralocorticoid-related disease	Young children with stage 1 hypertension and any child or adolescent with stage 2 hypertension Positive family history of severe hypertension
Renovascular imaging Isotopic scintigraphy (renal scan) MRA Duplex Doppler flow studies 3-Dimensional CT Arteriography: DSA or classic	Identify renovascular disease	Young children with stage 1 hypertension and any child or adolescent with stage 2 hypertension
Plasma and urine steroid levels	Identify steroid-mediated hypertension	Young children with stage 1 hypertension and any child or adolescent with stage 2 hypertension
Plasma and urine catecholamines	Identify catecholamine-mediated hypertension	Young children with stage 1 hypertension and any child or adolescent with stage 2 hypertension

BUN, blood urea nitrogen; CBC, complete blood count; R/O, rule out; U/S, ultrasound.
* Comorbid risk factors also include diabetes mellitus and kidney disease.

Hypertension in Children (Hypertension Management Algorithm over)

Fig. 1: Hypertension Management Algorithm

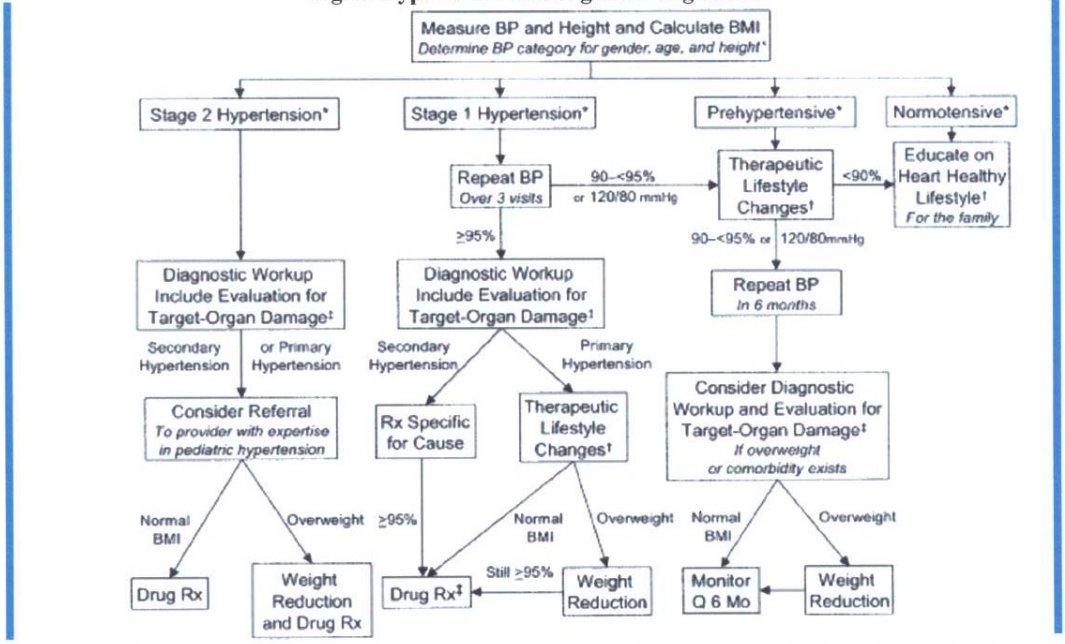


Fig 1. Management algorithm. Rx indicates prescription; Q, every. *, See Tables 3, 4, and 5; †, diet modification and physical acti especially if younger, very high BP, little or no family history, diabetic, or other risk factors.

THERAPEUTIC LIFESTYLE CHANGES

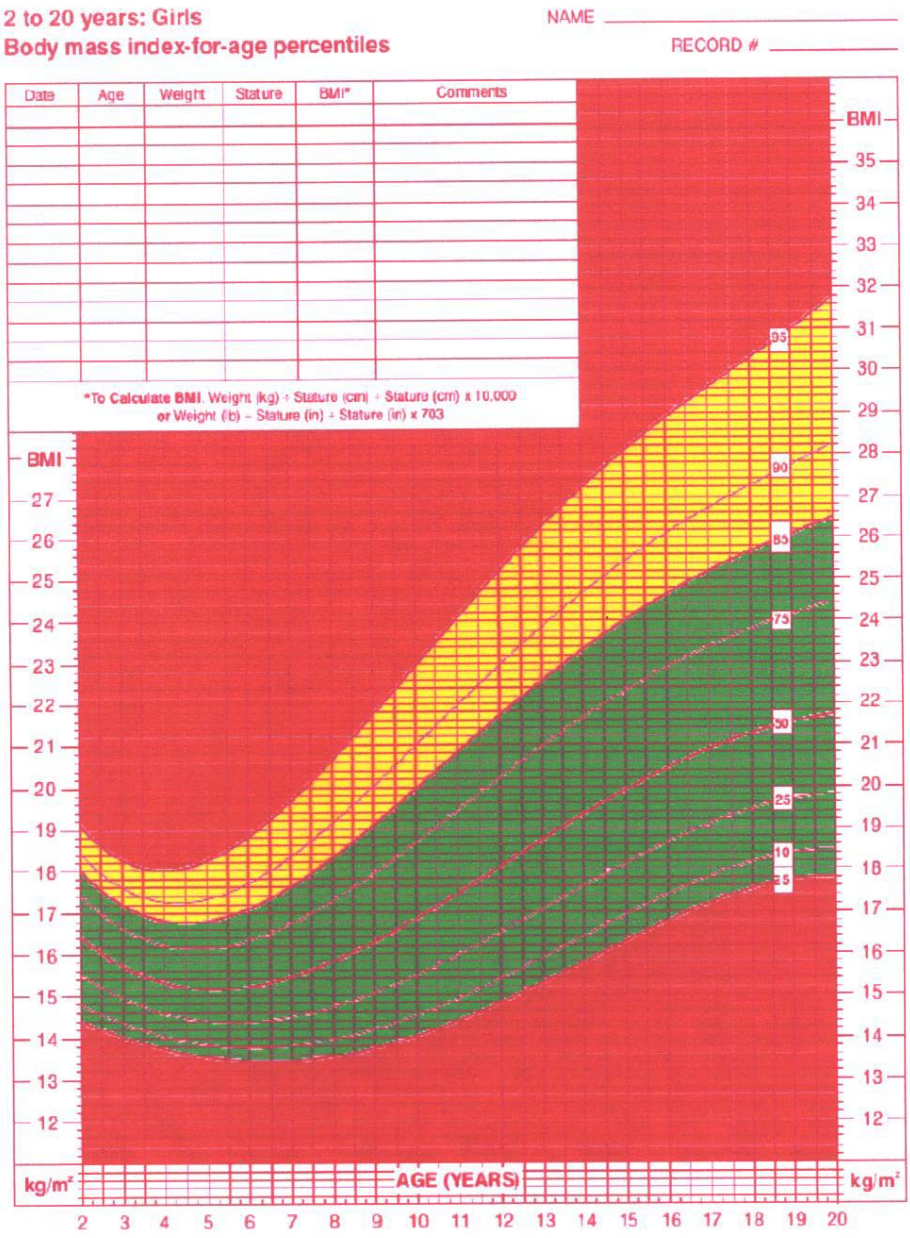
- Weight reduction is the primary therapy for obesity-related hypertension. Prevention of excess or abnormal weight gain will limit future increases in BP.
- Regular physical activity and restriction of sedentary activity will improve efforts at weight management and may prevent an excess increase in BP over time.
- Dietary modification should be strongly encouraged in children and adolescents who have BP levels in the prehypertensive range as well as those with hypertension.
- Family-based intervention improves success.

Table 6. Indications for Antihypertensive Drug Therapy in Children

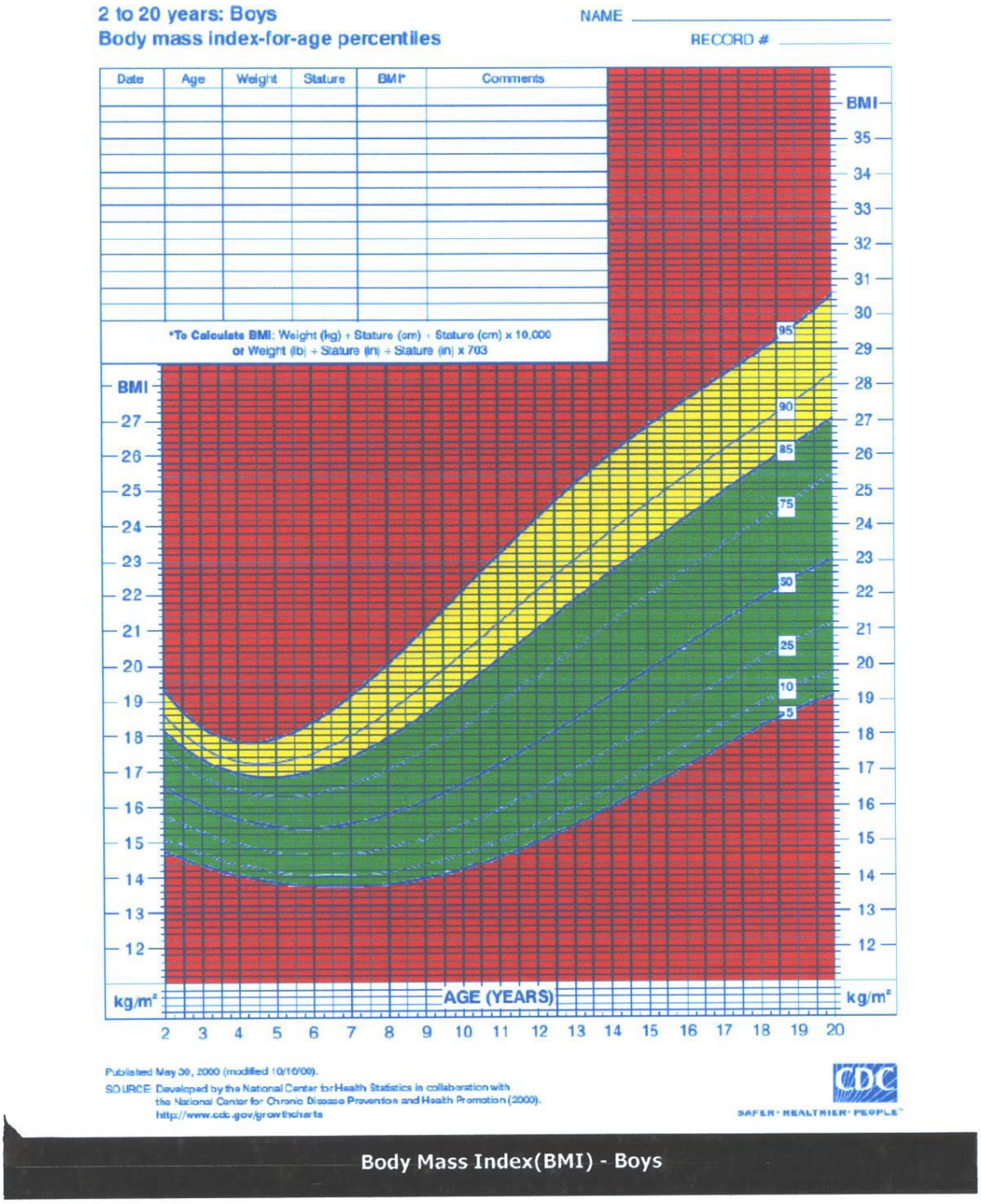
- Symptomatic hypertension
- Secondary hypertension
- Hypertensive target-organ damage
- Diabetes (types 1 and 2)
- Persistent hypertension despite nonpharmacologic measures

From "The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents," Pediatrics, Vol. 114 No. 2, August 2004

Hypertension Management Algorithm



Body Mass Index(BMI) - Girls (Boys over)



Body Mass Index(BMI) - Boys

What Are The Potential Limitations to BMI?

William Dietz, MD, PHD, Director, Division of Nutrition & Physical Activity – Centers for Disease Control & Prevention

There are several potential limitations to Body Mass Index which require that it not be used as the exclusive standard by which to judge a child at risk of overweight or overweight. The first limitation is that, as you know, BMI is weight divided by height squared.

Weight and height do not directly measure body fatness, so that an additional criteria that should be used for determining whether somebody who is overweight (as indicated by BMI greater than the 95th percentile) is overfat, is a measure of a skinfold thickness – like the tricep skinfold thickness. This will help differentiate children and teenagers who are both overweight and overfat from those who are overweight because of increased muscle mass or bone mass.

One of the questions is how sensitive and specific the BMI is for the identification of children with increased fatness. We compared body fatness in children and teenagers measured by DEXA (which is a definitive measure of body composition) with children with a BMI over the 95th percentile. The overwhelming majority of those children – 95 percent of those children with a BMI greater than the 95th percentile – also had increases in percent body fat compared to the general population.

The second consideration is how valid Body Mass Index is as a predictor of risk.

We know, from studies of 5 to 10 year-old children whose BMI is greater than the 95th percentile, that 60 percent have a least one additional cardiovascular disease risk factor – like elevated systolic or diastolic blood pressure, elevated cholesterol or triglycerides, or elevated insulin levels. In addition about 15 percent of those same children (with a BMI greater than the 95th percentile) have two or more risk factors.

Therefore, BMI not only identifies children who have increased body fatness, but in addition BMI also indicates that those children who are overweight have associated risk factors.

Smoothed 95th Percentiles of Triceps Skinfold Thickness for NHANES 1 Subjects[1]

To determine triceps skinfold measurements: measure the midpoint between the acromion and olecranon process on the posterior surface of the right arm and mark it. With the patient's arm relaxed, grasp the skinfold about 1 cm above the midpoint, taking care to exclude muscle from the grasp. Measure the skinfold thickness with calipers, such as Lange or Holtain calipers, that provide standardized pressure. Repeat two to three times.

Males	95th Percentile	Females	95th Percentile
Years	mm	Years	mm
6-6.9	14	6-6.9	16
7-7.9	16	7-7.9	18
8-8.9	17	8-8.9	20
9-9.9	19	9-9.9	22
10-10.9	21	10-10.9	24
11-11.9	22	11-11.9	26
12-12.9	23	12-12.9	28
13-13.9	24	13-13.9	30
14-14.9	23	14-14.9	31
15-15.9	22	15-15.9	32
16-16.9	22	16-16.9	33
17-17.9	22	17-17.9	34
18-18.9	22	18-18.9	34
19-19.9	22	19-19.9	35

[1] Barlow SE and Dietz WH. Obesity recommendations and treatment. *Journal of Pediatrics* 1998; 102(3).

Appendix C:
Post-Test Provider Survey Open-Ended Questions and Responses

One of the most positive things you are doing now for overweight patients as compared to before

- More follow up is being done, better follow up with dietician, phone f\u.
- Careful interview and assessment of readiness for change.
- I find the 5-2-1-0 survey a good way to start the discussion about healthy eating and exercise habits.
- Discussing 5-2-1-0 message with all pts.
- Scheduling close f\u visits. Giving concise, easy to follow recommendations in terms of 5-2-1-0 recommendations.
- I am tracking BMI. I am asking about screen time with all patients.
- Motivational interviewing.
- Feeling more comfortable addressing issue with families.
- Realistic goal setting and attempts with follow up, more motivational interviewing.
- Using BMI as often as I can.
- 5-2-1-0 rule. Tracking BMI and wt. graph more frequently.
- I am using the 5-2-1-0 too!
- Decreased soda consumption, more eating breakfast rather than skip it.
- More focused education.
- Looking for them and documenting BMI% consistently.
- I calculate BMI on all patients over 2 years old at well-child check-ups and often at routine appts. as well.
- Having patient education posters and materials to reinforce what I am suggesting.
- It's easier to connect with families in these issues because of the posters and office information. People come in asking for help.
- Recommending 5-2-1-0, encouraging activity.
- Confronting it, have some strategy. More important is prevention piece.
- Talking more about 5-2-1-0 and listening to what things they think will help and what doesn't.
- Specific focused changes to make (5-2-1-0), clear definitions of when to send labs. Motivational interviewing.
- Started healthy weight clinic.
- Refer for counseling.
- Talking about it in a way that feels comfortable to patient and to me. Before using the survey, I didn't know how to bring up the topic at all, now I bring it up with everyone, and easily get to goal-setting when necessary.
- I am doing all the same things as for counseling.
- Putting 3+4 x0 on BMI chart quite informative.

- Having an actual system to use to help us with overweight patients.
- Giving more handouts.
- Use 5-2-1-0 survey on all.
- Keeping track of BMI for all patients, catches other kids with elevated BMI trend earlier then easier to help them.
- Being able to make a positive change in our practice that renders a difference for patients instead of by doing the same thing over again.
- More consistent approach to overweight issue. I've had much better success with weight reduction than before MYOC.
- Open discussion.
- Follow laboratory data more carefully for overweight children.
- Closer follow up, discussing 5-2-1-0 plan consistently, establishing small goals.
- I have a new approach to gaining permission to respectfully discuss issues of elevated BMI/overweight with all patients.
- Measuring BMI for everyone using the 5-2-1-0, great tool. Addressing weight with all overweight patients.
- N/A-new to practice in area.
- Tracking BMI with patients and parents and addressing weight with tools provided by MYOC.

Greatest challenges addressing physical activity and nutrition with all patients

- Getting parents to meet with nutrition/dietician, lack of resources.
- Resources for physical activity.
- Patients/families being able to implement changes.
- Motivation of kids and often more important families regarding making changes.
- Culture, motivation!
- Time constraints.
- Getting height in charts to do BMI.
- Available resources, socioeconomic status, obese parents raising obese (overweight) children with poor eating habits.
- Large practice with many providers and small pediatric population.
- Time, motivation level of pts and families. Getting parents to reduce their own and the children's screen time.
- Lack of insight of parents into seriousness of childhood obesity.
- Baseline is no exercise in most kids. I handed out pedometers and encouraged 10,000 steps per day after MYOC. Many leave early on long bus route and skip breakfast.
- The "discomfort" associated with discussing weight issues with people in general. Families reluctance to see obesity as a condition over which they have significant control.
- Resistance to change, acceptance of overweight as the norm.
- Old habits die hard. Parents are often leading by example, watching TV, eating too much, not exercising.

- Community resources for physical activity, not enough classes such as dance that kids would like, sports for kids. We do have Y memberships for Medicare pts. Not enough nutritionists in our area. Augusta.
- Third party payers won't pay for a follow up visit. Some parents aren't ready for change. The eating/feeding behavior is adaptive for them.
- Poor compliance, not ready.
- Compliance.
- Rural Maine-decrease access to YMCA's/gyms. Money to buy more fresh foods vs. processed. Self motivation.
- Being ready to change getting the whole family involved (many parents don't want to give up whole milk/soda), finding places to do physical activity (cold weather), snow, cost of YMCA, distance/transportation to YMCA.
- Some weren't ready for change, especially with TV.
- Limited access to physical activity in rural areas and economic limitations in diet compliance.
- This is so individual that it seems to take a lot of time. With nutrition, there are so many currently popular diet plans that can lead to a longer discussion. In a nutshell, time limitation.
- Some patients BMI is high but they don't look overweight. I hesitate especially with girls to talk about obesity if their BMI is high because of height
- Not enough time. People don't want to hear about it. I don't perceive there being enough community support for interview.
- Limited time and resources and family buy in.
- Coming to f\u, patients not being motivated.
- Motivation.
- Motivation by patients and families.
- Convincing the administrators that overweight issues are an important part of pediatrics when it is not being measured by the quality programs. Other diseases take precedence like diabetes, one of the complications we are trying to prevent. Also convincing families that they need to change their entire lifestyle.
- Winter, "it's too cold outside," Medicaid pays for one nutritionist visit unless underlying medical problem.
- Some parents get angry. Some families don't care.
- Resistance if familiar.
- Lifestyle changes are difficult. Community resources are limited.
- Parental resistance, poor nutritional choices at school, poor resources with regards to physical activities.
- Finding community resources and helping the entire family to make dietary and exercise changes.
- Families that are dual-household-split parents, (inconsistent parenting). Families with limited income/education and means.
- Poor f\u in most patients, unmotivated despite time spent.

- Financial constraints-families with limited incomes/resources/education. Time constraints-both provide for patient/family. Parental divorce-2 households, 2 different parenting styles and approaches to nutrition. Parental alcoholism/substance abuse and dysfunction.

Greatest challenges addressing physical activity and nutrition with overweight patients

- Same in general population.
- Lack of resources for physical activity.
- Patients/families being able to implement changes.
- Motivation of kids and often more important families regarding changes.
- Culture, family lifestyle/family dz.
- Getting them to feel there was something in lifestyle which could be contributing to problem.
- Social stigma regarding using term overweight in children.
- Getting people motivated, lack of social support/family support to make these changes.
- Time, motivation level of pts and families. Getting parents to reduce their own and the children's screen time.
- Patients and families tend to be defensive. They tend to under report eating behavior.
- Lack of insight, difficulty changing behaviors.
- Baseline no exercise and too large portion size.
- Getting buy in for the presence of a problem in the first place.
- Parents and patients are not very accurate with diet histories. A dietician or nutritionist interested in following/counseling overweight kids and their families is not really available.
- Motivation to change.
- Lack of nutrition.
- Maintaining the behavior.
- Patient not ready, does not admit weight is a problem, embarrassed to talk about this, does no t want help.
- Self motivation, money for fresh produce. Inability of family to see better choices/feeling that they were doing the best they could.
- Poor motivation, not wanting to try exercise, to be seen out of shape or in a bathing suit.
- Some weren't ready for change.
- Resource.
- Getting the entire family engaged.
- In our climate it is difficult to regularly exercise outside and people who can't afford the Y or have no transportation have a hard time.
- Money-can't afford YMCA etc. Live in area where nowhere safe for walking.
- Limited time and resources and family buy in.

- Coming to f\u.
- Motivation and PA resources.
- Motivation by patients and families.
- Convincing families that there is a problem.
- Making them understand that it's a family systems change.
- "Too cold to go outside", father buys whole milk.
- TV.
- Lack of opportunities in area to be active. Lots of child/parents says "too cold to walk, isolated roads, no pool in area etc."
- Changing family practices with diet and activity.
- Families that are dual-household-split parents (inconsistent parenting). Families with limited income/education and means. Readiness to change.
- Lack of community resources and lack of patient motivation.
- Financial constraints-families with limited incomes/resources/education. Time constraints-both provide for patient/family. Parental divorce-2 households, 2 different parenting styles and approaches to nutrition. Parental alcoholism/substance abuse and dysfunction.

Successes with regard to addressing physical activity and nutrition

- Have seen kids in f\u who have increased exercise and lowered BMI.
- Success with limited step wise change, decrease whole milk to 1 or 2 % or skim.
- Have had some success with decreasing BMI slowly for some kids, have also had improvement in cholesterol for some kids although BMI not decreasing.
- I am much more comfortable discussing weight.
- Parent teaching in an overweight 3 year old. I think their bad habits regarding his diet were highlighted by our discussion.
- With family support and encouragement patients are more motivated to change behavior such as increase activity and drink less soda or switch to diet.
- Once a patient is convinced to act, they are often successful.
- Have not followed my overweight patients long enough to be able to address success.
- I have used this program with all overweight or at risk overweight children at their well-child check and handed out a pedometer to each one (compliments BCBS insurance company). Gave other handouts and done contact and f\u phone call in one month if desired by family. I have had no success.
- Overall increase in community awareness, good regional partnerships formed through HMP and school connections.
- Patients and families that are motivated to improve can, others don't.
- One boy weighed 360 lbs at his physical. He started walking and stopped all soda. He lost 46 lbs and his mother lost 30
- Some success, some weight loss overall, patient have been more receptive to one change at a time.
- Have had a few level off.

- One family that incorporated exercise and healthy eating, the child lost 20 lbs over 4-5 month period.
- Some actually lost weight only applying 5-2-1-0.
- Several patients are close to achieving at/BMI goals.
- Some motivated families whose younger children were 90-95% BMI were able to make small changes and prevent overweight. Some fears (a few) made changes on their own or with interviews for nutrition.
- A few times actually "seeing the light" and succeeding with decreased rate of wt gain or actual weight loss.
- Helped to have handouts.
- 5-2-1-0 nutrition messages received. Simply being better armed with knowledge and evidence based guidelines.
- One child at grade school level had open gym time and got "points" for walking miles. Had actually lost quite a bit of weight (school based program).
- Many families have made a change and we have had multiple successes with kids with gradual but steady weight loss.
- 5-2-10 survey provides an excellent opportunity to address healthy choices/recommendations. In the past overweight issues were very difficult to manage. I have had much better success this time dealing with this issue.
- Some.
- Several families, especially those committed to close follow up have made significant lifestyle changes and a number have began to lose weight.
- Very difficult, baby steps.
- Several motivated patients truly benefit from motivational interview and weight loss and physical fitness as a way to become healthier and prevent health problems.
- Lots of success with knocking out juice and soda. Some success with increasing physical activities. Some wonderful moments when at annual f\u the BMI dropped-we think due to our 5-2-1-0 rule.
- A couple of patients have very seriously pursued healthy lifestyle modification, with good results.

What support you would like now

- Dietary support, nutrition support, psych support, referral for morbid obesity.
- More nutrition support, more psych support, support finding and utilizing community resources.
- Up and running referral center. Increase community access and physical activity in schools.
- I think the majority of changes need to come on a macro rather than micro level. I still find dealing with overweight patients a frustrating issue, as the proportion able to implement changes is by far the minority.
- More behavioral brochure change training.
- Continued training.

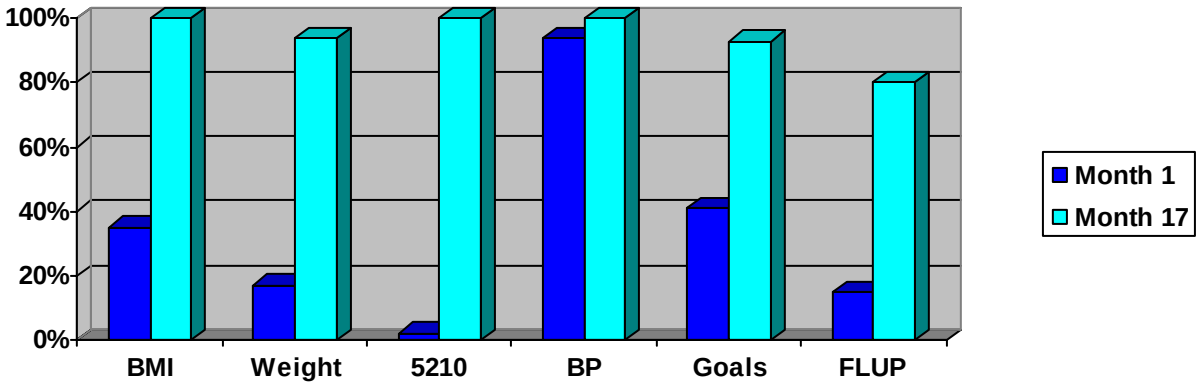
- Community resources, education on appropriate lab tests.
- BMI and behavioral goal setting and motivational interviewing resource materials.
- Specific resources list within community to help support nutritional behavioral changes.
- If grants available I would like grant written to install step/dance videogame (popular version commercially at movie theatre) as trial in waiting room. Suggest seek funding to open all school gyms for every morning walks for families and evaluate if used.
- Expression of practices from collaborative to become the norm for all practice.
- An itinerant nutritionist or dietician interested in counseling, follow up overweight kids and their families.
- Get third party payers to pay for f\u. Print brochures for families.
- Exercise and activity for those who do not have their (cannot read rest of response).
- Sub specialists for different cases.
- A nurse manager to help run this program in the clinic.
- We need to engage schools as resource for physical activity.
- Free or low-cost exercise programs/vouchers.
- Improved community support such as tie-in with programs at places like the Y including financial support. How to affect the food choices in schools including vending machines.
- How do we get patients to come and how to motivate unmotivated patients.
- Need to stay involved in MYOC, to continue to work out system barriers.
- Ideas on how to get patients/families to f\u on MYOC visits.
- Continued support with the administration state support for making this a quality issue.
- Continued community involvement.
- Plastic models of normal portion sizes would be helpful to use during visits.
- YMCA in area?
- More help with a really nice registry. Educational/continued monitoring. The chart audits we did were great for keeping us going.
- Technical support with registry would be valuable.

Appendix D:
Practice Team Bimonthly Summary Reports, Bimonthly Percentages and Baseline/Post Table

Table 12: Average Bimonthly Required Measures From Summary Team Reports

	MYOC Month								
	1	3	5	7	9	11	13	15	17
BMI %ile for age, gender	35%	81%	80%	93%	93%	93%	95%	93%	100%
Weight classification	17%	65%	70%	80%	70%	80%	80%	90%	94%
5210 messages	2%	28%	70%	80%	80%	75%	76%	90%	100%
Blood Pressure	94%	99%	99%	99%	100%	93%	100%	100%	100%
Goal Setting	41%	70%	37%	63%	72%	79%	86%	60%	93%
Follow-up Appointment made	15%	53%	58%	43%	50%	50%	67%	51%	80%

Figure 4: Month 1 and Month 17 Average scores for Required Bimonthly measures



Appendix E:
Team Highlights from Learning Sessions 2 and 3

Table 13: Team Highlights from Learning Session #2

Accomplishments	Challenges	Plan for Action Period 2
Site 1		
• Using 5-2-1-0 tool for all kids at preventive care visit • Using EMR to calculate BMI & chart overweight diagnosis • Have established better relationship with local dieticians for referrals • Have been working with HMP to develop one page listing of community resources for physical activity & local agencies to be more receptive to taking kids into programs	• Next steps—try to incorporate negotiation into visit • Negative reception from patients & families about BMI (not sure if it's how they're doing this) • Particular concerns about triggering eating disorders	• Dietician referrals & visit notes to be in EMR • Ongoing staff development re 5-2-1-0 (educational sessions) • Hospital grand rounds to spread message • Educational session at residency to spread message • Educate other providers re—negotiation • Test accuracy of EMR as registry • Quantify % overweight with follow-up
Site 2		
• Using 5-2-1-0 survey in all preventive care visits • Doing BMI in all preventive care visits • Early start at using registry for >95th % • Starting to work with HMP to begin community mapping (creating state map with pins of various towns served and corresponding list of local resources) • Using soda bottle displays to show sugar content	• Spread to other doc's in practice—especially how to spread MI training • How to facilitate well-child chart reviews • Hoping to use RNs & MAs to do some of the follow-up with >95th %	Community: • Work with HMP to complete community map & PA resources • Link with Bangor regional school nurses • Meet with UMO Cooperative Extension • Find and meet regional athletic trainers Office System: • Spread to partners and monthly chart review • Pilot access registry versus excel • Timeline for projects • Use RN for follow-up visits Tools: • Develop portion size tools for exam rooms • Increase visual tools—posters • New flip chart for patients with 5-2-1-0 references
Site 3		
• Were doing BMI—now classifying more • Using 5-2-1-0 survey • Starting to work with HMP & schools	• EMR coming—not yet • Using registry to track >95th % • 3 different school districts • How to get kids	• Increase awareness of 5-2-1-0 in community & schools • Improve data collection / tracking / registry • Develop community resources guide

Accomplishments	Challenges	Plan for Action Period 2
	back in for follow-up—fitting in schedule • Not enough senior leader support	
Site 4		
• Have made practice of using 5-2-1-0 survey & BMI measurement with all 4 doc's in practice. Things they did to help facilitate this include: ↬ Put 5-2-1-0 survey on purple paper on purple clipboard ↬ Outlined process flow for members of practice team ↬ Designed stamp for us on well-child form that documents BMI, risk factors, 5-2-1-0 message and goals ↬ Flag charts for entry into overweight registry • Began work with Mid Coast Hospital obesity task force	• How to get patients back for follow-up visits • Support from administration to go beyond practice walls and work in the community	• Identify community resources and make available to patients (meet HMP) • Present progress reports at monthly nurse / provider meeting • Explore creative ideas to engage patients • Turn closet into library
Site 5		
• Working with community ↬ Met with school nurses and provided tools from MYOC toolbox for them to use ↬ Met with business leaders ↬ PSAs, local newspaper and radio message on 5-2-1-0 ↬ Partnering with Piscataquis CAP to include 5-2-1-0 message in their newsletter • Spreading to other practices in Piscataquis County • Have put MYOC tools into 5 other practices • Docs & RNs all have palm pilots that have stat code software for BMI calculation • Working within practice on 5-2-1-0 survey, BMI measurement, & 5-2-1-0 posters in each exam room	• Tried to start early AM walking program at schools but not enough interest • Need to find the time to get out to other practices and meet with them—help support them	• Schedule session for provider to go to other practices and assess use of 5-2-1-0 messages • Chart reviews ongoing at DFFM—other practices one point review • Data base Milo FP pilot • Further school efforts (on hold over summer)
Site 6		
• Changes within practice; ↬ BMI measurement & 5-2-1-0 survey 100%--Used PDSA cycles ↬ Created solid team within practice ↬ Have brought in other docs in practice—others are asking • Connecting with community: ↬ Made efforts to connect with dietician, counselor, patient trauma ↬ Creating healthy weight clinic—	• Need EMR—tough to maintain separate registry • Negotiation skills—difficult to continue to develop • Healthy weight clinic—need to follow-up more	• Develop time line for clinic—post aims / goals for all to see • Buy play station and calipers • Develop 5-2-1-0 stamp • Get registry • Practice negotiation skills • Involve YMCA, patient and HMP with weight clinic—develop community resources list

Accomplishments	Challenges	Plan for Action Period 2
see patient for ½ day per month by multidisciplinary team - Partnering with HMP—offered mini grant to do planning and solidify link with HMP, YMCA & school - Partnering with existing school programs—school did snow shoeing program - Connecting with school nurses from region to address multiple health issues and share MYOC tools - Getting attention from Hospital CEO and advising this is a help to meeting goals for community	frequently—going to try email for feedback • Concerns about triggering eating disorders	• Nurse educator for intermediate visits • Keep meeting schedule each month • Attach 5-2-1-0 to all well-child visits • Initiate BMI measurement to start at age 3 year • Referral dietary form
Site 7		
• Practice changes include BMI & 5-2-1-0 • Developed own data base using Alpha 5 software • Chart reviews important to process • School outreach	• Convincing partners to engage in this and getting attention from rest of organization • Private dietician in area will not take MaineCare patients	• Start registry • School & community involvement • Start patient follow-up and education
Site 8		
• Using existing EMR to calculate, track BMI and identify >95th% patients for follow-up • Spread to rest of clinic - Did lecture for providers - Using posters (5-2-1-0) across clinic	• Population served is challenging: - Fewer young kids - Underserved - Pregnant teens - Somalis • Hoping to set up group visits for >95th%	• Meeting monthly among team members to discuss progress of goals • Developing informational packets for healthy lifestyles • Meet with Healthy Partnership—resources and connect with community / plan group visit activities • Design group visits and children in group ≥ 95th % • Chart review & assessment of progress • Distribute / utilize patient education materials • Continue 5210 surveys and height/weight charting
Site 9		
• Practice changes—great nursing support • Were already doing BMI • Using 5-2-1-0 surveys (using to age 2) • Using registry of chronic diseases that includes asthma, ADHD &	• Spread to other docs in community and to adults • Start at earliest stages of childhood • Involve	• Spread info on motivational interviewing to other providers in practice • Commit to motivational interviewing with 2 patients / monthly • Focus on 100% BMI documentation

Accomplishments	Challenges	Plan for Action Period 2
overweight—kept it simple	community to support early childhood healthy lifestyle	• Review registry end of each month to ensure 3 month follow-up visits • Commit to monthly team meetings • Increase visual aids in office • Increase use of snow shoeing and x-country skiing in schools • Work with schools to eliminate sugared breakfast cereal
Site 10		
• Practice changes started out with EMR & BMI calculated ↬ Doing BMI % assessment and weight classification ↬ 5-2-1-0 surveys ↬ Developed metric form ↬ Role for CNAs • Spread (22 residents)—did lectures, skills training and demos • Connection to schools: ↬ Work in school based health centers ↬ Working with school nurses ↬ Using 5-2-1-0 posters in schools	• Population served • Larger group of providers and learners • Community resources	• Maintain 95% or better for current assessment & classification parameters • Ensure proper medical evaluation for >95% population • Develop mechanism for patient identification / registry • Further development of framework for BBCH/ACC (new interns, RNs, and team members) • Identification and partnering with community partners • Identify funding support / billing for follow-up in office
Site 11		
• Using EMR—had way to calculate BMI • Developed quick text • Spread to other providers	• Not all docs using all the tools—used shared data to drive healthy competition • Fell off of use when gets busy or overtime • Using stickers on computer for BMI % • Connecting with community	• Continue monthly chart reviews • Continue monthly planning meetings • Develop quick text for goal setting, 5-2-1-0 responses, follow-up encounter • Begin registry • Meet with HMP • Contact school health programs • Contact MG athletic trainers • Information display in waiting room • Posters in room • Links to practice website
Site 12		
• Office changes—good nursing support • BMI • 5-2-1-0 surveys • Brief motivational interviewing • Doing better at medical evaluation • Using PDSA cycles • Community: ↬ Meeting with school nurses	• Getting new providers in practice in August • Awaiting EMR • Moving physical practice site—opportunity to spread to family practice	• Continue to hold team meetings every 2 weeks • Every other month—10 charts pulled and audited for reporting • Start a registry—excel or EMR depending on our abilities • Continue motivational interviewing • Follow-up visits

Accomplishments	Challenges	Plan for Action Period 2
➢ Working on school breakfast ➢ Met with HMP ➢ Considering pedometer program with school		• Continue provider education

Table 14: Team Highlights from Learning Session #3

Success	Challenge	Plan for Action Period 3
Site 1		
• BMI & 5210 message incorporated • Established registry • Enhanced relationship with dieticians • Some success with patients coming back for follow up and lower BMI	• Improvement spread—Bob Holmberg presented to hospital • Increased momentum through hospital	• Spread to other care sites & residency practice • Develop exercise script • Establish monthly group meeting with MaineGeneral
Site 2		
• Map with patient population & solicited resources • Met with Bangor regional nurses & spreading 5210 message • ***Patient lost 72 pounds with 5210 & dropped Atkins plan	• New provider in practice • Time for MYOC • Getting patients to come back for follow up visits	• Getting 4 remaining providers on board • Making stronger connections with Y's & school nurses • Establishing follow up with nurse rather than physician • Logician coming soon—Feb?
Site 3		
• Implemented 5210 and other forms into EMR • ***15 year old lost 50 pounds in last year	• EMR started last few months • Establishing registry & who to do follow up with on staff	• Working with community/school partners on Changing the Scene & Wellness Policy requirement • Increase awareness of 5210 in schools • Improve tracking registry • Work on development of community resource guide • Follow up timing & schedules and assess if patients actually coming back • Spread MYOC across the state
Site 4		
• Office spread and penetration • All the providers are assessing BMU and using 5210 tools • Administrative management is using this program as physician incentive reimbursement criteria (will share info with other teams)	• Manual data collection on 5210 survey & other info • EMR in January—may help	• Make new EMR work for this program • Spread into community & schools with a focus on 8th grade community service • Continue to meet with clinic, hospital & community partners • Presentation to school class regarding healthy snacks & 5210
Site 5		

Success	Challenge	Plan for Action Period 3
• Community partnerships • Meeting with Superintendents & school staff regarding BMI in schools • UCE—Eat Well program	• Sharing message throughout PCYOC • Not everyone is doing everything reliably • MI tools not implemented yet—PM not on board • No registry yet—new billing software in next 6 months	• Healthy dining guide • Grocery store prompts—heart wise stickers • Chart reviews—outreach to affiliate practices • Wellness committee participation and new school education kit including BMI, 5210, school lunch programs, wellness committees
Success	**Challenge**	**Plan for Action Period 3**
	Site 6	
• See separate report on new Healthy Weight Clinic	• Registry changing and evolution--Need palm based—for the doc on the go	• Increase regular contact with overweight patients • Combine nutrition & medical billing • Invite teacher for noon conference • Increase exercise component in group • Solidify program—outline time, deposit component, assign organizational component • Explore very low calorie diet component • Work on implementing a usable registry • Spreading—invite family medicine to participate, news paper articles on obesity in kids • Funding—Maine Community Foundation • Survey patients on best days & times for clinic • Partner with Hannaford on education
	Site 7	
• Making change at all—doing BMI, 5210 & follow up • Incremental change patients • Using tools like Power Up posters to supplement work	• No ICD code for overweight—just obesity (check 307.5 code for billing?) • Federal Postal Worker & Self Insured Employers not covering obesity • BMI check at follow up visit –	• Community outreach and meeting with local school nurses • Talk at school and promote 5210 posters • SuperSize "PrimeCare Building" • Dieticians to work with team & trainer for fitness to establish a program at the YMCA • Group meeting before April • Utilize HMP • Tote bags for 5210 for

Success	Challenge	Plan for Action Period 3
	need help with reimbursement issue – not being accepted • Staff turnover • Asthma registry – PTE - $ Pay for Performance incentive competing for attention	overweight families
Success	**Challenge**	**Plan for Action Period 3**
Site 8		
• Healthy Lifestyle Luau for age 5—12 and families • 93% capturing BMI	• Large group with small pediatric numbers—hard to keep motivated • Residents still not looking consistently at info	• Plan & evaluate Health Food Fair for adolescents/parents • Get residents to address & do follow up • Family Health Expo & Healthy Lifestyles exhibit • Tote bags of healthy lifestyle info to give out at WCC visits to at-risk & overweight • Lecture/presentation to staff/residents to promote dissemination of info regarding motivation of patients & brief negotiation • Improve spread of 5210, follow up visit #'s, deliver healthy lifestyle choice info to public & patients, educate residents & staff, continue improvement of office systems promoting healthy lifestyle opportunities and identifying children in need
Site 9		
• Collection of data and sharing with community • MYOC helps address individual styles of various providers	• Location—population • Provider education & patient access to information	• Tackling transportation issue to programs like Shape Down or after school activities • Increase referral rate to Shape Down Program • Increase visual aids in office • Pull charts of any patient who has participated in the Shape Down program and monitor their progress • Increase weight classifications completed
Site 10		
• Getting staff on board, doing BMI & 5210 survey • Raising awareness with residents—computer prompt on what to do with	• Alternating pool of residents • Somali—culturally diverse	• Sharing 5210 and working with School Based Health Center and school nurses to create more support for patients in the

Success	Challenge	Plan for Action Period 3
overweight patient • Connection with School Based Health Center & school nurses	population • EMR both positive & negative—prompts BMI but doesn't lend itself to registry	community • Same message 6 times 6 ways to spread • Incorporate follow up into clinic by addressing guidelines and how to schedule with attendings & residents • Re-energize resident involvement in MYOC activities • Incorporate all members of the attending team with the MYOC goals and efforts to better support the residents
Success	**Challenge**	**Plan for Action Period 3**
	Site 11	
• Documenting classification • Pushing lifestyle choices info	• Logician—need to manually record % • Establish registry • Increase documentation • Community outreach to other providers and schools	• Continue monthly chart reviews • Registry • Continue monthly team meetings • Contact school nurses • Links to website • Waterville Peds staff training with HMP • Contact Hannaford regarding 5210 • Contact Morning Sentinel • Talk about MA entering BMI %
	Site 12	
• 2 new physicians • Measuring & tracking BMI • Started excel registry • Legitimized BMI interaction with patient • Meet with school nurses monthly • Speaking to 100 school folks in Monmouth • Established walking trails	• Rural area with high poverty rate • High obesity rate and limited opportunity • Normalize issues in schools • Spread to family practice & other practice sites • EMR starting next week	• Continue to track BMI & utilize 5210 tools • Continue work on registry and hold monthly meetings with staff to discuss findings • Continue MI & follow up • Try to capture better documentation regarding follow up visits • Make sure HMP partners come to monthly meetings with school nurses and build more community partners • Invite speakers to further educate team about behavior modification

Appendix F:
Post-Test Practice Team Survey Responses Compiled

Table 15: Post-Test Practice Team Survey results
*If average score, average represents the average response from 1-5, where 1=Strongly Disagree and 5=Strongly Agree.

Survey Question	Response*
Collaborative Team Role	
-Provider	29%
-Medical Assistant	8%
-Nurse	29%
-Office Manager	4%
-Other	29%
As a result of Participation in the Collaborative, I feel that our team…	4.78
-Put BMI percentile for age/gender screening systems in place	4.36
-Improved clinical management of overweight patients	3.86
-Put systems in place to track overweight children	4.14
-Is better able to set self-management goals with patients	4.17
-Has information they need to provide care for overweight patients	4.57
-Put systems in place to routinely deliver 5210 messages	4.05
-Put systems in place to routinely run labs on overweight patients	3.86
-Experience higher satisfaction in caring for overweight patients	
As a result of our participation in the Collaborative, I feel that our patients….	4.00
-are better able to self-manage	3.95
-are more willing to set goals with provider	3.95
-are more aware of long-term complications	
Please indicate the following percentages….	
-Percent of overweight patients impacted by Collaborative	51-75%
-Percent of Providers who made changes because of Collaborative	51-75%
-Percent of all patients impacted by Collaborative	51-75%
During participation in the Collaborative, I feel our team…	
-Functioned well	3.86
-Had clear support from senior leaders	3.73
-Had dedicated time to perform Collaborative tasks	3.32
-Had enough time to perform Collaborative Tasks	3.23
Please estimate the overall amount of time you spent per month on collaborative activities	
-Less than 1 hour	14%
-1-2 hours	18%
-2-4 hours	23%
-4-6 hours	18%
-More than 6 hours	27%
After the Collaborative, as a team we plan to continue to….	

Survey Question	Response*
-Use registry to identify and manage overweight patients	3.62
-Use registry to offer proactive care to overweight patients	3.14
-Use well-child visits to routinely review needs of overweight patients	4.59
-Collect clinical measures of care and share them with senior leaders	3.76
-Spread improvements to other providers in your organization	3.91
Please list any other plans you have to continue overweight improvement that are not listed above • Intensive weight management program • Group visits • Continue working in whatever capacity necessary • Variety of plans • Continue with schools and local HMPs • Healthy weight clinic • New link with healthy weight clinic • Develop a community-based program • Refer patients to YMCA • Intensive weight loss program	
In order to sustain the changes our team made during the Collaborative, we need..	4.18
-Better data systems	3.67
-More support from senior leaders	4.05
-Dedicated office time	3.64
-Better delineation of roles	4.00
-Efforts to work with payers	
If you have ideas for additional support or resources, please list them… • More age appropriate nutrition education materials • Continued work with the Collaborative • Continued support from HMPs • Need HER • Technical support for EMR to create user friendly registry	
Please indicate the components of the collaborative your team found most or least useful for each….	
-Meeting with other teams	4.77
-Learning Sessions	4.68
-Storyboards	3.27
-Learning from other teams' storyboards	3.55
-Bimonthly calls	3.45
-Bimonthly reports	3.59
-Support from MYOC staff	4.48
-Site visits	4.00
-Using the Care Model	3.82
-Using PDSA cycles	3.81
-Using BMI percentile for age and gender	4.82
-Using 5210 messages	4.95
-Provider tools	4.29

Survey Question	Response*
-Patient tools	4.41
Please suggest other ways we could better support teams in the Collaborative • Provide specific tools to specific team members • More providers in a practice should go to learning sessions • Do site visits at beginning and at end • More idea sharing • Site visit was never scheduled for us • Need more resources for Collaborative activities such as data entry, etc. • More information for those who speak other languages • Flip charts and poster are great	
Please indicate anything you felt was a particular weakness • Very useful • Everything was great, very inspiring • Learning sessions were always helpful • Learning sessions were tremendous benefit • Collaborative provided important tools. Weaknesses were internal. • Registry is weakest piece—need more support	
Our Team…. • Feels that Collaborative was worth the effort • Would recommend Collaborative to a colleague • Will consider participating in MYOC2 • Definitely plan to participate in MYOC2	 4.59 4.68 4.64 4.05
Any additional Comments • Participation depends on whether provider wants to continue—would be very valuable • Has been a wonderful experience • Learning sessions were beneficial—look forward to phase 2 • Felt privileged to participate—Thank You! • Need better registry first. Please tell us more about phase 2.	

Appendix G:
Post-Test Provider "Script" Telephone Interview Responses

Table 16: Post-Test Provider "Scripts" Telephone Interview Responses

Survey Question	Survey Question Response, summarized
Sandie Roberts introduced us to Brief Focused Negotiation (BFN) (a counseling style that provides an effective and structured approach to behavior change counseling in brief clinical encounters), are you using it? Yes/No	All clinicians interviewed were using either Brief Focused Negotiation (BFN), combination of Motivational Interviewing and BFN or their own scaled down BFN model.
What do you call it (BFN)?	When talking with colleagues or in a teaching moment, most referred to the approach as BFN. Some also called it MI – Motivational Interviewing. Clinicians have attended trainings on both topics recently. No one addressed "what was happening" in the visit as BFN. Rather, it is what you do. Ask the patient "May I take a few moments to discuss …".
What is it like?	*Effective.* Patient takes ownership, buy into it rather than like antibiotics where we tell patient what to do. Patient takes ownership for own help habits. *Motivational* but hard to get patients back. Using BFN but not as much as would have liked and expected. Good to step back and allow patient to assume control about what will work. *Positive, useful.* Allows me to ask permission to talk about something with a patient. Coincides with personal style.
What triggers you to start using BFN? What makes it happen? What triggers opening the encounter?	• 5-2-1-0 survey sets the agenda. Makes lifestyle changes obvious. Survey in hand allows conversation to flow because both looking at something. The survey helps communicate what clinician hopes to see. It does require extra time, so depends on how busy, stressed, tired the clinician is but 5-2-1-0 helps but have to probe for it. • BFN is patient centered. Clinician recognizes "something" in the patient, there appears to be a struggle, contemplation to change, patient recognizes there is an issue and the

Survey Question	Survey Question Response, summarized
	patient appears ready to change. • Talking about lifestyle change patient wants to accomplish. • Exam has evidence of overweight. Finding a child >95th%. Want to stimulate some change, so try to open the conversation by giving information about BMI and showing concern and interest. For kids, the value of 5-2-1-0 has been fantastic. • Readiness to change model. • If teaching the model to interns, often it is a goal entering the room to demonstrate the technique.
Do you use BFN at other visits?	No. Only if a nutrition visit. Use it mostly in the beginning to get patient interest and area of focus. Less on follow up visits. Yes, at follow ups. If a goal is reached/met, chose another. If you get to a point that is static, you are able to congratulate that the patient has maintained change. Continue to use throughout visits, like braiding ribbons into lifestyle
How comfortable are you with BFN?	*Becoming more comfortable.* Fits in well to a short visit time. Able to talk about difficult conversations. Well received by patients even if lower on the scale than originally thought. Gives a good framework to start conversations about harder topics. It is not easy to bring up overweight but with BFN you can do it in a time limited scenario and not put the patient on the defensive. *Moderately comfortable.* Such a change from traditional training. BFN is a totally different approach not used to doing. Two clinician's said *pretty comfortable.* Not taking ownership, able to empower the patient. The field needed something new. Nothing's really worked before, likes this idea/approach (been doing this for 20 years). *Comfortable.* But has a ready and willing group, so not sure they could be a BFN demonstration.
Have you felt using BFN has been successful with some patients?	Yes ✓✓✓✓✓
What made it successful?	• Combo of right time, right patient. There is a high level of dialogue involved – can get a patient to express a level of concern and where they might be willing to work. • Helps with adolescents. Able to step back and let them make their own decisions. Allows the patient to buy into decisions rather than just what to do. • The process (5-2-1-0 survey) is successful. The survey shows patients we are concerned about this for all patients.

Survey Question	Survey Question Response, summarized
	• "Thank you for filling out our 5-2-1-0 survey. Would you mind if we took a look at it together?" Use the survey as a tool to take some history about behaviors – use reflective questions: o What kinds of things do you do for exercise? What do you do? How much tv do you think you watch? When's the first time you eat? Give compliments to behaviors doing well. Re-state what patient says. • Empowering the patient. They have a say in what they want to focus on at a particular time. • Helps negotiate the agenda. Break down change and let the patient come up with action steps. Takes the pressure off. • Fits into a short time frame. • Allows you to ask permission when maybe you don't know how to bring up a topic. • Once patient sees improvement more motivated to address a more difficult behavior. • Don't go to the place where it is hardest, even though that may be the most important change needed.
So for a successful patient who was ready to make a change, what have you said to engage the patient (and family) in BFN (open the encounter)? What does that 2 minute conversation you have with patients sound like?	• "I'd like to talk about your weight and height and the fact that we measure BMI. [Show growth chart and that weight has been accelerating], has clinician concerned for overweight and I'd like to know what you (patient) thinks about that? Would you be willing to talk? Interested in any ideas to work on that?" • "Really looking healthy. I don't see any other big issues but concerned about the direction of BMI and what do you think about that." • "This is what I am hearing you say and this is what your problem is. What do you want to do about that?" • At WCV bring out 5-2-1-0 survey, ask who filled it out and get a sense what the answers mean. Give praise for "true" answers and then point out "false" answers. Talk about rationale to make a change to a true answer. With teens, use humor, to change everything but only to chose one thing they think they could do. "What kinds of things do you need to be able to make change?" Give positive words, finish exam and then review what agreed to try. "How about come back in six weeks to see how doing- does that sound ok?" • "Would you mind if we talked a little bit about healthy lifestyle activities?" Stays away from BMI and weight.
Again for that successful patient, what	• Not to be confrontational. Rather reassuring. Tough because folks are sensitive about weight. • Visit flow: review the survey, complete exam, then go back

Survey Question	Survey Question Response, summarized
have you said to keep the conversation going?	to the survey – repeat what you noticed today. Anything you can work on? What do you think you could eat? Your weight has gone up since last visit, more than your height (show growth chart) … "What do you think that means for you?, Do you think you are willing to (insert behavior). Important to turn things around." • Repeat what the patient would like to see multiple times. • Have the patient verbalize and imagine they see self being successful. Check in to see if this will really work. "Is this something you see yourself doing? What are the stumbling blocks that may get in the way? How do you think this will be successful?"
Now that successful patient starts to give some push back, what have you said when you encounter barriers?	• Quickly drop out. Do feel responsible to point it out the situation but appreciate the emotion and keep focus on the future because you want them to come back. • If pushing back, then they are not ready and that's fine. Think about it and talk again in a month or so. Back off. • Try and see if there something to work on … encourage to change to skim milk. • Not really because only pick what willing to work on. Little changes make huge changes. • Print out information. In writing is powerful. • Clearly they are further down the readiness scale than thought, so be supportive and encouraging because they are not ready. Re-create the importance but need to recognize the time and place because don't want to alienate.
You are using BFN and you are pretty comfortable but have you ever said something that didn't quite work and closed down the encounter?	• Patient clearly indicates they don't have a problem, so don't go too much further but need to let the patient know this could be a problem in the future. • Start to talk about weight but parents don't want to deal with their own. • Talking about overweight with a girl whose mother wanted to talk about behavior. She ended up in tears but agreed to set up another appointment. • Show growth chart and go over survey. My job is to share these recommendations with you. You're job as the parent, as the child is to use this information as you will. • Can be overzealous reporting BMI and weight so the visit atmosphere really changes. Timing is important.
Is there anything else you would like me to know about your experience with BFN?	• Issues with the way office team was organized. Need more buy in. • Still evolving but has value for all kids. • MYOC II can help with motivating kids, focus on afternoon time.

Survey Question	Survey Question Response, summarized
	• Relatively few abnormal labs during MYOC I. • Good thing. • Helpful to use in many ways, can apply to other fields – teaching has changed but that is a good thing. • More autonomous. • Great thing but needs more training. Others in our practice who have tried 5-2-1-0 without training didn't go as well. • BFN breaks behavior change into specific sections. Gives patients opportunity to make some changes, even little. Gives specifics for overweight. Have patient buy into one thing and reinforce at each visit. • Generally liked working with overweight but often felt discouraged. 5-2-1-0 really helps. • Others in office not having much success with overweight so they refer patients to those who are part of MYOC. • Patients don't sign a contract but do repeat multiple times what agreed to. • Rollnick's book good. • Hearing about MI and BFN at national conferences, hot topic. • Need to promote BFN in other venues not just overweight.
In regard to working with patients and families around 5-2-1-0 … **Are you using standardized tools from MYOC and/or Kaiser when you talk to patients about behavior change? (Probe: What are they?)** **✓ = 1 vote**	Readiness Ruler ✓ 5-2-1-0 survey ✓✓✓✓ 150 calorie sheet ✓ Flip charts for BP, labs – but don't really need it anymore! ✓ Quick healthy meals ✓ Parent information on health risks ✓ Portion sizes and the dishes received at one of the learning sessions ✓ Posters in exam room, routinely ✓✓ Guidelines are in each exam room ✓ Contract forms but don't really look for it ✓ ✓ Write stuff on pads of paper ✓ Comment: For those with an EMR, cumbersome to use something not on a computer.
During the encounter about behavior change, do you talk about BMI? What language do you use to describe BMI?	• Yes. Go over 5-2-1-0 survey and use the computer to show height and weight. Say that BMI compares height and weight together and gives you percentages for healthy, at risk and over. Doesn't say overweight. Uses EMR to show where patients fall. If they are over they usually know it, so work to make changes to make lifestyle habits forever. For those at risk, parents think child looks fine but still make suggestions to move some of the "false" 5-2-1-0 survey

Survey Question	Survey Question Response, summarized
	answers to true so have healthy lifestyles. Clinician really doesn't want to see losing weight so much as change lifestyle to come over and straighten the BMI line. • Show growth charts. They are instructive, big picture to help explain BMI. • Yes but less likely with an at risk patient. Might bring it up but don't show BMI. Won't explore it as aggressively, than would with an overweight patient.
Do you talk about overweight? What language do you use?	• Yes but try not to stir someone. Use humor to engage child to help parent empower to make change. • Low level reading patient population, so standard materials don't always work. Trying to standardize language and keep it simpler and politically correct. It is easier to speak with a "skinny" kid and mom. • Stays away from exercise rather "What do you do for fun outside?," "Do you do an activity that makes you sweat or tired when you are done?" • "Your weight has gone up higher than your height." • Don't say "obese."
Do you use different language when talking to an overweight child?	• Not too much because there is an answer in 5-2-1-0 survey to work on dietary history with those patient who have accelerating weight. Look for dietary habits. • For younger kids, talk to parents. Older talk to patient.
When talking to a child with an overweight parent?	• Parents don't necessarily want to make changes for themselves but encourage to have a family health style. Talk about parents as role models. Make household changes, habits everyone needs to establish. • Language changes when talking to an overweight parents and child because basically you are talking about the parent in the same breath whether you mean to or not, so soften the language. • No but maybe more sensitive to give positive feedback
What about different ethnicities?	• Try to ask more questions when unsure of cultural differences – proceed with questions. • Only so much as it's a language issue because use phone translations but for English speaking, different races – no. • Try to use the same language but doesn't know how it is translated. "What types of eating foods do you eat that are healthy, good for you?" • Not a lot of heterogeneity.
Different socio-economic classes?	• If you sense there is not much opportunity, get the patient to talk. Don't ask "how often they ride their bike" if you are

Survey Question	Survey Question Response, summarized
	sensing there are no resources for a bike. Rather "what do you enjoy doing?"
Was there a behavior that was more difficult to address? Why?	Better to assign one thing to change for 5-8 year olds because they want to do everything and have older kids pick one thing and then another at next visit.
Harder to address:	TV in the Bedroom: ✓ • Use it to go to sleep, like it • When mention it, kids look like they are going to have a heart attack, so go over quickly and skip it. Taking it out is "stressful." Screen Time: ✓✓ • Have made progress though, but many are unwilling to touch it. • Gets push back. Socially people have used it to control their child, otherwise parents have to interact and do something with them. Physical Activity: ✓✓ • Time, rural area – streets are narrow and non-lit, poor population, cost, stigma kids are self-conscious. Not enough health clubs, YMCA. • So few options. • Harder to implement. Clinician struggles herself. Takes more energy. Breaks down the activity into increments. Fruits and Vegetables/Picky Eaters: ✓✓✓ • Cost. • Nobody does this. • Usually has to be the one to bring it up.
Easier to address:	Soda – has substitutions, people willing to give up. Vegetables can work to incorporate, be more flexible with meals. Screen Time can breakdown 3 hours and get to 2 ½ - walk around during commercials.

Appendix H:
Healthy Maine Partnership Director Telephone Interview Survey Responses Compiled

Table 17: A Summary of Healthy Maine Partnership Directors Survey Responses

When did you first make contact with your local MYOC practice?
• Before LS1 provider X approached us to be on team • Provider X on board of HMP prior to MYOC, attended first LS • Feb 2006 • Has known Provider X—was chair of first HMP local group but did not hear about MYOC from provider X—met team first learning session, but first meeting of HMP PD'd w/me. • Provider X was part of CSHP leadership • Soon after MYOC began • It took forever to make telephone contact • Fall of 04 • Right after first LS—took a couple of months to get back to her—very busy practice • Later on in the process sometime after the second training • 3 months after MYOC • December 2005
How often have you been in contact since?
• Weekly to biweekly • Met in beginning but have lost touch • Two times, trying for once a month • 5 times on infrequent basis. Provider X spoke at each coalition meeting and attended one "changing the scene" meeting • Monthly meetings, weekly emails • About once a month—we've met at least nine times • Erratic—once with full staff, once with several office managers, 4-5 other times • Yes but not real strong connection---wish we could do more • 2 meetings • Two or three times • Not very often • 4X since
Where did/do you meet with your local MYOC practice members?
• Both practice site and PDs office, also via email • At the practice site • Once at practice site, email and telephone • Hospital or their office

- Before MYOC—Provider X
- At practice site
- At practice site
- Once practice site, once a local coffee shop
- Practice site both times
- Their office
- Practice site
- 2x at learning session, 2X at practice site

Who did you meet with?

- Provider X, superintendent, SHCs, nurses, other office staff
- HMP staff and director met with entire practice staff in early AM
- Providers and office staff -about schools
- Two providers
- Provider X
- Provider X and school nurses from 3 systems
- Full staff once and some short meetings with whoever was around
- Provider X
- Provider X and nurse and practice manager
- Twice with the whole team at the training and the doc first time and nurses and MA second time
- Provider X
- Provider X, administrator, and nurse

Did you make any plan to work together?

- Lots
- Yes
- Yes
- Yes
- Nothing specific
- Yes
- Yes
- Yes
- Yes
- Yes, but could have done better follow-through
- Yes
- Yes—tentative long term not immediate

If yes, what were those plans?

- Too many to list-pending-grocery store healthy choice stickers
- Map of area and where patients are located and pinpointed resources for specific areas—display and info by area, "did you know" and "where to go"---work better with federally qualified Penobscot community health center
- Sending materials for HMP, eating healthy and resources, power up

- Changing the scene, family fitness guide, presentations, develop resource guide
- Other than spread 5210 to other programs and downeast health group and HMP gave mini grant to work on clinic—riding the obesity wave
- Work with schools for wellness policies and addressing barriers to change
- Completed one project-created referral system for low income patients to go to YMCA for free with free evaluation, personal plan, and support
- Connections with schools, Provider X has done slide shows, incorporating and spreading 5210, food and nutrition task force presentation—addressing resistance to change in schools
- School wellness policies, food service directors---, presentations on nutrition by Provider X, develop list of fitness opportunities at no or low cost to pass out to pts.
- Working with Hannaford to put 5210 in grocery stores---and where kids are getting the message, we did a community education session, and "dinner with a doctor" is in the works, and PA guide for practice sites.
- One event—Healthy Living Right
- Clinic at YMCA for overweight youth

If yes, were you able to accomplish what you'd planned to do?

- Yes, still working on grocery store project
- Yes
- No, no plans other than sharing information (looking at language in area but this is what the HMP mini grant is doing already)
- No, not yet
- Yes-presentation to coalition on spreading 5210, and working to establish SB health clinic
- Yes, partially
- Yes, all of them
- Partially only
- Yes, event was held
- Partially—provided clinic with resources and connected them to Move More and they did training for staff

Did you encounter any barriers to working with your local MYOC practice?

- Time
- Too little time and hard to get hold of practice
- Bethany, no-just new to position
- Time and attention
- Too little time and resources
- Nothing other than time
- Their group is very independent—they're very large and hard to make contact with
- Yes, practice site is too busy—we're too busy but have enjoyed contact
- Just initially because they're so busy but then it was fine

- Docs are too busy, hard for HMP to get into clinical setting, need "a way in the door"
- Time and work load on both sides—couldn't commit as much time as wanted to
- Took a long time to get connected

Is there anything that might enhance your work with your local MYOC practice?

- For MCPH to customize posters with organizational logos
- Should have had a clearer notion of what HMP role should be from Practice site
- Just being able to attend learning sessions and being involved from the beginning
- Access, need to be able to connect more often
- No personal barriers or organizational barriers
- More people resources re HMP
- More people resources, more formal way to establish relationship---need someone designated as the contact person in the practice site
- Get a solid task force together—more formal
- To have more direction on what to do instead of having to figure it out
- Need team approach to get the work done---too much going on for everyone need to be realistic about what can be accomplished
- If HMP set goals and objectives before MYOC started
- Better to have connected earlier in the process and make it more structured
- Give us some materials like posters

Has this relationship helped you with any other work that you are doing?

- Too much to list-bountifully!
- No
- We have a natural partnership with the hospital now
- No
- Yes
- Yes
- Yes, its all connected
- Not really
- Yes, with food service directors, have used list of fitness opportunities for other projects, built relationship with Provider X
- Yes, especially the PA guides, Provider X is tremendous resource to us
- Yes, program promotion
- Yes through weighing action we are spreading what we're doing to other practice sites

Has your interaction with your local MYOC practice enhanced your work in any other way?

- Yes, very much as above
- No

- Above
- No
- Yes—now have community leaders and champions for issues
- Definitely yes, its been good to connect with school nurses
- Yes
- Not really
- Above
- Yes, quit line info, better understanding of HMPs for provider, making other connections
- MNN Somali project great insight
- Yes, the messaging

Any key lessons you want to share?

- relationship with superintendents is very important, leadership like Provider X makes all the difference
- Needed to have a clearer role
- None
- Didn't know about MYOC soon enough due to change in staff—need more dedicated time together
- Too busy to get connected and feel like as long as Provider X is happy and doing good work—that's enough
- All these relationships highlight the need for comprehensive community-wide intervention especially in low-income populations/communities. We haven't done family empowerment yet.
- Same as above
- Need more time with providers
- Wanted to do more, need more concrete examples—need to hook up with sites early on in a formal way
- Be sure to be realistic, need to be part of team from beginning---build it in.
- MYOC held meetings that were very helpful at beginning
- Need more formal way to do work through funding

Appendix I:
Learning Session Evaluation Results

Learning Session #1—November 4 & 5

RESULTS
(Return Rate = 61%)

Please circle the number that corresponds to your answer or note that you did not attend for each of the following sections of the Learning Session.

	Not Useful				Very Useful	Did not attend
Shared Vision for the Collaborative	1	2	3	4	5	○ **4.36**

[Comments_____

What Good Clinical Care for the Overweight Youth Looks Like

1 2 3 4 5 ○ **4.81**

Comments

- **Excellent presentation. Thanks for sharing slides.**
- **Excellent presentation, extremely helpful and entertaining.**

Where are we? Using Data to Improve Care

1 2 3 4 5 ○ **4.06**

Comments_____

The Care Model: a practical approach for primary care practices to improve care for overweight youth.

1 2 3 4 5 ○ **4.53**

Comments_____

Breakout 1

The Follow-Up Visit & Brief Negotiation 1 2 3 4 5 ○ **4.72**

Comments

- **Very good.**

Breakout 2

Designing Systems That Work 1 2 3 4 5 ○ **4.44**

Comments_____

Breakout 3

Practicalities of Clinical Measurement & Guidelines for Medical Evaluation

1 2 3 4 5 ○ **4.73**

Comments

- **Very knowledgeable – Helpful to take materials back.**

Still Got Questions, Q&A with all Faculty 1 2 3 4 5 ○ **4.07**

Comments

- **Nice to get feedback from other groups.**

Why Use a Registry? 1 2 3 4 5 ○ **4.30**

Comments

- **I like the idea of Excel-based rather than Access.**

But…My Intentions Were Good & Accelerating Improvement

1 2 3 4 5 ○ **4.42**

Comments

- **A great motivator.**

Sharing Results for Success/Collaborative Reporting

1 2 3 4 5 ○ **4.12**

Comments

- **Basic material. Very good visual with the nesting dolls.**

The Experience as a Whole

	Not Useful				Very Useful	
Team Meetings	1	2	3	4	5	**4.52**

Comments

- **Very useful time – you were right – we would not have done this at home.**

The Pre-work Packet	1	2	3	4	5	**4.36**

Comments

- **Great!**

The Meeting as a Whole	1	2	3	4	5	**4.68**

Comments

- **Great!**

Course Objectives

Have you improved your knowledge +/or ability to: (Please circle the appropriate number).

	Hardly At All				**Very Much So**	
1. Describe overview of Collaborative & Care Models for Improvement	1	2	3	4	5	**4.55**
2. Implement a rapid PDSA cycle for change	1	2	3	4	5	**4.22**
3. Inspire, build enthusiasm for quality teamwork & collaboration for practice members at home	1	2	3	4	5	**4.38**
4. Set aims for Collaborative	1	2	3	4	5	**4.39**
5. To:						
• Support patient self-management	1	2	3	4	5	**4.24**
• Perform decision support	1	2	3	4	5	**4.17**
• Improve delivery system design and	1	2	3	4	5	**4.03**
• Design clinical information systems.	1	2	3	4	5	**3.91**
6. Develop change strategies for good chronic illness care.	1	2	3	4	5	**4.22**
7. Perform routine assessment and management of youth at risk for overweight and youth overweight.	1	2	3	4	5	**4.73**
8. Improve your adherence to evidence-based guidelines, appropriate roles and visits for patients at or above the 85%'ile BMI for age, and accessing clinically useful information.	1	2	3	4	5	**4.39**
Did the **facility** meet your needs?	1	2	3	4	5	**4.50**

Comments

- **As a nurse, I would have appreciated the CME's for continuing education credits. Possible future credits may apply for future credit may apply for future sessions.**
- **Cold under our table, brrr.**
- **Good meals, comfortable rooms.**

- **Cozy, comfortable.**
- **Yes. Incredibly helpful.**

Was the **staff** knowledgeable and helpful? 1 2 3 4 5 **4.84**

Comments

- **Yes, very informative and user friendly.**
- **Extremely. Excellent leaders/mentors.**

Additional Comments

- **This information is useable for our own knowledge and can be applied starting now! Thank you. It is a privilege to be a part of this collaborative.**
- **Great day.**
- **Could have been done in one day I think.**
- **Very well presented.**
- **Excellent!**
- **Had trouble keeping paper handouts "organized."**
- **Great work/seminar.**
- **These last two days are vital to team members.**
- **Great speakers!**
- **Could be done in one day.**
- **Great conference – I hope we can implement.**

Learning Session #2—May 19 & 20, 2005

Evaluation RESULTS (Return Rate = 62% or 31 Returned)

	Not Useful				Very Useful	Did not attend
Update on Collaborative Evaluation & Progress to Date						
	1	2	3	4	5	○ **4.19**

- **Lack of data on some practices disappointing due to fact we are voluntary participants and need recognition for our efforts.**

Update from Maine AAP: Intervening with Patients with BMI ≥95%'ile						
	1	2	3	4	5	○ **3.7**

Comments_____

Brief Focused Advice						
	1	2	3	4	5	○ **4.79**

- **I'm not a clinical person.**
- **This was great! See other comment on back.**
- **Outstanding session. I regret all our practice teams could not attend.**

Strategies for Patient Goal Setting & Problem Solving						
	1	2	3	4	5	○ **4.76**

Comments_____

Breakout 1						
The Patient Needing Additional Assessment						
	1	2	3	4	5	○ **4.0**

Comments_____

Breakout 2						
Get Moving	1	2	3	4	5	○ **4.43**

- **Needed more info on what providers needed to know.**

Breakout 3						
Connecting with the Community						
	1	2	3	4	5	○ **3.47**

- **Little weak.**
- **Not geared to provider audience.**

Breakout 4						
Mental Health & the Overweight Patient						
	1	2	3	4	5	○ **3.59**

Comments_____

Collaborative Learning & Action Period 2						
	1	2	3	4	5	○ **4.14**

- **This toolbox looks great.**
- **Caught us when we're motivated.**

The Experience as a Whole

	Not Useful				Very Useful	
Team Meetings	1	2	3	4	5	**4.3**

Comments_____

The Packet of Materials	1	2	3	4	5	**4.5**

Comments_____

The Meeting as a Whole	1	2	3	4	5	**4.65**

- **Fun toys.**
- **Liked helping hand theme.**

Course Objectives

Have you improved your knowledge +/or ability to: (Please circle the appropriate number).

		Hardly At All			Very Much So	
9.	Provide brief focused advice to patients	1 2	3	4	5	**4.41**
10.	Promote team self assessment regarding Collaborative work	1 2	3	4	5	**4.21**
11.	Describe additional specific changes in clinical information systems, decision support, delivery system redesign, and patient self management that have been successfully tested and implemented in clinical settings	1 2	3	4	5	**3.96**
12.	Identify community resources to support Collaborative work	1 2	3	4	5	**3.64**
13.	Adopt a strategy already in place at another team site	1 2	3	4	5	**4.0**
14.	Describe ways to accelerate testing of change strategies for improvement	1 2	3	4	5	**3.64**
15.	Revise and adapt aims already set in Learning Session 1 to Action Period 2	1 2	3	4	5	**4.14**

Did the **facility** meet your needs? 1 2 3 4 5 **4.42**

- **Comfortable, spacious.**

Was the **staff** knowledgeable and helpful? 1 2 3 4 5 **4.73**

- **MYOC staff very helpful (no interaction with Civic Center staff).**

Additional Comments_____

- **Good forum to share ideas "steal shamelessly and share seamlessly."**
- **Very good. Very well done.**
- **Thank you for Learning Session #2.**
- **I would like to hear Presenter X about what her follow-up visits look like.**

Learning Session #3—September 29th & 30th, 2005

RESULTS (N=43)

Not Useful **Very Useful**

Update on Collaborative Evaluation Plans & Progress to Date
1 2 3 4 5 **4.08**

- **Nice to see how far we've come.**

Theory & Culture for Improvement Spread 1 2 3 4 5 **4.08**
Comments_____

Clinical Plenary—Shared Medical Appts., Group Visits & Family Dynamics for PCP's
1 2 3 4 5 **4.16**

- **Would be interested in long term study re: change in group vs. life style changes.**
- **I missed a significant portion of the session because questions were not audible. Took too long to set up the intervention.**
- **A lot of info to digest – but great stuff.**
- **Spent a lot of time on a short-duration program with insufficient data on long-term flu to make it useful.**

Specific Strategies & Skills for Group Visits
[Oren Abramson] 1 2 3 4 5 **4.20**

- **Better than day one.**

Ideas for Transfer of Skill Sets for Improvement Spread
1 2 3 4 5 **4.10**
Comments_____

Team Highlights 1 2 3 4 5 **4.33**

- **Good ideas to take home.**
- **Always get great ideas!**

Overview of the Maine Obesity Primary Prevention Program
1 2 3 4 5 **3.55**
Comments_____

Introduction of New Materials/Tools—Physical Activity & the Overweight Child
1 2 3 4 5 **3.94**

- **Unfortunately not any good data out there.**
- **I love this part – ideas, ideas, ideas.**

Collaborative Learning & Action Period 3 1 2 3 4 5 **4.21**

- **Helpful to set goals.**
- **This is what always gets me very excited! I love to hear the ideas flow.**

The Experience as a Whole

Not Useful **Very Useful**

Team Meetings 1 2 3 4 5 **4.55**

- **Always worthwhile.**
- **Would be more useful if the team stayed all day – Not your fault.**
- **Somewhat long.**

- **Brainstorming – Love it!!**

The Packet of Materials 1 2 3 4 5 **4.20**

- **Thank you for the collection of articles – very valuable to me as I prepare to give talk to school system on obesity.**
- **Free stuff to make useful for us!**

The Meeting as a Whole 1 2 3 4 5 **4.38**

- **Gave time to reassess and refine.**
- **The least helpful of the three meetings.**
- **Excellent.**
- **I love all the ideas flowing…**

Course Objectives

Have you improved your knowledge +/or ability to: (Please circle the appropriate number).

Hardly At All **Very Much So**

16. Develop a plan for follow up visits with overweight patients
    1 2 3 4 5 **3.74**
17. Identify skills & knowledge needed to facilitate group visits
    1 2 3 4 5 **3.84**
18. Understand some of the issues of family dynamics around behavior change
    1 2 3 4 5 **3.87**
19. Promote team self assessment and identify related strengths & weaknesses regarding Collaborative work
    1 2 3 4 5 **4.11**
20. Develop common goals with community partners to support Collaborative work
    1 2 3 4 5 **3.97**
21. Adopt an idea or strategy already in place at another team site
    1 2 3 4 5 **4.11**
22. Understand ways to spread improvement throughout your practice site or health system
    1 2 3 4 5 **4.08**
23. Revise and adapt aims already set in Learning Session 1 & 2 to Action Period 3
    1 2 3 4 5 **4.09**

Did the **facility** meet your needs? 1 2 3 4 5 **4.39**

- **Suggest whole wheat rolls. Suggest more fruit available for dessert/snack. Need to offer healthy food – AM snack was high fat breads. Suggest more protein in lunch selection of legumes/bean dish if want to stay vegetarian. Saw only cottage cheese, shredded cheese, few kidney beans in 3 bean salad.**
- **Chair fell apart.**

Was the **staff** knowledgeable and helpful? 1 2 3 4 5 **4.77**

- **Somewhat – it was motivational, not very applicable with regard to person X's sessions.**
- **Our community rep wasn't here –**

Additional Comments

- **I was disappointed in Person X's (only heard him one day) presentation. No new information/concepts shared. He did not seem familiar with nutrition/dietary guidelines e.g. DRIs for nutrients, Dietary Guidelines 2005 that include specifics for special population of children and the My Pyramid system, tracking systems available for truly motivated folks. We were unable to comment on study results he shared**

without the actual studies to review/critique. I think we need to refer to our message 5-2-1-0 not 52-10; with the 52-10 the message is lost.

- **Been a great experience. Could be compressed.**
- **Learning about other successes and plans of sites helped stimulate our own ideas for outreach.**
- **Effective speakers. Always feel the support and resources are there and accessible at any time.**
- **I would love to have more meetings with education in "mindful" eating, more tools to arm us.**
- **Lighting – unable to dim – off – too dark – on – too bright for AV presentations.**
- **Can we continue to monitor our progress in the state of Maine? Can we look at our obesity data and see if our 12 practices are making a difference? Let's have another session on "mindfulness."**
- **Thank you for inviting me.**
- **MYOC staff persons X, Y and Z are always helpful and pushy – in the best possible way.**

Appendix J:
Steering Committee Evaluation Results

Table 18: Steering Committee Evaluation Form Responses (N=10)
*(1=Strongly Disagree, 5= Strongly Agree)

Evaluation form question	Average Response*
The steering committee meetings were: -Well facilitated -Productive -Provided opportunities for meaningful discussion -Provided useful written materials	 4.56 4.44 4.56 4.38
The role of the MYOC steering committee is clear	4.56
I feel that my participation on the Steering Committee has had an impact on the work of the MYOC	3.89
The composition of the steering committee is appropriate for the work of the MYOC	4.56
In general, I'm satisfied that MYOC is moving in the right direction	4.67
I was given sufficient opportunity to provide input into the development of MYOC	4.78
Sufficient progress was made in implementing MYOC	4.67
The steering committee workgroup structure is adequate	4.29
I was satisfied with the level of communication between meetings	4.78
I attended 3 or more steering committee meetings	9-Yes
I would be interested in participating on the steering committee for MYOC2	8-Yes, 1-No
Additional Comments: • Great project; great work. Thank you for including me • It was a great experience being part of this group. Such important work. Thank you. • Role of SC-approval/input/right group at times? • Sorry for the delay in getting this back. Was on vacation then ill with the flu!	

Maine Youth Overweight Collaborative
Steering Committee Members

Meredith Anderson
Bureau of Health

Naomi Anderson
MaineHealth

Richard Aronson
Maine Bureau of Health

Laureen Biczak
Bureau of Medical Services

Nancy Birkhimer
Bureau of Health, Dept. of Human Services

Anne Boniface
Eastern Maine Medical Center

Donald Burgess
PrimeCare Pediatrics

Barbara Leonard
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