# "Key Change Package" Proposed for the Maine Youth Overweight Collaborative {MYOC3}

**New Teams**, **Veteran Teams**, **Specific Pilots**

| Care Model Component | Change Concept / Strategies |
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| **Healthcare System Support:**<br>Promote leadership on youth overweight among healthcare system leaders, including public and private payers | • Identify and engage key clinical leaders for change (individuals and organizations, such as AAP, AAFP)<br>• Engage payers in improvement effort, and identify potential financial barriers to improving care<br>• Encourage providers to use ICD 9 codes of 278.00, 278.01 and 278.02 for diagnosis of obesity to help identify and overcome barriers including potential payment issues<br>• Encourage use of regular office visit CPT codes for follow-up visits as appropriate<br>• Encourage education & support for breastfeeding beginning with pre-natal/newborn visits<br>• Identify % of patient panel enrolled in MaineCare & use Bright Futures forms to refer to PHN as appropriate<br>• Develop capacity to treat and offer appropriate overweight patients tertiary care<br>• Build on linkages to hospital systems and increase awareness of issue and spread of key changes |
| **Family / Self-Management Support:** Educate families & patients about the risks and complications of youth overweight, and provide compassionate support for behavior change that promotes healthy lifestyles | • Deliver, consistent, focused messages about healthy lifestyles (5-2-1-0 for all as gateway message & additionally age-appropriate messages i.e. breastfeeding counseling, no TV and tummy-time)<br>• Assess readiness to change and self-efficacy, and provide advice for behavior change consistent with patient and family's readiness. Distinguish strategies / approach by age & development.<br>• Use collaborative approach to setting goals with patients and families based on assessment of (importance / confidence) readiness to change<br>• Promote self-management skills for patient & family<br>• Encourage families to participate in community programs<br>• Match patient with best approach by increasing provider sensitivity around developmental stage, literacy level, and cultural diversity |
| **Delivery System Design:**<br>Identify the care team in the PCP practice, and clarify roles for each team member | • Identify roles/expectations of each team member, and explore opportunities to enhance team functioning and communication (exploring who measures & classifies, who delivers preventive message & survey, who provides counseling around breastfeeding, who schedules follow-up, who calls for reminders etc)<br>• Add a community member to team<br>• Consider inviting a parent to join team<br>• Provide care through planned care visits for follow up of overweight<br>• Consider alternative models of care (e.g. group visits, telephone follow up calls) |

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| **Clinical Decision Support:**<br>Assess weight for length in age 0—2 and BMI % for age/gender on all children (ages 2-18yo) annually, evaluate change from last visit and follow recommendations for medical assessment of overweight patients | • Use "Medical Assessment of Overweight Patient" algorithm to consisten evaluate appropriate patients (BMI class, age, co-morbidity, family histo and parental weight status)<br>• Use available clinical tools (e.g. algorithms) and incorporate them into routine care based on patient / family readiness and knowledge<br>• Incorporate specialty expertise routinely into care including lactation specialists, nutritionists & exercise physiologists<br>• See patients at recommended intervals for routine follow up |
| **Clinical Information Systems:**<br>Use a registry to track outcomes and improve care & reminder systems for follow-up appointments. | • Organize data to facilitate population-based care<br>• Identify population of patients obese (BMI >95%'ile for age) and overweight (BMI 85-94%'ile for age) and track outcomes data on BMI and key clinical metrics<br>• Use registry to identify patients who would benefit from proactive care - e.g.<br>    o Identify patients with BMI% for age >95%'ile and create specific plan to support behavior change (e.g. referral to nutritionist, medical specialists, mental health providers, etc).<br>• Use registry to monitor performance of practice team and improvement spread within clinical site (track ethnicity?) |
| **Community:**<br>Partner with one or more community organizations that have the potential to impact healthy lifestyles for children | • Identify and connect with local Healthy Maine Partnership or other appropriate organization and become familiar with resources in your community<br>• Encourage development of a coalition of clinical / community partners to work together to increase the number of adequate resources & knowledge/awareness of the problems<br>• Use parent team member to help explore available community resources that promote physical activity and/or healthy eating (e.g. YMCA, community recreation programs) and actively refer patients for participation<br>• Connect with your local school (school nurse, coordinated school health program, PTO, School Board, School-based Health Centers) to address issues of physical activity, the built environment and/or healthy eating in the school<br>• Connect with school physician & identify if any local schools are assessing BMI'ile for age/gender and coordinate referrals as appropriate<br>• Form linkages with daycare and family service organizations that teach parenting skills and deliver healthy lifestyle messages (WIC, HeadStart, PHN, Lactation Specialists)<br>• Be an advocate for change within the community and other appropriate settings<br>• Work with community and families to be sensitive to cultural diversity needed within programs and resources |