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Small Steps to Health: Building Sustainable Partnerships in Pediatric Obesity Care

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ABSTRACT

BACKGROUND. Given the prevalence of childhood obesity and the limited support for preventing and managing obesity in primary care settings, the Seattle Children's Hospital's Children's Obesity Action Team has partnered with Steps to Health King County to develop a pediatric obesity quality-improvement project.

METHODS. Primary care clinics joined year-long quality-improvement collaboratives to integrate obesity prevention and management into the clinic setting by using the chronic-disease model. Sustainability was enhanced through integration at multiple levels by emphasizing small, consistent behavior changes and self-regulation of eating/feeding practices with children, teenagers, and families; building local community partnerships; and encouraging broader advocacy and policy change. Cultural competency and attention to disparities were integrated into quality-improvement efforts.

RESULTS. Participating clinics were able to increase BMI measurement and weight classification; integrate management of overweight/obese children and family and self-management support; and grow community collaborations. Over the course of 4 years, this project grew from a local effort involving 3 clinics to a statewide program recently adopted by the Washington State Department of Health.

CONCLUSIONS. This model can be used by other states/regions to develop pediatric obesity quality-improvement programs to support the assessment, prevention, and management of childhood obesity. Furthermore, these health care efforts can be integrated into broader community-wide childhood-obesity action plans. *Pediatrics* 2009;123:S308–S316

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Key Words

overweight, obesity, quality improvement, child, primary care, chronic care model, community oriented primary care

Abbreviations

COAT—Children's Obesity Action Team
STEPS—Steps to Health King County

QI—quality improvement

NICHQ—National Initiative of Children's Healthcare Quality

CHIC—Children's Health Improvement Collaborative

CDEMS—Chronic Disease Electronic Management System

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OVER THE PAST 3 decades, the childhood-obesity rate has more than doubled for preschool-aged children and adolescents and more than tripled for school-aged children. Minorities have been disproportionately affected. Approximately 25% of black and Hispanic children are above the 95th BMI percentile for age.^{1–3} The dramatic increase in the prevalence of childhood obesity and its resultant comorbidities is associated with significant health and financial burdens that warrant strong and comprehensive prevention efforts.

RECOMMENDATIONS FOR A SOLUTION

The US Institute of Medicine report for preventing childhood obesity⁴ recommended that organizations at multiple levels (federal, national, statewide, and local) take action to address the complex interactions across social, environmental, and policy contexts that influence childhood obesity. Notably, community-engagement and grass-roots efforts were highlighted to build effective coalitions and programs for community-wide interventions, particularly in high-risk populations. In the health care sector, the Institute of Medicine recommended that health care professionals routinely track BMI in children and youth and offer appropriate counseling and guidance to children and their families and, at the same time, asked parents and families to engage in and promote more healthful dietary intakes and active lifestyles. Moreover, prevention efforts must be attentive to culture, language, and inequities in social, economic, and physical environments and should be targeted to reach high-risk populations.

Reversing these trends requires changes in individual and family behavior and making environments that support healthier lifestyle choices. In particular, primary care practices can have an important role in promoting preventive measures and encouraging positive lifestyle behaviors and by identifying and treating obesity and related comorbidities. However, despite the magnitude of pediatric obesity, providers struggle with how best to communicate and

intervene with families who are faced with issues of overweight.^{4,5} In addition, providers are often isolated from the broader community context. There are advantages of connecting the two. For example, “community-oriented primary care” blends principles of public health and primary care and emphasizes that clinical responsibility goes beyond the individual and family to the broader community. This approach has resulted in collaborative programs of intervention and prevention in service delivery not always achieved by primary care providers.^{6,7} Finding ways to engage primary care providers with community partners strengthens both the community contribution to pediatric obesity management and the primary care providers’ contributions to community-based obesity-prevention efforts.

A LOCAL OPPORTUNITY TO IMPROVE CARE

Within the context of a 2002 statewide plan to improve physical activity and nutrition within Washington State, Seattle Children’s Hospital in Seattle, Washington, partnered with several local groups including Public Health–Seattle & King County to address childhood obesity.

Children’s Obesity Action Team

At Children’s Hospital, a group of professionals representing various disciplines and services formed the Children’s Obesity Action Team (COAT) in 2002. COAT is dedicated to the research and development of culturally responsive and developmentally appropriate resources for youth, families, and providers to decrease childhood overweight and obesity. The philosophy of the COAT is based on the principles of promoting self-regulatory skills around eating, activity, and emotions in the context of the socioecological model of health. On the basis of initial needs assessments with providers ($n = 54$), parents ($n = 78$), and teenagers ($n = 32$), COAT developed a vision of linked resources to prevent, assess/identify, and address pediatric obesity: (1) community-based programs and partnerships (including advocacy); (2) primary care providers/practices; and (3) an evidence-based clinical program at Children’s Hospital. This vision led to the development of age-specific healthy eating/activity information for families, a community-based healthy-lifestyle program developed in partnership with the YMCA of Greater Seattle for overweight/obese youth aged 8 to 14 and their parents, and training for providers to increase their effectiveness in promoting healthy lifestyles, addressing pediatric obesity including motivation interviewing skill building. Motivational interviewing has been described as a skillful clinical style for eliciting from patients their own motivations for making behavior changes in the interest of their health.⁸ Partnering with Steps to Health King County provided a unique opportunity to merge our common interests in improving chronic-disease management of pediatric obesity within primary care practice.

Steps to Health King County

In 2003, Public Health–Seattle & King County and multiple community partners received funding from the

Centers for Disease Control and Prevention to develop the Steps to Health King County (STEPS) program.⁹ This program funds states, cities, and tribal entities to implement community-based chronic-disease prevention efforts that are focused on reducing the burden of obesity, diabetes, and asthma and addressing 3 related risk factors: physical inactivity, poor nutrition, and tobacco use.

The STEPS program is working to build healthier communities (in 6 contiguous cities in south Seattle and in southwest King County) by working with a consortium of 75 members representing schools, health care providers, hospitals, health plans, clinics, universities, work sites, community-based organizations, faith-based groups, government agencies, and community leaders. Programmatic efforts are focused on people who are most affected by chronic diseases, including racial/ethnic minorities (Vietnamese and Spanish-speaking communities are a special focus), and people who live below the federal poverty line. One key aspect of the STEPS program is engaging the health care sector in chronic-care management and improvement of quality of care through chronic disease/wellness coordinators and quality-improvement (QI) collaboratives.

MULTILEVEL/CROSS-SECTOR APPROACH DEVELOPED

The socioecological model as applied to obesity recognizes that an individual’s eating and activity behaviors are multifaceted and are part of a much larger social context that influence behavior. Changes in individual health behaviors require supportive changes at many other levels including family, institutions (such as health care settings and schools), community, and public policy.^{10,11} Using this model, we designed a clinic-based QI project that integrated and supported change at these multiple levels.

CLINIC-LEVEL QI WORK

A QI and chronic-disease management initiative was created through a partnership among 3 local health care organizations, all with leadership in the community and experience with diverse populations. Program goals included (1) improving clinical outcomes, (2) provider training, (3) expanding registries, (4) enhancing communication between hospitals, primary care providers, and health plans, and (5) implementing health system policies to address cultural competence. The initiative’s work related to pediatric obesity has been a multiphased project.

The first phase (Table 1) began in 2005–2006 as a pilot learning collaborative named “Small Steps to Health.” Three primary care clinics primarily serving minorities, immigrants, and non-English-speaking families participated. Partnering with the clinic teams, Children’s Hospital COAT faculty (clinical nurse specialist, master’s level registered dietician, and physician) provided oversight and technical assistance for improvement activities with National Initiative of Children’s Healthcare Quality (NICHQ) QI advisors. In the second phase (2006–2007), experience gained from the pilot program was integrated into a statewide collaborative

TABLE 1 Overview of the Multiphase Collaborative

Multi-Phase Collaborative	Description	Expansion of Partners
Phase 1: Small Steps to Health Pilot (2005–2006)	1 track (obesity) with 3 participating practices	Seattle Children's Hospital Harborview Medical Center Highline Medical Center Molina Healthcare Steps to Health King County; Public Health–Seattle & King County
Phase 2: Children's Health Improvement Collaborative (CHIC) (2006–2007)	3 tracks (obesity, asthma, ADHD) 4 of 36 participating practices in obesity track	Acumentra Health Seattle Children's Hospital NICHQ Public Health–Seattle & King County Steps to Health King County University of Washington's Child Health Institute Washington State Department of Social and Health Services' Health and Recovery Services Administration
Phase 3: Washington State Collaborative to Improve Health (2008–2009)	5 tracks (adult diabetes, adult hypertension, asthma for all ages, pediatric obesity, pediatric medical home) 5 of XX participating practices in obesity track	Aetna Children's Health Improvement Collaborative GlaxoSmithKline Northwest Physicians Network Premera BlueCross Puget Sound Health Alliance Qualis Health Regence BlueShield University of Washington Washington Academy of Family Physicians Washington State Department of Social and Health Services Washington State Department of Health Washington State Health Care Authority

ADHD indicates attention-deficit/hyperactivity disorder.

named the Children's Health Improvement Collaborative (CHIC). Multiple agencies partnered with 5 Medicaid managed care plans to support 20 medical practices participating in this QI project. Eight clinics from western Washington worked on improving care for pediatric obesity. In 2008, the CHIC joined the Washington State Collaborative to Improve Health, which has supported long-standing adult diabetes and cardiovascular health collaboratives.

Methods/Description of QI Work

Using the model for improvement and the chronic-care model,^{12–14} participating practices integrated changes within their clinic system to improve the assessment, prevention, and management of pediatric obesity. Key evidence-based messages (eg, daily breakfast, 5 servings of fruit/vegetables per day, <2 hours screen time, >1 hour physical activity, limit sugar-sweetened beverages) were used for this effort and were translated into several languages (Spanish, Vietnamese, and Somali). Key changes and a change toolkit (Appendixes 1 and 2) were

modified to reflect the COAT's goals and philosophy, with permission from the Maine Youth Overweight Collaborative and Kaiser Permanente.

During each of the year-long collaboratives, clinics worked to improve care for pediatric obesity through three 8-hour learning sessions, monthly conference calls, and coaching and support as needed. Unique to the current Washington State collaborative is the use of intensive QI coaching with each participating practice, including 3 site visits and additional calls. The initial site visit before starting the learning sessions included preparation for using a registry, establishing a pilot population, and clinical assessment of some basic processes of care. Follow-up site visits were focused on specific clinical or QI needs.

Learning sessions for each collaborative included core content and also addressed needs expressed by the participating practices (Table 2). For example, providers requested additional support in counseling parents who restricted food for themselves and their overweight/obese children and teenagers. Birch et al¹⁵ (2003) have

TABLE 2 Learning-Session Agendas

Learning Session 1	Learning Session 2	Learning Session 3	Conference Calls
Chronic-care model	Parent advisory board	Eating disorders and obesity	Sleep apnea
Motivational interviewing	Cultural competency (1)	Cultural competency (2)	Steatohepatitis
Obesity toolkit overview	Partnerships	Registry development	Infant nutrition
	Nutrition and self-regulation counseling strategies		Restrictive feeding practices
			Registries

shown that children brought up with restrictive eating or feeding practices can end up eating in the absence of hunger or overeating. Dieting by teenagers may also lead to dysregulation around eating and promote additional issues of binge eating and increased BMI.¹⁶ Given this research, along with clinical experience, counseling advice shared with the providers included regular provision of meals and snacks (not skipping meals), avoiding constant grazing, and the division of responsibility in feeding. These 3 concepts may ultimately allow a child or teenager to develop the ability to eat when hungry and stop when satisfied most of the time.^{17,18} In addition, parenting skills were emphasized to promote self-regulation around eating. Of note, a more authoritative parent style (warm, responsive, and appropriately demanding) is less likely to be related to restrictive feeding practices and an increased incidence of overweight.^{19–21}

In addition, issues of cultural competency and disparities (particularly socioeconomic) with regard to childhood obesity were addressed. Topics included access to healthy foods and activities, food insecurity, neighborhood safety, and costs associated with physical activity

participation. Teams were encouraged to identify race/ethnicity and language preference in addition to obesity-related measures. Discussion about how to talk about obesity within the context of different racial/ethnic groups and cultural perceptions of what is “healthy” or “overweight” were integrated into BMI measurement and weight classification.

Measures

These 3 obesity collaboratives required monthly measures (Table 3). The main outcome measures were the percentage of overweight and obese patients. Required process measures included percentage of patients with BMI measured, weight classification, receiving healthy-lifestyle messages, assessment of readiness to change and/or self-management goal, documented race/ethnicity, and planned follow-up. Clinical teams reviewed ~20 charts per month to assess their progress with the measures. Results of measures were pooled over the course of the action periods.

One notable addition to the third collaborative was the required use of a registry. This collaborative requires

TABLE 3 Obesity Measures

Measure	Description ^a
Outcome	Weight classification Underweight: <5th percentile Healthy weight: 5th–84th percentile Overweight: 85th–94th percentile Obese: 95th–98th BMI percentile ≥99th percentile
Percent overweight	Numerator: No. of children with a BMI at 85th–94th percentile at last well-child visit
Percent obese	Numerator: No. of children with a BMI at 95th–98th percentile at last well-child visit
Percent ≥99th percentile	Numerator: No. of children with a BMI at ≥99th percentile at last well-child visit
Process	
BMI percentile and weight classification	Numerator: No. of children with a BMI percentile and documented weight classification at last well-child visit
Healthy-lifestyle messages	Numerator: No. of children/families who received healthy-lifestyle messages (breastfeeding, eating breakfast, more meals at home or with family, fruits/vegetables, television-viewing reduction, 1 h of physical activity, limit sweet drinks) at last well-child visit
Current self-management goal	Numerator: No. of children with a BMI at ≥85th percentile with a documented self-management goal or readiness to change evaluated at last well-child visit or overweight follow-up visit Denominator: No. of children with a BMI at ≥85th percentile at last well-child visit or overweight follow-up visit
Referral	Numerator: No. of children with a BMI at ≥85th percentile with a documented referral to at least 1 of the following: nutrition, physical activity, or healthy-lifestyle program, mental health provider, or subspecialist at last well-child visit or overweight follow-up visit Denominator: No. of children with a BMI at ≥85th percentile at last well-child visit or overweight follow-up visit
Overweight follow-up visit	Numerator: No. of children with a BMI at ≥85th percentile with an overweight follow-up visit planned within 4 wk of being classified as overweight, obese, or ≥99th percentile or with a documented high readiness to change at last well-child visit Denominator: No. of children with a BMI at ≥85th percentile at last well-child visit
Appropriate laboratory tests	Numerator: No. of children ≥10 y old with a BMI at ≥85th percentile at last well-child visit or overweight follow-up visit with all recommended blood tests per weight classification and risk-factor profile ^b Denominator: No. of children ≥10 y old with a BMI ≥85th percentile at last well-child visit or overweight follow-up visit
Identification of race/ethnicity and language preference	Numerator: No. of children with a documented race/ethnicity and language preference

^a Numerator divided by denominator, then multiplied by 100, equals the percent of patients meeting the measure requirements. Denominator includes all registry patients unless otherwise specified.

^b Lab recommendations based on Expert Committee Recommendations (2007).

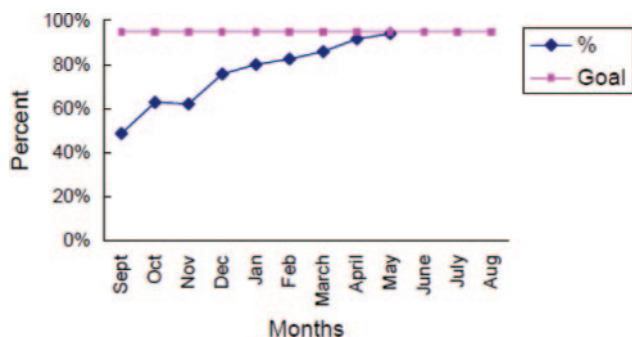


FIGURE 1
Percentage of patients with BMI and classified weight pooled across clinics during collaborative.

clinical teams to enter patient data into a registry before the first learning session. One registry option is the Chronic Disease Electronic Management System (CDEMS), a publicly available (www.cdems.com) software application developed by the Washington State Diabetes Prevention and Control Program in 2002. The CDEMS is a Microsoft (Redmond, WA) Access database application designed to assist medical providers and management in tracking the care of patients with chronic health conditions. The CDEMS is precoded to track diabetes, asthma, and adult preventive health but has been customized for use in pediatric obesity. Printed progress notes, patient lists, and summary reports generated from the registry database can support and measure QI efforts.

Outcomes

Throughout the course of the collaborative, medical practices demonstrated improvement in several outcome measurements including BMI measurement and classi-

fication, provision of healthy messages, increased follow-up, and referrals (Fig 1). Teams demonstrated increased engagement in all aspects of the chronic-disease model (Fig 2).

The following examples highlight the breadth of change experienced within the practices.

- One rural clinic developed a model in which children were referred to a nurse educator for counseling after assessment of overweight/obesity by their provider. Using the principles of division of responsibility and self-regulation, the nurse educator was able to support families struggling with feeding/eating issues. Their clinic was chosen from more than 80 proposals to present at the NICHQ 2008 Childhood Obesity Congress.
- One urban clinic in Seattle hired a nutritionist onto its staff who has provided individualized and regular group nutrition classes. This clinic is also working with other community organizations and community-supported agriculture to explore the issue of food insecurity and access to healthy foods.
- One large private pediatric group developed a healthy-lifestyle program for its clinical network.

Although these process measures are indicative of providers adopting obesity-prevention and -management recommendations, changes in patient BMIs and/or population overweight/obesity rates over time are clearly needed to demonstrate the effectiveness of these collaboratives. However, given the limited time frame of each collaborative phase (1 year), practices were only able to establish registries and begin to track individual BMIs. Also, with only a limited number of practices in the collaboratives, changes at county-based rates of

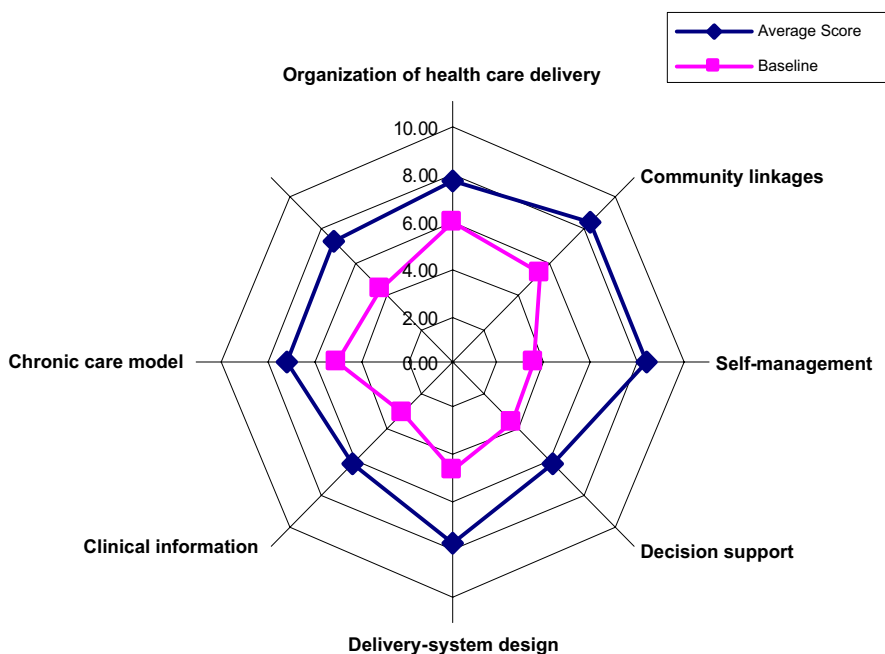


FIGURE 2
Assessment of the chronic-disease model. Shown are average scores (baseline versus follow-up).

overweight/obesity could not be attributed exclusively to the collaboratives.

COMMUNITY-LEVEL WORK

Primary care practices were encouraged to build community linkages and engage with community partners. Each collaborative invited a panel of community-based organizations (physical activity, school, faith-based) to present its programs/resources to the clinic teams. In addition, providers from previous and ongoing collaboratives could share community partnership successes with each other at learning sessions.

Participation in the STEPS program offered many opportunities to enhance established partnerships by connecting organizations/agencies and improving access to community resources for patients. For example, Children's Hospital had previously partnered with the YMCA of Greater Seattle to create the Strong Kids Strong Teens program, an 18-week community-based healthy-lifestyle program on nutrition, physical activity, and self-empowerment for overweight/obese youth (aged 8–14) and their parents. Funding from the STEPS program supported the ongoing availability of this program in high-need communities and enhanced recruitment and expansion. Collaborative practices used Strong Kids Strong Teens in communities where the program was available.

Pediatric practices built creative community partnerships by identifying resources and gaps and brainstorming solutions to promote healthy lifestyles for the families they served. For example, one family health clinic established a pool program, "Dive Into Health," with a local pool. Another created a resource directory on available physical-activity programs including scholarships and available bus services. One clinic started "Shop Arounds," tours at local grocery stores that support families to read nutrition labels, make healthier food choices, etc. The Shop Arounds were later adopted by an urban community into its healthy eating/activity plan with trainings for volunteers, public health nurses, and nutritionists to ensure sustainability. Models started within these collaboratives have been replicated by health care clinics and community organizations beyond STEPS partners.

POLICY-LEVEL WORK

Policy work and system change were fundamental components of the 3 collaboratives. This work included leveraging resources to target policy change in the broader community as well as within STEPS organizations. Some of the work was focused on encouraging providers to advocate for formal policy change. Clinicians within the collaboratives were oriented to local/statewide advocacy opportunities such as school-based efforts of the Washington Action for Healthy Kids and encouraged to engage in advocacy around childhood obesity. Other work was focused on procedure and process change in chronic care within their particular clinics.

Some clinic staff became engaged in local policy action and provided testimonies, spoke at local forums, or

attended community and school board meetings. Clinic nutritionists also served on school nutrition advisory boards to provide support for improvements in the school menus. Partnerships were also forged with local and state coalitions/workgroups advocating for improved nutrition and physical activity and obesity prevention/management such as the Action for Healthy Kids school-based efforts and the King County Food and Fitness Initiative funded by the Kellogg Foundation to improve access to healthy foods and activities. Children's Hospital collaborated on broader health- and safety-promotion efforts with Harborview Medical Center and Public Health Seattle & King County for a variety of active-living initiatives (walking school bus project, safe playgrounds, bike helmet usage).

To lay the foundation for future health policy change, keeping Department of Social and Health Services (DSHS) and other health plans abreast of the QI work was essential throughout this 3-phased project. By attending learning sessions, plan representatives observed teams' efforts in implementing obesity assessment and management into the clinical setting, including registry development such as CDEMS. Maintaining communication regarding collaborative outcomes with partnering health plans and DSHS will also help to encourage their adoption of incentives for medical practices that incorporate these obesity QI activities.

Finally, expanding childhood-obesity QI into Washington State's Department of Health's statewide effort optimized the dissemination of this model to other clinics. This spread will help to achieve the long range goal of creating an integrated approach to the prevention and management of pediatric obesity throughout all clinical practices in Washington State.

NEXT STEPS

Although the clinics participating in the collaboratives made significant progress in the assessment, management, and prevention of obesity, there are still several issues to be addressed. Reimbursement for management of obesity and its consequences continues to be a work in progress. COAT members have drafted an obesity benefit package with Medicaid. Piloting of this benefit package is being considered and would permit tracking and capturing of some initial data to help to move this issue forward. Furthermore, continued efforts are needed to support providers, particularly around motivational interviewing and other effective counseling techniques, promoting the concept around self-regulation, and incentivizing/rewarding clinics that are engaged in childhood-obesity prevention and management.

Significant local and statewide policy changes are needed to support families in healthy eating and activity. Although efforts can be made in the medical setting to evaluate, educate, and counsel, strong advocacy is needed to build a supportive environment and culture with access to healthy foods and active communities to sustain these healthy behaviors. Clinic staff can play a significant role in advocating for policy change through their testimony, speaking at local forums, and participating in workgroups or committees at the school, commu-

nity, or state level. This engagement will help to shape the policy agenda and leverage change. Until these changes are made, families (particularly low-income families) will continue to struggle with food insecurity, unsafe playgrounds, and other obesogenic environmental factors.

CONCLUSIONS

We have described a multiphased childhood-obesity QI program that developed from a partnership between a children's hospital and local health department through funding from the STEPS program to HealthierUS. From the clinicians' perspective, systematic change within their practices has established a more comprehensive and outcome-based approach to obesity prevention, identification, and management. Engagement with community partners improved access to community-based resources/programs and built coalitions to work toward policy change.

By engaging primary care clinics in supporting families to make healthier choices, connecting with community resources, and taking action in broader community efforts, the health care sector can play its role in sustainable change to prevent and decrease childhood obesity.

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APPENDIX 1 Key Changes

Recommended Standards of Care	Key Changes
Promote clinical care that is consistent with scientific evidence and family preferences	Use structured encounter form with embedded recommendations to guide decision-making about patient care. (DS, DSD) Use evidence-based algorithm to evaluate overweight/obese patients. (DS)
Ensure the delivery of effective, efficient, patient-centered care	Define roles and delegate tasks appropriately among team members to ensure that care is well organized and efficient and targets BMI assessment, healthy eating, activity, and self-management support. (DSD, SMS) Provide care for obesity prevention, assessment, and management through well-child and/or planned follow-up visits. (DSD)
Organize data to facilitate population-based care	Develop and maintain a registry of patients that includes information on proactive care, patient follow-up, and patient race, ethnicity, and language preference. (CIS, DS) Identify population of patients overweight (BMI \geq 95th percentile for age) and at risk for overweight (BMI at 85th–94th percentile for age) and track outcomes data on BMI and key clinical metrics. (CIS) Use registry to identify patients who would benefit from proactive care (eg, identify patients with BMI at \geq 95th BMI percentile for age and create specific plan to support behavior change [eg, referral to nutritionist, medical specialists, mental health providers, etc]). (CIS, DSD, DS) Establish a follow-up system for patients who do not show for planned visits. (DSD)
Support families to manage the health care of their children	Collaborate with patient and family on their role in the management of care and set and document shared management goals. (SMS, DSD) Deliver consistent, focused messages about healthy lifestyles. (DSD) Assess healthy-lifestyle behaviors, readiness to change, and self-efficacy, and provide advice and follow-up for behavior change consistent with patient and family's readiness to change. (SMS, DSD) Focus on eating self-regulation across the age spectrum. (SMS, DSD)
Create an environment and mechanisms that promote high-quality care	Provide culturally and linguistically appropriate care at all points of contact. (HCO, DSD) Engage payers in improvement effort, and identify potential financial barriers to improving care. (HCO) Promote organizational value around healthy-lifestyle behaviors across ages and weights (eg, including staff wellness). (HCO)
Partnerships to meet the needs of families and children	Emphasize the long-term process of health promotion and behavior change. (HCO) Establish methods to identify and partner with schools, specialty programs, and other community resources to advocate and encourage optimal care for each patient and mechanisms to ensure referral to these resources. (COM, DSD) Integrate parents, teenagers, and/or community partners (eg, on QI team or parent advisory council). (COM, DSD)

Teams will test and implement changes that address the various components of the planned-care model. DS indicates decision support; DSD, delivery system design; SMS, self-management support; CIS, clinical information systems; HCO, health care organization; COM, community resources.



Small Steps to Health Pediatric Obesity Toolkit Table of Contents

I. Prevention, Assessment and Diagnosis

a. Childhood Obesity Action Network (COAN) Implementation Guide

www.aap.org/healthtopics/overweight.cfm. Click on AAP Obesity website, click on what health professionals can do, click on clinical resources, scroll down list of clinical tools.

- Based on the Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity 2007
http://pediatrics.aappublications.org/content/vol120/Supplement_4/

b. Tools

- i. Small Steps to Health posters (icon, photo versions)
- ii. Well child survey on key messages (English, Spanish, Vietnamese, Somali)
- iii. BMI Wheels
- iv. COAN Childhood Obesity Algorithm—Assessment, Prevention and Treatment

II. Management and Treatment

a. Tools

- i. Clinical Encounter Forms
 1. CDEMS Sample Progress Note Obesity
 2. Fit 4 You Visit Planner
- ii. AAP Coding & Reimbursement for Obesity Related Services
www.aap.org/healthtopics/overweight.cfm. Click on AAP Obesity website, click on what health professionals can do, click on practice management resources, click Obesity Coding Fact Sheet.
- iii. Sample Clinic Flow Form

b. Self-Management Support

- i. Motivational Interviewing Tips
 1. Effective Communication with Families
 2. Brief Negotiation
- ii. Tips for Communication about Eating Well
 1. Your Child's Weight, Helping Without Harming
<http://www.ellynsatter.com/resources.jsp>. (also available in Spanish)
 2. Division of Responsibility <http://www.ellynsatter.com/resources.jsp>. (click on Division of Responsibility; also available in Spanish)
 3. Promoting Communication with Children and Families about Eating Well
- iii. Small Steps to Health Goal Planning Worksheet
- iv. Food and Eating Habits Survey
- v. Physical Activity Survey
- vi. Physical Activity/Healthy Lifestyle Program Referral Form
http://obesity.seattlechildrens.org/for_providers.htm. Click on Strong Kids Strong Teens referral form on Provider toolkits.

III. Additional Resources/Weblinks

- a. Children's Obesity Action Team
<http://obesity.seattlechildrens.org/>
- b. Weight Management Educational Materials Handout
<http://obesity.seattlechildrens.org/resources.htm>. Scroll down to Provider Packet on Pediatric Obesity
- c. School advocacy: Action for Healthy Kids
<http://www.actionforhealthykids.org/>
- d. Physical Activity Resource Directory/Community Organizational Form
http://obesity.seattlechildrens.org/clinical_services.htm#odessa_brown. Scroll down to Odessa Brown Children's Clinic section, Fit 4 You Brochure
- e. Physical Activity/Healthy Lifestyle Program Referral Form
<http://obesity.seattlechildrens.org/resources/htm>. Scroll down to the Small Steps to Health Pediatric Obesity Toolkit section.
- f. TV Reduction Toolkit
 - i. Overweight Prevention TV Reduction Toolkit (WA)
www.kingcountry.gov/healthservices/health/chronic/overweight/reducetv.aspx.
 - ii. Do More, Watch Less (CA)
http://ww2.cdph.ca.gov/programs/schoolhealth/Pages/DoMore_WatchLessTVTool.aspx.
- g. Culturally Appropriate Care—Expanding Perspectives Improving Cultural Competency in Children's Health Care
http://www.nichq.org/cultural_competency.html

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