

Health Plan Performance Improvement Project (PIP)

Passport Health Plan

**Childhood Obesity: Weight
Assessment and Counseling for
Nutrition and Physical Activity for
Children and Adolescents**

Final Report – September 2011

**Submission to:
Kentucky Department for Medicaid Services**

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MCO and Project Identifiers

Please complete all fields as accurately and as completely as possible.

1. Name of MCO: _Passport Health Plan

2. Select the Report Submission: [If any change from initial submission, please complete section 7 below.]

PIP Part I: Project Proposal Date submitted: **9/1/09**

PIP Part II: Interim Report Date submitted: **9/1/10**

PIP Part III: Final Report Date submitted: **09/1/11**

3. Contract Year: **2010-2011**

4. Principal Contact Person: **Christie Spencer**

[Person responsible for completing this report]

4a. Title: **Vice President, Clinical Operations**

4b. Phone: **502-585-7315**

4c. Email Address: **Christie.spencer@passporthealthplan.com**

5. Title of Project: **Childhood Obesity: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**

6. External Collaborators (if any): **Not Applicable**

7. For Final Reports Only: If Applicable, Report All Changes from Initial Proposal Submission: [Examples include: added a new survey, added new interventions, deviated from HEDIS® specifications, reduced sample sizes]

8. Attestation

The undersigned approve this PIP Project Proposal and assure their involvement in the PIP throughout the course of the project.

Signature on file

Stephen J. Houghland, MD, Chief Medical Officer

Signature on file

Christie Spencer, Vice President, Clinical Operations

NA

IS Director (when applicable)

Signature on file

Mark Carter, Chief Executive Officer

Abstract

This section should be approximately 1-2 pages in length. The Abstract should be completed only for the Final Report.

[Provide an abstract of the PIP highlighting the project topic and objectives, briefly describe the methodology and interventions, and summarize results and major conclusions of the project.]

1. Project Topic / Rationale / Aims

[Provide title of the project; State rationale for project, objectives, project questions, baseline and/or benchmark data, and goal for improvement.]

The title of this project is Childhood Obesity: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents. Topic selection was based on the fact that CDC trends indicate that 19,073 of the Plan's 131,799 members eligible for EPSDT are potentially at risk for the development of childhood obesity (National Health and Nutrition Examination Survey, 2009).

Preventive health guidelines based on the American Academy of Pediatrics (AAP) Standards of Care based on the ACOG standards of care, were adopted by the Plan in 1999 and revised as needed. The Plan initiated auditing the compliance of the Plan's pediatricians and family practitioners, who provide care to the EPSDT population, during HEDIS® 2000 data collection. This practice has continued annually.

Project objectives were to:

- **Utilize HEDIS® methodology to determine the population to be studied along with the Plan's adopted preventive health guidelines.**
- **Partner and collaborate with practitioners to improve compliance of standards of care regarding weight assessment and counseling for nutrition and physical activity for children and adolescents.**
- **Increase members' lack of knowledge about the importance of weight management, nutrition, and physical activity.**

The question this project was designed to answer is; "Does a robust approach to provider education increase the rate of documented compliance with the assessment of: childhood BMI percentile/BMI (BMI calculation for those aged 16 – 17 years of age), and counseling regarding nutrition and physical activity?"

2. Methodology

[Describe the population, study indicators, sampling method, baseline and remeasurement periods, and data collection procedures.]

Indicator utilized: HEDIS® 2009, Volume 2, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents p. 63-67. The percentage of members 3-17 years of age who had a visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. The denominator includes eligible members in the sample. The HEDIS® hybrid methodology was used to determine the sample. The numerator includes those who received weight assessment of: childhood BMI percentile/BMI (BMI calculation for those aged 16 – 17 years of age), and counseling regarding nutrition and physical activity. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

The denominator for the measures includes members between the ages of 3-17 years who were continuously enrolled during the measurement year. The numerators include documentation of the following during the measurement year:

- **Documentation of Height and Weight - documentation of both a height and weight documented on the same date of service,**
- **Documented BMI Percentile/Value –includes members between the ages of 3-15 years on the date of service with a documented BMI percentile or BMI percentile plotted on an age-growth chart and adolescents 16-17 years on the date of service with documentation of a BMI value expressed as kg/m²,**
- **Counseling for Nutrition – documentation of counseling for nutrition or referral for nutrition education, and**
- **Counseling for Physical Activity - Documentation of counseling for physical activity or referral for physical activity.**

The baseline period was calendar year 2008 and the final measurement period was calendar year 2010. Indicators were measured annually in conjunction with HEDIS® medical record review.

3. Interventions

[Describe the interventions and target of the interventions. This section may include interim results gleaned from using a PDSA method, if applicable.]

Interventions for this performance improvement project were targeted toward providers' lack of awareness of the Preventive health guidelines and medical record documentation of assessment/counseling in the member's medical records. Interventions for this performance improvement project were also targeted to members' lack of knowledge about the importance of weight management, nutrition, and physical activity. Multiple

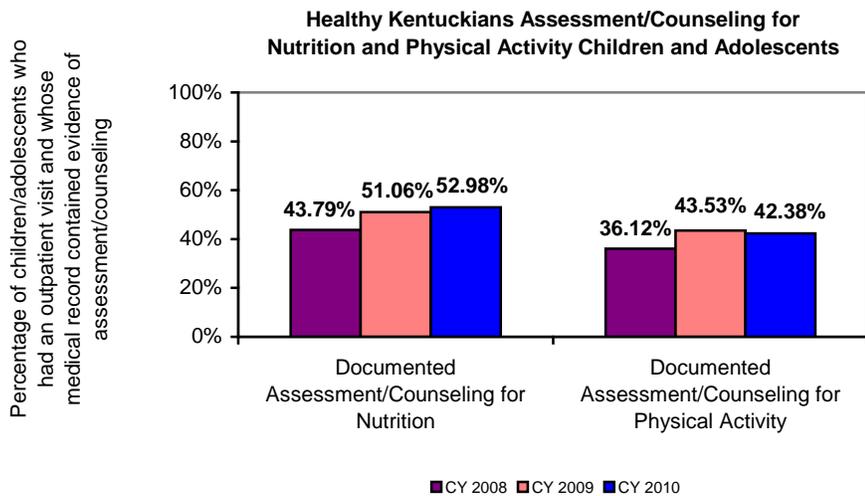
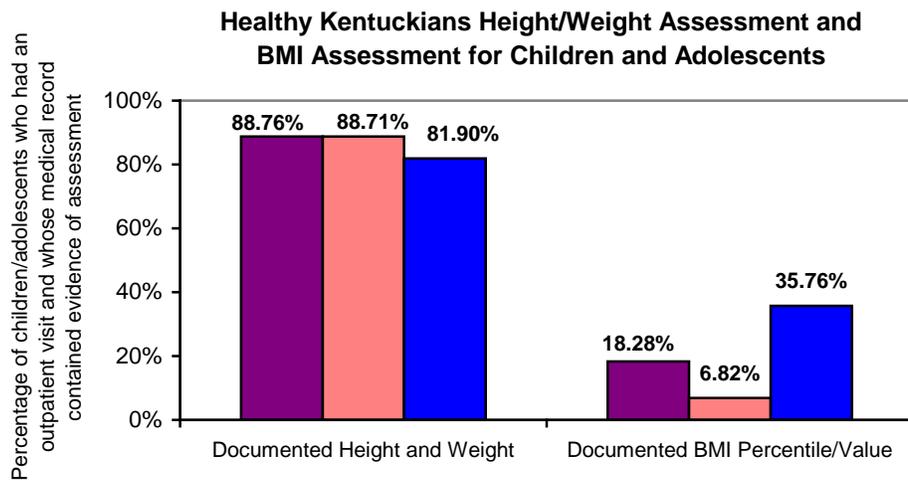
member, provider and community interventions were implemented to address these measures. These included but were not limited to:

- Updated and distributed the Preventive health guideline to providers as approved by the Quality Medical Management Committee (QMMC).
- Conducted ongoing care coordination with EPSDT members.
- Included scripts regarding the importance of weight management, nutrition, and physical activity via the Plan's on hold messaging system.
- Published articles in Member Newsletters regarding the importance of weight management, nutrition, and physical activity and avoiding high-risk behaviors that affect health outcomes.
- Collaborated with the outreach department to distribute information regarding the diet, nutrition, and exercise at all community events.
- Collaborated with community agencies to increase awareness of the importance of weight management, nutrition, and physical activity.

4. Results

[Specify number of cases in the project, remeasurement rates for project indicators, and statistical test results if applicable.]

Indicator	Baseline Results CY 2008			1 st Re- measurement CY 2009--reported in 2010			Increase/ Decrease Percentage Points	Final Re- measurement CY 2010--reported in 2011			Increase/ Decrease Percentage Points
	n	d	Rate	n	d	Rate		n	d	Rate	
Documented height and weight	388	443	87.58%	377	425	88.71%	↑1.13%	371	453	81.90%	↓ 6.81%
Documented BMI percentile	81	443	18.28%	29	425	6.82%	↓ 11.46%	162	453	35.76%	↑ 28.94%
Nutrition counseling	194	443	43.79%	217	425	51.06%	↑ 7.27%	240	453	52.98%	↑ 1.92%
Physical activity counseling	160	443	36.12%	185	425	43.53%	↑ 7.41%	192	453	42.38%	↓ 1.15%



The above graphs represent the rate of member assessment and counseling for the selected indicators from measurement years 2008-2010. Records audited for CY 2008 were 443, CY 2009 were 425, and CY 2010 were 453.

Between baseline and the first re-measurement year, two indicators demonstrated increases, while two indicators demonstrated decreases.

Documentation of BMI percentile increased 28.94 percentage points from CY 2009 results. The documentation of height and weight demonstrated a decrease of 6.81 percentage points from CY 2009 results.

Unlike clinical components of well-child visits, such as EPSDT examination indicators and routine screenings, member education rates have been much lower.

5. Conclusions

[Address whether the project objectives were met, any corresponding explanations, a synthesis of the major project findings, any major project limitations, barriers, financial impact and next steps.]

Project objectives were somewhat met. Improvement was not demonstrated for all key indicators over the course of the three year study. However, the indicator for BMI percentile documentation increased 28.94 percentage points. Providers' implementation of EMR systems is felt to be attributed to the increase. It is also important to note the BMI values were found in the majority of the records audited but the measure requires documentation of a BMI percentile. Provider education regarding documentation and importance of BMI percentiles is an area of needed improvement.

Project Topic

Provide a general description of the project topic that is clearly stated and relevant to the enrolled population.

1. Describe Project Topic

[Project topics should be based on the needs of the plan's member population (i.e., should reflect enrollee needs, care and services and reflect high-volume or high-risk conditions/events) and should be supported by current research, clinical guidelines or standards.]

In the last twenty years, the prevalence of childhood and adolescent obesity has demonstrated an upward trend. Childhood and adolescent obesity has been identified as a major health concern in the United States, particularly in the lower income and minority segments of the population. There exist a significant number of individuals enrolled in Passport Health Plan whose healthcare needs creates a predisposition and vulnerability placing them at risk to obesity related medical conditions. The goal is active disease prevention support, to promote health and reduce inequities in healthcare. Assessment and ongoing counseling and education of member needs by the Plan's network providers could address these concerns, promote greater participation in members own healthcare and an improvement in their overall quality of life.

2. Rationale for Topic Selection

[Explain why this activity is important to members or practitioners, *and* why there is an opportunity for improvement. Describe how the project or results will help practitioners, members, or plan processes. The rationale for the topic selected should be reasonable given MCO demographics, be based on objective supporting data (e.g., HEDIS®, MCO baseline data, enrollee/provider surveys), and pertain to a sufficient number of members to yield interpretable findings. Use documentation with citations from literature to support and substantiate topic rationale].

According to the National Health and Nutrition Examination Survey (NHANES) as published by the Centers for Disease Control and Prevention (CDC) the following increases in the national trends toward the prevalence of childhood obesity from 1976 through 2006 indicated: ages 2 through 5 increased from 5% to 12.4%; ages 6 through 11 increased from 6.5 % to 17.0%; and ages 12 through 19 increased from 5% to 17.6%. For adolescent boys aged 12-19 years from 1988 through 2006: Non-Hispanic White increased from 11.6% to 17.3%; Non-Hispanic Black increased from 10.7% to 18.5%; and

Mexican American increased from 14.1% to 22.1%. For adolescent girls aged 12-19 years from 1988 through 2006: Non-Hispanic White increased from 7.4 % to 14.5%; Non-Hispanic Black increased from 13.2% to 27.7%; and Mexican American increased from 9.2% to 19.9% (National Health and Nutrition Examination Survey, 2009).

The CDC's Pediatric Nutrition Surveillance System (PedNSS), which monitors the nutritional status of children from birth to age 4 enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) indicated between 1998 and 2008 the average annual change in the prevalence of obesity among children aged 2 to 4 years of age in Kentucky increased from 12.1% to 15.7 %. Preschool obesity tends to extend into adolescence and adulthood, and precipitates the development of diabetes, hypertension, hyperlipidemia, asthma, and sleep apnea. One of the goals of the Healthy People 2010 initiative is to reduce the percentage of children and adolescents who are obese to 5% (Sharma, Grummer-Strawn, Dalenius, Galuska, Anadappa, Borland, and Smith, 2009).

Currently, Passport Health Plan has 131,799 members eligible for EPSDT. Based upon the CDC's trends for the percentage of childhood overweight and obesity, from 1976 through 2006 the following estimates can be made for children and adolescents currently being served by Passport Health Plan:

- Ages 1-5 total 40,632 members (5,038 or 12.4% at risk);**
- Ages 6-14 total 54,659 members (9,292 or 17% at risk); and**
- Ages 15-20 total 26,949 members (4,743 or 17.6% at risk).**

These estimates, based on CDC trends, indicate 19,073 of the Plan's 131,700 EPSDT eligible members potentially are at risk for the development of childhood obesity (National Health and Nutrition Examination Survey, 2009).

Obesity and its associated health problems significantly impact the United States healthcare system. The direct costs, including preventive, diagnostic, and treatment services, and indirect costs, income lost from decreased productivity, restricted activity, absenteeism, and bed days; along with lost future income are all associated economic consequences. According to the Behavioral Risk Factor Surveillance System (BRFSS) used to estimate obesity-attributable Medicaid percentages and expenditures by state, and published by the CDC, 11.4% of the Medicaid population in Kentucky was obese and accounted for an estimated \$340 million dollars in related healthcare costs (Finkelstein, Fiebelkorn, and Wang, 2004).

3. Aim Statement

[State the question(s) that the project is designed to answer. Address what the project is trying to accomplish, including WHO (patient population), WHAT (the intent of the project), WHERE (pilot site and spread sites), and WHEN (timeline). Align the aim with the strategic goal of the organization. The project objectives should be clear and set the framework for data collection, analysis, and interpretation. Anticipated barriers and how they will be addressed may be considered. Examples of objectives include improving HEDIS rates, customer satisfaction, access to care, and adherence to clinical guidelines. Specify a target or goal for improvement that is practical, achievable, unambiguous, and quantifiable. Benchmark data can be used for comparative purposes (e.g., HEDIS® rates, Healthy People 2010, published articles).]

“Does a robust approach to provider education increase the rate of documented compliance with the assessment of: childhood BMI percentile/BMI (BMI calculation for

those aged 16 – 17 years of age), and counseling regarding nutrition and physical activity?”

Methodology

The methodology section describes how the data for the project are obtained.

1. Performance Indicators

[Indicators should be measurable, objective, clearly defined, and flow directly from the study aim. If using HEDIS®, specify reporting year used. If not using HEDIS® or using a modified HEDIS® measure, clearly state how your indicators will be measured, including a description of the indicator numerator and denominator. Define the criteria used for selecting the eligible population, and describe any exclusion criteria. State whether the methodology for the remeasurement differs in any way from that used for the baseline assessment; include type of change, rationale for change, and any bias that could affect the results. When employing a quality improvement model, it is preferable to report an intermediate measure to evaluate performance and the further need for change. Process measures are the workings of the system, i.e., the parts/steps in the system, whereas outcome measures are the result, i.e., how the system is performing. Examples are the percentage of patients with an LDL test in the past year, (process) and percentage of patients with LDL <100 (outcome).]

Indicator utilized: HEDIS® 2009, Volume 2, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents p. 63-67. The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

2. Procedures

[Describe the method of data collection, including who collects the data and the instruments used, as well as efforts to ensure validity and reliability. Clearly identify the sources of data, and specify if using administrative data, medical record data, hybrid methodology, and/or surveys. Report procedures and methods implemented to protect member confidentiality. Describe any data collection tools that are employed. Report whether sampling is used. If so, describe the sampling method, and if stratification was used. Report the sample size and verify that it includes all relevant subsets of the population. If a survey is used, detail the mode of survey (e.g., mail, phone), the number of cases to receive a survey, and follow-up attempts to increase response rates, if any (e.g., re-mailing of surveys). If using statistical testing, specify the procedures used for analysis.]

Utilizing the hybrid methodology specifications:

- **The denominator is a systematic sample drawn from the eligible population for the total age band (3-17 years). The total sample is stratified by age to report rates for the 3-11 and 12-17 age stratifications.**

- Exclusions-Members who have a diagnosis of pregnancy during the measurement year or valid data error
- The numerators consist of:
 - BMI Percentile during the measurement year as identified by administrative data or medical record review.
 - Medical record documentation must include a note indicating the date on which the BMI percentile was documented and evidence of either of the following.
 - BMI percentile, or
 - BMI percentile plotted on age-growth chart
 - For adolescents 16-17 years, documentation of a BMI value expressed as kg/m² is acceptable.
 - Counseling for Nutrition documentation or referral for nutrition education during the measurement year as identified by administrative data* or medical record review.
 - Medical record documentation must include a note indicating the date and at least one of the following.
 - Engagement in discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
 - Checklist indicating nutrition was addressed
 - Counseling or referral for nutrition education
 - Member received educational materials on nutrition
 - Anticipatory guidance for nutrition
 - Counseling for Physical Activity documentation or referral for physical activity during the measurement year as identified by administrative data* or medical record review.
 - Medical record documentation must include a note indicating the date and at least one of the following.
 - Engagement in discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation behaviors)
 - Checklist indicating physical activity was addressed
 - Counseling or referral for physical activity
 - Member received educational materials on physical activity
 - Anticipatory guidance for physical activity

*Administrative data-refer to HEDIS[®] Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure specification to identify positive numerator hits from the administrative data.

3. Member Confidentiality

[Clearly identify the sources of data, and specify if using administrative data, medical record data, hybrid methodology, and/or surveys. Report procedures and methods implemented to protect member confidentiality.]

All Plan associates including temporary employees receive a copy of the Code of Conduct and the Corporate Compliance Confidentiality policy and, must sign a statement that the policy has been received and understood. (Compliance Policy #4.03-Confidentiality and Privacy Guidelines)

4. Timeline

[Indicate a timeline for the aspects of the project, including the start and end dates for the baseline and remeasurement periods].

3rd Quarter 2009

- **Submit and obtain approval of project topic**

4th Quarter 2009

- **Meet with DMS and IPRO to discuss intervention strategy and timeline for approved project**

1st Quarter 2010

- **Reviewed technical specifications recommendation with the EQRO and DMS.**
- **Developed reviewer instructions for training purposes.**
- **Completed training and testing of medical record reviewers.**

2nd Quarter 2010

- **Conducted medical record review utilizing HEDIS® hybrid methodology to determine the members to include in the sample to obtain baseline audit results.**

Interventions / Changes for Improvement

Interventions should be targeted to the study aim and should be reasonable and practical to implement given plan population and resources.

1. Interventions Planned and Implemented

[Describe each intervention. Detail the extent of member participation in the project. Discuss how the intervention is reasonably able to impact the enrolled population/improve health outcomes, and likely to induce a permanent change rather than a short-term or one-time effect. Interventions should be based on evidence of effectiveness. If the intervention is based on literature, include appropriate citations. Describe whose performance the intervention is intended to affect (e.g., members, MCO clinical staff, providers, and community.)]

Complete the sections in the table below, and add more rows as needed.

Timeframe	Description of intervention	Barriers addressed
4 th Qtr 2009	Report results for Wt. Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents. to the Child and Adolescent Committee and Quality Member Access Committee and request recommendations regarding provider and member education.	Lack of provider and member awareness of the Plan's results for Wt. Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.
4 th Qtr 2009	Initiate development on the PHP web site, a page devoted to measurement of BMI and BMI percentile.	Lack of provider use of available appropriate weight assessment tools for children and adolescents.
2010	Initiate development of a tool kit to	Lack of provider knowledge of

Timeframe	Description of intervention	Barriers addressed
	distribute documentation tools to primary care providers who provide EPSDT services to increase compliance with the measurement of BMI and BMI percentile, counseling and education for nutrition and physical activity.	appropriate weight assessment tools for children and adolescents.
2010	Provider Newsletter article regarding the measurement of BMI and BMI percentile, counseling and education for nutrition and physical activity.	Lack of provider knowledge of appropriate weight assessment tools for children and adolescents.
2010	Member Newsletter article regarding the measurement of BMI and BMI percentile, counseling and education for nutrition and physical activity.	Lack of member awareness of the tools providers use to determine measurement of BMI and BMI percentile.

2. Intervention Timeframe

[Provide the start and end dates of each discrete intervention. The interventions should be timed for optimal impact, ideally after baseline, allowing enough time to impact remeasurement. Given the time parameters of the project, an interval of at least 6 to 9 months is generally necessary to detect measurable impact of your interventions.]

Intervention	Start Date	End Date
Report results for Wt. Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents to the Child and Adolescent Committee and Quality Member Access Committee and request recommendations regarding provider and member education.	Child & Adolescent Committee Meeting, November 12, 2009 QMAC meeting, December 7, 2009	Quarterly as needed
Initiate development on the PHP web site, a page devoted to measurement of BMI and BMI percentile and other documentation tools and information regarding age appropriate interventions for nutrition and physical activity education.	4 th quarter 2009	Update as needed
Member Newsletter article published in the 2009 Issue 3 "Obesity: You can do something."	4 th quarter 2009	Annually
Continued participation and collaboration with the Louisville Youth Training Center Childhood Obesity Program which provides fitness and nutrition training to 15 Plan teenaged members.	4 th quarter 2009	Ongoing
Develop and distribute documentation tools to increase compliance with member BMI	January 1, 2010	Ongoing

Intervention	Start Date	End Date
assessment, counseling and education to existing network providers, in addition, include tools in new provider toolkit.		
Information regarding nutrition and physical activity posted on the member section of the Plan's website. The website topics include "How to Read a Food Label", "Food Pyramid", "Wheel of Vitamins", "We CAN – Ways to Enhance Children's Activity and Nutrition", and "Exercise Those Calories Away".	1 st quarter 2010	Ongoing
Mailed information to PCPs regarding the " <i>Healthy for Life!</i> " program, a comprehensive pediatric obesity evaluation and treatment program.	1 st quarter 2010	One time
Published three Member Newsletter articles regarding nutrition, exercise, and BMI.	2 nd quarter 2010	Annually
Included a script regarding the importance of physical activity/exercise, weight maintenance, and a healthy diet on the Plan's on hold messaging system.	2 nd quarter 2010	Annually
Provider education regarding the measurement of BMI and BMI percentile, counseling and education for nutrition and physical activity.	4 th quarter 2010	Annually
Member Newsletter article regarding the measurement of BMI and BMI percentile, counseling and education for nutrition and physical activity. Member Newsletter article published in the 2010 Issue 2 "The Simple Weight-Loss Secret: Calories Count."	2 nd quarter 2010	Annually
Report re-measurement results for Wt. Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents to the Child and Adolescent Committee and Quality Member Access Committee and request recommendations regarding provider and member education.	Child & Adolescent Committee Meeting, November 11, 2010 QMAC meeting, December 13, 2010	Quarterly as needed
Published article in Member Newsletter 2010 Edition 1. The article encourages members to exercise 30 minutes every day and to eat more fruits, vegetables, whole grains and lean meats while avoiding fatty foods, sodium and fast foods.	1 st Quarter 2010	Annually
Participated in Louisville Water Company's " <i>Tap into Fitness</i> " program. The program is	2 nd Quarter 2010	Annually

Intervention	Start Date	End Date
collaboration between Louisville Water Company and various community agencies for the purpose of providing programs in ten elementary schools that incorporate "real-world learning to improve students' individual nutrition and fitness."		
Participated in the Mayor's Healthy Hometown School Committee, which provides education and support to teachers and students regarding the importance of physical fitness and proper nutrition.	3 rd Quarter 2010	Annually
Staff attended seminar "2010 Howard L Bost Memorial Health Policy Forum--Policy Today for a Healthier Tomorrow: Curbing Obesity in Kentucky" which focused on developing ways to improve the health of Kentuckians through nutrition and physical activity.	3 rd Quarter 2010	Annually

3. Barrier Analyses

[If barrier analyses were conducted as part of the project design, describe the barriers and how they were addressed (e.g., difficulty locating Medicaid members, lack of resources / insufficient nurses for chart abstraction, reasons for low response rates to surveys, insufficient number of providers in rural areas). Indicate if an intervention was planned but was not implemented, or if the intervention changed in any way, and why.]

No key barriers were identified prior to project design.

4. PDSA (Plan-Do-Study-Act) Project Phases

[If a PDSA method was performed, provide information regarding the interim phases of the project; i.e., (1) the objective and plan to test for change, (2) the action carried out (including documenting problems or unexpected observations), (3) the results or knowledge gained, and (4) the actions that were taken as a result of the cycle (e.g., modifications made based on what was learned). Discuss any changes or tailoring of interventions and rationale for doing so. Process measures that led to modifications in your interventions should be presented here.]

Results

The results section should quantify project findings related to each study question and project indicators. **Do not** interpret the results in this section.

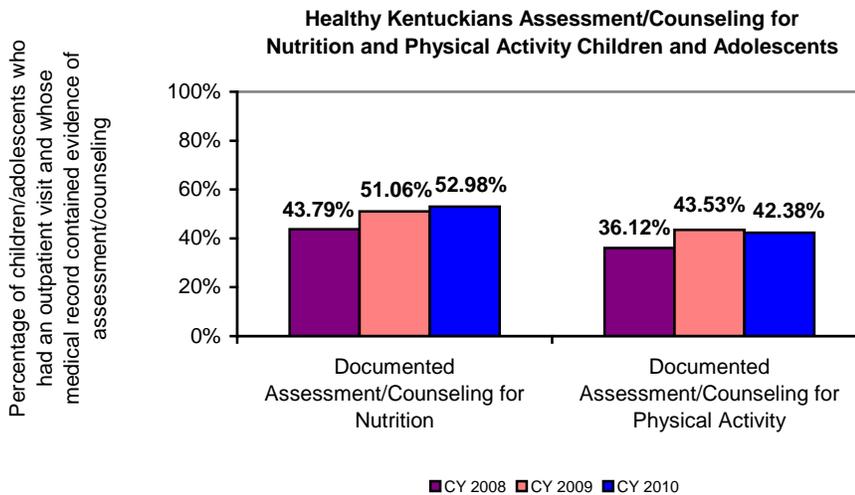
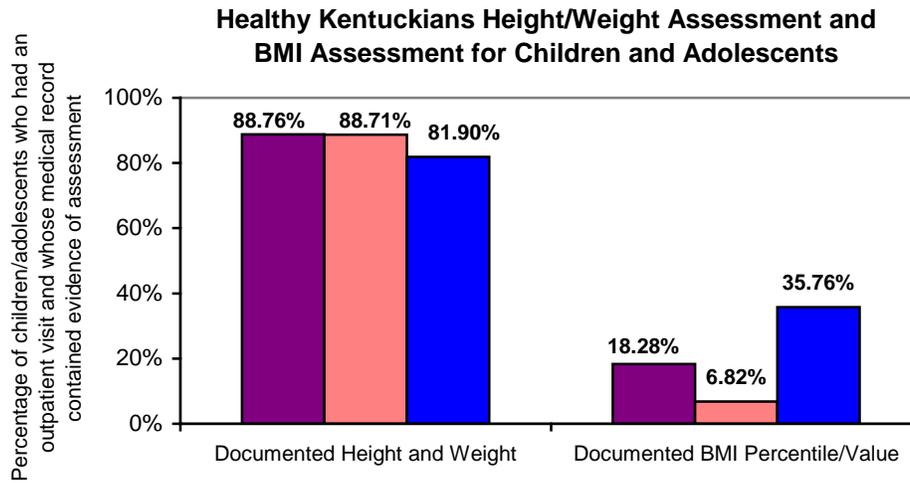
[Explain how the data were analyzed to address the objectives. Important results to include:

- Entire population size and number of cases in the project sample
- Number of cases excluded due to failure to meet criteria
- Rates for project indicators—numerator and denominator for baseline and remeasurement
- Performance targets
- Statistical tests and results (if applicable)
- Run / Control Charts

Tables/graphs/bar charts are an effective means of displaying data in a concise way to the reader. Appendix A contains examples of tables. They should be accompanied by text that points out the most important results, simplifies the results, and highlights significant trends or relationships. Tables should be able to stand-alone for interpretation.

If a survey was conducted, list the final sample size, the number of responses received, and the response rate. Reasons for low response rates or failure to obtain eligible records should be described.]

Indicator	Baseline Results CY 2008			1 st Re- measurement CY 2009--reported in 2010			Increase/ Decrease Percentage Points	Final Re- measurement CY 2010--reported in 2011			Increase/ Decrease Percentage Points
	n	d	Rate	n	d	Rate		n	d	Rate	
Documented height and weight	388	443	87.58%	377	425	88.71%	↑1.13%	371	453	81.90%	↓ 6.81%
Documented BMI percentile	81	443	18.28%	29	425	6.82%	↓ 11.46	162	453	35.76%	↑ 28.94%
Nutrition counseling	194	443	43.79%	217	425	51.06%	↑ 7.27	240	453	52.98%	↑ 1.92%
Physical activity counseling	160	443	36.12%	185	425	43.53%	↑ 7.41	192	453	42.38%	↓ 1.15%



Discussion

The discussion section is for explanation and interpretation of the results.

1. Discussion of Results

[Explain and interpret the results by reviewing the degree to which objectives and goals were achieved, the meaningfulness of improvements, and what factors were associated with success or failure. Describe whether results were expected or unexpected, and provide other possible explanations for the results. A brief conclusion should be provided based on the reported results. The basis for all conclusions should be explained.]

Between baseline and the first re-measurement year, two indicators demonstrated increases, while two indicators demonstrated decreases.

Documentation of BMI percentile increased 28.94 percentage points from CY 2009 results. The documentation of height and weight demonstrated a decrease of 6.81 percentage points from CY 2009 results.

Unlike clinical components of well-child visits, such as EPSDT examination indicators and routine screenings, member education rates have been much lower.

The outcome of the results is were not unexpected to the Plan and realizes that unlike clinical components of well-child visits, such as EPSDT examination indicators and routine screenings, member education rates remain lower.

2. Limitations

[Address some of the limitations of your project design. Identify factors that may jeopardize the internal or external validity of the findings.]

- Limited provider use of the BMI percentile growth chart.
- Electronic medical records that document actual BMI versus BMI percentile for members age 3 – 15.
- Variations of EMR components between provider offices.

3. Member Participation

[Detail the extent of member participation in the project. In what aspects of the project did members participate (topic selection, measurement, focus group, interventions etc.)? What methods were utilized to solicit or encourage membership participation?]

Members indirectly participate in the project by seeing their PCP for their EPSDT visit. By initiating and keeping the appointment the member is able to obtain necessary screening.

4. Financial Impact

[Describe any long or short-term financial impacts of the project including cost/benefit analysis as appropriate. Address the bottom line, project beneficiaries and the extent of cost savings]

Financial impact is not an initial expectation of the project. The savings are long term as achieved by overall improved health status and reduced incidence of chronic and long term illness.

Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

1. Lessons Learned

[Describe what was learned from the project, what remains to be learned, and whether findings can be extrapolated to other members or systems.]

- Provider education is needed regarding documentation and assessment of BMI values and counseling components.
- All EMR systems are different and identifying all features within the system may take time and use to ensure all documentation is accounted for.

2. Dissemination of Findings

[Address how the results and conclusions have been/will be made available to members, providers or other interested individuals. Identify future goals for disseminating the key findings and lessons learned of the project.]

- Findings will be reviewed with Quality Medical Management Committee and Quality Member Access Committee.

3. System-level Changes Made and/or Planned

[Describe how findings will be used, actions that will be taken to sustain improvement, and plans to spread successful interventions to other applicable processes in your organization.]

Investigate feasibility of implementing provider utilization of CPT II codes to capture information.

Investigate feasibility of pediatric provider collaborations to increase member awareness of the importance of good nutrition and physical activity.

Investigate feasibility of community agency collaboration to offer nutrition classes and facilities for safe physical activity for children and their families.

Appendix A: Examples of Tables

Tables can include 95% confidence intervals corresponding to each of the proportions, goals and benchmarks, or other descriptive statistics such as average, median, range, and outliers, if appropriate.

You do not have to choose one of these tables: they are for reference purposes only. Create a table that is appropriate for your unique data, but follow the general guidelines:

- Table titles should always be understandable and stand-alone.
- Table column headings should include the number of members in each group.
- Each column should have a heading.
- Report statistical significance using asterisks or significance level in a column.
- Totals for rows and columns can be useful.

Sample Table 1: Rate of [*Project Indicator*], Year 1-3

Year	Numerator	Denominator	%	95% CI
Year 1				
Year 2				
Year 3				

Sample Table 2: Baseline and Remeasurement Rates for Each Project Indicator

Indicator	Baseline		Remeasurement		P value
	n	%	n	%	
Indicator 1					
Indicator 2					
Indicator 3					

Sample Table 3: Record Retrieval Information by Provider

	Records from Provider 1	Records from Provider 2	Total
Records Requested			
Records Received			
Records Not Received (but included in analysis)			
Records Excluded			
Total Usable Cases			

Sample Table 4: Survey Responses by Region

	Surveys from Region 1	Surveys from Region 2	Total
Sample Size			
Responses Received			
Response Rate			