AIM STATEMENT

The CHCANYs Childhood Obesity Initiative aims to improve the overall screening rate and help reduce the prevalence of childhood obesity in children between the ages of 2 to 18 years.

Using the Recommendations from the Expert Committee on Childhood Obesity, the goal is to enable primary care providers in New York City based Federally Qualified Health Centers (FQHCs) to better prevent, identify, and treat children who are overweight or obese.

CHRONIC CARE MODEL

A population-based model that summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. www.chcanych.org

MODEL FOR IMPROVEMENT (PDSA)

Trial and learning model to discover an effective and efficient way to change a process. www.chcanych.org

BREAKTHROUGH SERIES LEARNING MODEL

An improvement method that relies on spread and adoption of existing knowledge to multiple settings to accomplish a common aim. www.chcanych.org

MEASURES

OUTCOME MEASURES

50% or more of children 2 to 18 years old identified as overweight or obese will experience movement towards healthy BMI for age and gender.

75% or more of patients/families will report increases in healthy behavior.

PROCESS MEASURES

DELIVERY SYSTEM DESIGN

98% of families with children 2 to 18 years old identified as overweight or obese will receive consistent messages about healthy food choices, decrease TV screen time, and the value of physical activity at well-child visits.

50% of children identified as overweight or obese will have a nutritional consult.

DECISION SUPPORT

98% of children 2 to 18 years old will have their weight classified as: Underweight, Healthy Weight, Overweight, or Obese.

85% of children 2 to 18 years old will have a BMI recorded in their chart.

95% of patients/families who are overweight or obese will have a follow-up contact with the patient within 6 months of initial finding for being overweight or obese.

FAMILY/SELF-MANAGEMENT SUPPORT

50% of patients/families with a positive readiness to change assessment will have a documented care plan and self-management goals.

OUTCOMES

INITIATIVE PROGRESS SPIRAL

OUTCOMES

LEARNING OBJECTIVES

CHALLENGES

Resources and tools in surrounding community environments

Cultural behaviors regarding food and health

Community health center infrastructure

Technical capabilities surrounding data collection and/or electronic medical records

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