Tools to Guide the Implementation of a Childhood Obesity Initiative

Once your organization has determined that it is ready to implement a childhood obesity prevention and treatment initiative, your health plan will need to consider a number of factors to ensure that your program best meets the needs of your priority groups. The following implementation tools will assist your organization in this process:

Featured Tools:

1. **CHildhood Obesity Prevention & Treatment (CHOPT)-Action Statement (CHOPT-AS)**

   The CHOPT-AS template is a four-step process to guide your planning and implementation efforts. Most importantly, this template includes an Operational Worksheet to organize and collect your preliminary thoughts for your initiative.

2. **A Step-by-Step Worksheet of the Four-Step Process**

   The step-by-step worksheet accompanies the CHOPT-AS template, providing guidance on completing the four-step process. Each step of the process is described at length, posing thought-provoking questions and providing tips to complete the CHOPT-AS tool.

Supplemental Tools to Facilitate the Completion of the CHOPT-AS:

3. **A Goal-Setting Worksheet**

   The goal-setting worksheet may prove helpful if your team or organization is facing difficulty identifying the appropriate goals for your initiative in Step 2. This tool follows the SMART (Specific, Measurable, Attainable, Relevant, Time-Bound) method of identifying goals and will help to shape the aims you identify and work toward in Steps 2 and 3 of the CHOPT-AS.

4. **Aims and Drivers for Improvement Template**

   The Aims and Drivers for Improvement template offers a visual aid of a driver diagram to assist your organization with Steps 2 and 3 of the CHOPT-AS. Although your driver diagrams may be more robust or complex than those pictured in the template, it will nevertheless serve as a basic starting point to gather your thoughts around the primary and secondary drivers to effect changes in your pediatric populations affected by overweight and obesity.

5. **Communications Plan Worksheet**

   The communications plan worksheet provides your organization with questions to consider as you develop strategies to communicate with your key stakeholders and community resources upon completing Steps 1 through 4 of the CHOPT-AS. However, your organization might have a different communication plan to utilize for this purpose.

Childhood Obesity Prevention & Treatment Action Statement (CHOPT-AS)

The CHOPT-AS (CHildhood Obesity Prevention & Treatment Action Statement) tool was adapted in consultation with the Centers for Medicare & Medicaid Services (CMS) from their original Disparities Action Statement (DAS) template. CHOPT-AS offers a framework to help you:

- Understand the childhood obesity-related health disparities and social determinants of health influencing families enrolled in your Medicaid managed care organization;
- Design and test solutions to address childhood obesity in your community; and,
- Take action through continuous quality improvement for health equity.

This worksheet will guide your efforts in identifying childhood obesity-related disparities in and among the pediatric populations you serve, set goals, develop a plan, and improve the health of your community. A CHOPT-AS offers your organization guidance in building health equity into the culture of your program to enhance the care that you offer your pediatric members and their families while also improving community health and lowering costs through quality improvement.

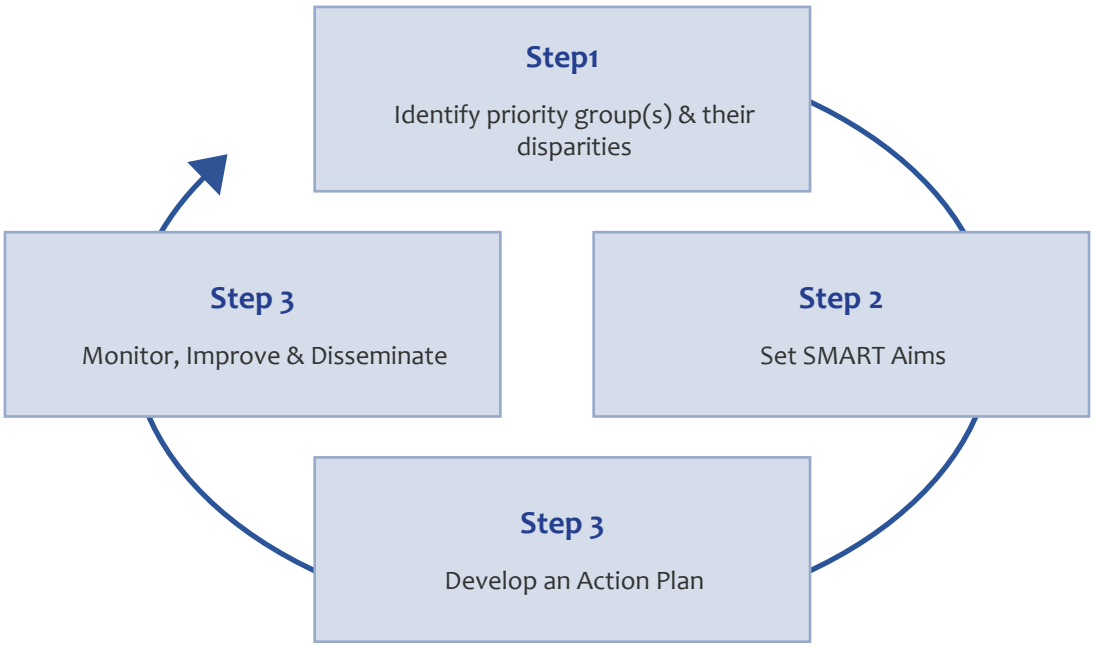
Clinician/Case Manager Champion (CHOPT-AS Lead):

Department or Organization:

Reason(s) for the Program:

Projected Timeframe for 4-Step CHOPT-AS Planning Process:

Area(s) of Improvement You Are Considering:



Key Definitions

Health disparities *– differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics, including race, ethnicity, disability, sexual orientation or gender identification, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.*[105]

Social determinants of health *– The complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services comprise the structural and societal factors that are responsible for most health inequities. Social determinants of health are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices.*[106] *Examples of social determinants of health include income, educational level, availability of stable and affordable housing, access to affordable and nutritious food, and access to regular primary care.*

STEP 1: IDENTIFY PRIORITY GROUP(S) AND THEIR DISPARITIES

Identify the priority group(s) and health disparities within the population you serve

- **Assess** available data and identify **priority group(s)**, within the total pediatric population you serve that have notable **health disparities** and are at risk for overweight and obesity, as identified through referrals, data mining, etc.

  NOTE: *Use multiple data sources to creatively compare and contrast populations and health disparities within the broader pediatric population in your health plan. Please list data sources used.*

  Refer to the Data Sources to Understand Your Community table for possible data sources.

  Priority Group(s) may include:

  - Racial or ethnic minorities
  - Sexual and gender minorities (LGBT)
  - Individuals with a disability
  - Those living in rural or frontier communities

  Health Disparities may include:

  - Health status
  - Disease prevalence
  - Death rates, such as mortality and morbidity rates
  - Emergency department visits for potentially avoidable utilization or readmission
  - Utilization of preventive services
  - Access to care
  - Quality/Safety
  - Chronic disease management
  - Poverty/economic factors
  - Other social factors

- After careful consideration of the highest-priority groups and greatest needs, select the **priority group(s)** you will target and the **health disparities** you plan to address within your CHOPT program.

STEP 2: SET SMART AIMS

[START POPULATING YOUR OPERATIONAL TABLE]

Identify your aim

Your aim is what you want to improve for the population you identified. As it relates to childhood obesity, your aims may focus on improving body-mass-index (BMI) scores, encouraging healthy lifestyle changes, or providing access to treat or prevent obesity.

Make sure your **aim is SMART** [**S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**ime-based].

Use the **Goal-Setting Worksheet** for setting SMART aims.

Stakeholder engagement is key to the success of your initiative. You may engage with stakeholders and community resources in many ways throughout your initiative, depending on your program's aims and design. It is important to consider how and when you will strategically engage key stakeholders and community resources. There is guidance in the **Stakeholder & Community Engagement Plan** and in the **CHOPTAS Step-by-Step Worksheet.**

STEP 3: DEVELOP AN ACTION PLAN

[CONTINUE WORKING ON YOUR OPERATIONAL TABLE, BEGIN YOUR STAKEHOLDER & COMMUNITY ENGAGEMENT PLAN]

Identify key system elements (Primary Drivers) necessary to achieve your aim

Key (primary) drivers are the things that have to occur for you to achieve your aim. You can have multiple key drivers.

Involve key stakeholders and community members from the priority group(s) you are targeting when you are:

- Brainstorming about your primary driver; and
- Gaining buy-in and valuable insights.

Note how, when, and why you are engaging each partner in your **Stakeholder & Community Engagement Plan**. These stakeholders and resources may also be helpful in decreasing the role or impact of health disparities.

Identify activities or interventions (Secondary Drivers) to make progress

Secondary drivers are the specific activities or interventions (the "how") needed to impact the primary drivers.

Each secondary driver contributes to at least one primary driver. You can have multiple secondary drivers for each key driver.

> It may be helpful to draw a driver diagram or flow chart. Use the **Aims and Drivers for Improvement template** to assist you with your driver diagrams.

Remember to involve community stakeholders as needed – continue making notes to your **Stakeholder & Community Engagement Plan.**

Identify key individuals and organizations

Note the key staff, partners, stakeholders, or members of the community leading and contributing to the secondary drivers.

- Include these in your **Stakeholder & Community Engagement Plan.**

Write out your Action Plan

Compile information gathered in Steps 1, 2, and 3 into an action plan using the **Operational Table** on the next page.

STEP 4: MONITOR, IMPROVE, DISSEMINATE [COMPLETE OPERATIONAL TABLE, USE THESE TOOLS TO EVALUATE, IMPROVE & SHARE YOUR LEARNINGS]
Define metrics to monitor progress and assess impact toward your aim
Define measures and metrics you will use to track progress toward your aim in the **Operational Table.** Define how you will measure success. Define how often the data will be tracked.
Define measurable outcomes
Define outcomes in your **Operational Table.** These outcomes should be aligned with or linked to your aim. How many individuals in your priority group will this impact? Remember that outcomes need a timeline.
Improve: Use quality improvement methods to keep a pulse on your progress
Use the Plan Do Study Act (PDSA) methodology to fluidly adjust your course of action. Refer to the **Plan, Do, Study, Act Diagram** for guidance. Engage stakeholders in your community to address challenges/barriers you've identified. Note how in your **Stakeholder & Community Engagement Plan.**

Operational Table

SMART Aim What you are trying to improve for the priority group you identified?	**Primary Drivers** What is needed to achieve your aim? *You may have more than three drivers for each aim, just add lines to the table.*	**Secondary Drivers** What interventions will help you achieve the primary drivers?	**Key Individuals and Organizations** Key staff, partners, stakeholders, or members of the community leading the secondary drivers.	**Metrics** Which data will be used to track progress toward your aim and how often?	**Measurable Outcomes with Timeline** Should align with aims.
AIM #1	Primary Driver #1				
	Primary Driver #2				
	Primary Driver #3				
AIM #2	Primary Driver #1				
	Primary Driver #2				
	Primary Driver #3				
AIM #3	Primary Driver #1				
	Primary Driver #2				
	Primary Driver #3				

Plan, Do, Study, Act (PDSA) DIAGRAM
Once implementation has begun, if changes need to be made to the design of the program, explain your changes and secure buy-in from stakeholders and community partners.

Evidence to explain and support your changes may include:

- Interventions attempted
- Results/findings
- Lessons learned or emerging issues
- New data identified
- Stakeholders involved
- New actions warranted

Resource:
More on the PSDA cycle: https://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle

CHOPT-AS STEP-BY-STEP WORKSHEET

This worksheet will help guide you through the four steps of your CHOPT-AS. It was adapted in consultation with the Centers for Medicare & Medicaid Services from the Disparities Actions Statement Step-by-Step Worksheet.

Step 1: Identify priority groups(s) and their disparities

These questions are intended to guide you in identifying a population to focus on.

Which population(s) should you focus on?

- List the priority groups(s) impacted by your program.
    - For example, this might include racial or ethnic minorities or those living in rural or frontier communities.
- Select one priority group to focus your efforts on first.
    - You may find that several populations are impacted by health disparities and social determinants of health that contribute to overweight and obesity. Use the questions in Step 1 to narrow your focus to a specific priority group among your pediatric population. You may find a priority group or that disparities surface that you were not previously aware of – you can always amend your action plan as you learn and improve.

How does this population compare to your total pediatric population?

- Assess available data and see how the health of your priority group compares with your total pediatric population, and if available, the broader pediatric population in the community.
    - For example: data reported to state and federal agencies, available local community health data, claims data, census, and other federal data sets. Use stratified data to identify priority groups.
    - **Data Sources to Understand Your Community table** has information on potential data sources.
- Compare a priority group's overall health status and outcomes and access to health care with your total pediatric population and the community's pediatric population, if possible. You may also want to consider comparing the social determinants of health impacting your priority group with their impact on the children in the community.
- Make notes of the health disparities your priority group faces, including data sources where available.

How does your focus population compare with your total pediatric population in:

- Disease prevalence
- Mortality and morbidity rates
- Emergency department utilization
- Readmissions
- Preventive service utilization
- Chronic disease management
- Prescription drug utilization and adherence

Which disparities will you focus on?

- Select a priority group and set of disparities to focus on.
- Talk with partners serving your priority group and individuals in the community. Ask what they think is causing or contributing to the disparities or if there are obstacles to addressing them. Although your organization might not be able to address all disparities, you will gain useful information to guide the development of your childhood obesity prevention and treatment initiative. This information will also inform your **Stakeholder & Community Engagement Plan.**

Step 2: Set SMART Aims

As you consider your approach to addressing childhood obesity in your health plan, you will need to set an aim(s) in coordination with your community partners or key stakeholders. It is important that your aim(s) are specific, measurable, attainable, relevant, and time-based (SMART). Begin populating your **Operational Table** in the **CHildhood Obesity Prevention & Treatment Action Statement** as you think through this step.

Write down your SMART aim(s). Your aims will guide your action plan and can help you bring your organization and community together around a shared goal.

- Write down your overall aim(s) related to the priority group and driver(s) you are focusing on to reduce childhood overweight and obesity. Your aims should be clear, concise statements of the target outcomes for each priority group. If you are unsure of your drivers, do not dwell on this section of the action plan. You can come back and refine your aims when you fill in your **Operational Table** or driver diagram.
- Talk with some of the key groups you identified in Step 1 to gather reactions and feedback on your aims. You may also want to develop aims together as a group and work toward them together. The more your

aims are shared, the bigger will be your team effort toward improvement. Note these in your **Stakeholder & Community Engagement Plan.**

- Once your aims have been identified, you will need to consider what change(s) you will make, what effect you want each change to have, and how long you think it will take to achieve your aims. Be as specific as possible. And, if you can, tie your aims to what your community needs and wants. Set a time frame for each target outcome so you can track and measure progress.

The following statement is a formula for SMART objectives, which are specific, measurable, attainable, relevant, and time-bound:

I will do _____, in order to _____, by _____.

> **For example:**
>
> Our health plan will reduce BMI scores among children ages 2-5 years identified as overweight and obese within 6 months.

For guidance on how to set SMART aims, see the **Goal Setting Worksheet.**

Can you measure it? What are the specific indicators or data points you will monitor, and how often?

- List the indicator or data points that you will monitor and the frequency. You can use these as benchmarks to measure and share your progress as you go.

Check for relevance: How are you involving your community?

- List three ways you can include stakeholders as you work toward your aim. For example, you could use pilot testing, focus groups, and dissemination of resources. The more specific you are, the easier your next step (Action Plan) will be.

Check for duplication: Are there other stakeholders or groups who are already addressing childhood obesity in the community? Or perhaps, related health disparities or social determinants of health? If so, how do your aims overlap?

- Look at your list from the beginning of this step and note which partners and stakeholders you know are already addressing this disparity, or have overlapping aims around this disparity.
- For each partner, write down an idea for how you can work together to reach or support your shared aims. Make notes in your **Stakeholder & Community Engagement Plan.**

Step 3: Develop an Action Plan

The following questions will help you to complete the **Operational Table** and **Stakeholder & Community Engagement Plan**.

Use the Operational Table or create a separate driver diagram to identify the root causes or drivers of your priority group's obesity problem, including relevant health disparities and social determinants of health.

- Make a list of factors contributing to the obesity issues of the priority group, noting health disparities and social determinants of health that might make it difficult to address the obesity issue. Use this list to create a driver diagram or a flow chart. For guidance on creating driver diagrams, use the **Aim and Drivers for Improvement** template.
    - Think about all of the factors that could create a gap in health care outcomes, quality, or access for your priority group, or that could make a disparity worse.
    - Consider what you learned from key stakeholders and resources in the community about what is causing local disparities or affecting health.
    - Be ready to revise your driver diagram as you go. You may learn of a driver or circumstances that you did not realize existed.

Choose one or two root causes – or drivers – you want to start with.

- The outcome of your aim should be attainable. Focus on areas you can change, and pick one or two drivers your organization can directly affect.
- As you make plans or strategies to address certain drivers, consider including your key stakeholders or community resources. Later in this step you will think about what aims you share with your partners and how to work together.

List key community groups and local partners who serve and/or support your target population.

- Focus on community resources or stakeholders who work in the geographic areas that your pediatric members and their families reside in.
    - For example, if your focus is addressing disproportionate rates of childhood obesity among your African American or Hispanic members, consider local health care clinicians, community recreation centers, nutrition assistance, and social and supportive services for African American and Hispanic residents in the community.

How many individuals in the priority group will you reach through your childhood obesity prevention and treatment initiative?

- Provide an estimate. Your estimate should be based on data available to your health plan. Data sources you might consider include encounter data, claims data, and clinician referrals.

What outcomes do you expect to have, and by when?

- Consider the change(s) you expect to see in your priority group once your initiative is completed.
- Identify time frames by which you expect change(s) to occur, and the incremental changes you expect to see.
    - There are more questions about benchmarks and milestones to mark your progress in Step 4. You can make notes now to help you later.

What barriers do you expect to encounter?

- List potential obstacles you may encounter throughout your initiative, especially those identified by your community resources and stakeholders.
    - You can map these on your driver diagram to help you visualize how they might affect your initiative and its priority group.

How can those barriers be addressed?

- You will need to develop strategies to address the barriers you have identified.
- Talk with your community resources and stakeholders to see if they have encountered and overcome similar obstacles and learn what might work for your priority group.

How will you integrate your community resources in your engagement with the priority group?

- Discuss how you will work with stakeholders and local groups, including how or if you plan to partner with others to reach your aims. Consider formal and informal relationships, and opportunities to convene and learn from each other.

Write down a rough timeline for when you plan to engage with your local partners.

Step 4: Monitor, Improve, Disseminate

Complete your **Operational Table** by writing out how you will monitor and improve upon your aims. The questions and ideas below will help you identify metrics and measurable outcomes and your timeline for the **Data Management Plan**.

What do you hope to achieve for the target population(s)?

- Look at your SMART aim(s) on your **Operational Table**.

How will you assess changes in your target group(s)?

- Take a look at your notes from Step 2 that describe the changes you are expecting to see and the measures you have identified. Now, write out the answers to these questions:
    - What specific outcome measures will you use to show change?
    - How will you stratify your data to compare populations and monitor emerging disparities?
    - How often will you check them?

What benchmarks will you use, and how will you track them?

- For each outcome, list the benchmarks or milestones you'll use, and how often you'll check them.
    - How will you collect and track this information?
    - How will you share your progress with your team and community?

How will you use the available data to manage your work and improve health equity for your target population?

- Look at the measures and benchmarks you have identified; what are the quantitative and qualitative data sources you will need to measure change?
- Note where you will get the data you have identified, and which staff members will be responsible for ensuring that your data are available, reliable, and as current as possible.

How will you measure success?

- Using your answers to the questions above, fill in the Metrics and Measurable Outcomes and Timelines columns on your **Operational Table.**

How frequently will you revisit your target outcomes to assess progress and revise your Action Plan?

- How often will you revisit your Action Plan from Step 3 and update it based on what you have observed?
- How will you involve your community and target population in updating your Action Plan? Note this in your **Stakeholder & Community Engagement Plan.**

How will you share, spread, and scale what you learn?

- Your initiative to prevent and treat childhood obesity in the Medicaid pediatric population may yield results and lessons that can help other health plans, clinicians, and community groups who are struggling with similar challenges.
    - How do you plan to share your results and lessons with others, including peers and colleagues, associations and networks of health care clinicians, policymakers, and government officials at the federal, state, and local levels?
- Sharing your lessons and progress with your community can also establish credibility with your stakeholders and bring new partners into your work, which in turn, builds momentum.

Congratulations!

You have completed a Childhood Obesity Prevention & Treatment Action Statement.

» As you implement your CHOPT-AS, you might see outcomes you did not expect. Revisit and revise your approach as you learn.

» Keep testing and improving to reduce childhood obesity and achieve health equity!

GOAL-SETTING WORKSHEET

This document was adapted in consultation with the Centers for Medicare & Medicaid Services from the QAPI Goal Setting Worksheet.

Directions: Goal setting is important when measuring quality and performance improvement. This worksheet is intended to help health plan staff identify appropriate goals for measure related to performance improvement projects. This worksheet does not include the necessary steps to be taken to reach your organization's goals. Goals should be clear and describe what your health plan or team seeks to accomplish. Use this worksheet to identify goals that follow the SMART formula outlined below.

Describe the childhood obesity problem to be solved. If possible, identify the relevant health disparities or social determinants of health linked to childhood obesity.

[Example: We have found that children living in Area 1 are experiencing high rates of overweight and obesity. Clinicians have notified case management staff of ongoing chronic disease management for comorbid conditions. Area I is considered a food desert and has a very transient population.]

Use the SMART formula to develop a goal:

SPECIFIC

Describe the goal in terms of 3 'W' questions:

What does your organization want to accomplish? [Example: Reduce obesity rates in pediatric members.]

Who will be involved? Who will be affected? [Example: Children ages 5-12 years.]

Where will your program or initiative take place? [Example: Areas with the highest rates of obesity among pediatric members.]

MEASURABLE

Describe how you will know if the goal is reached:

What measure(s) will your organization use? [Example: Decrease body-mass-index (BMI) scores, decrease utilization of prescription drugs for obesity-related conditions.]
What are the baseline data for the measure(s)? [Example: Used obesity-related ICD-10 codes in claims data to find that 15 percent of pediatric members have BMIs greater than those in the 95th percentile.]
What is the target you would like your measure(s) to meet? [Example: The national average for children with BMI scores greater than the 95th percentile is 8 percent.]

ATTAINABLE

Defend the rationale for setting the goal measure(s) above:

Did you identify the measure(s) based on a particular average score or benchmark? [Example: The target is based on the national average for pediatric obesity rates.]
Are the goal measures set too low?
Are the goal measures reasonable?

RELEVANT

Briefly describe how the goal will address the childhood obesity problem stated above.

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.

[*Example:* Improve body-mass-index (BMI) scores and reduce utilization of prescription drugs to treat obesity-related condition within 12 weeks.]

Tip: It is prudent to post the written goal in a visible space and regularly communicate the goal during meetings in order to stay focused and remind health plan staff that everyone is working toward the same goal.

KEY DATA SOURCES TO COMPARE YOUR PRIORITY GROUP TO THE COMMUNITY

The "Key Data Sources to Compare Your Priority Group to the Community" resource was adapted in consultation with the Centers for Medicare & Medicaid Services (CMS) from their original Data Sources to Understand You.

*Use this table of data sources to help you with Step 1 of your **CHildhood Obesity Prevention & Treatment Action Statement (CHOPT-AS)**. Although these resources do not contain information on children in each community, they do provide a representation of the households in which your pediatric population will live and be impacted by.*

Data	Description	Level	HEALTH & HEALTH CARE					DEMOGRAPHIC					
			Q/O	C	A	U	P	SES/ SDH	R/E	L	D	SO/ GI	R/U
Community Health Status Indicators *Centers for Disease Control*	Provides indicators of health outcomes, access and quality, health behaviors, social factors, and the physical environment.	County	X		X	X	X	X	X	X	X		X
Healthcare Cost and Utilization Project *Agency for Healthcare Research and Quality*	Contains diagnoses and procedures, discharge status, patient demographics, and charges for all patients regardless of payer.	County, State, National	X	X		X		X	X				X
Area Health Resource Files *Health Resources and Services Administration*	Compares population characteristics, health resources, and demographics.	County, State, National		X	X	X		X	X	X	X		X
Health Indicators Website *National Center for Health Statistics*	Describes community's health status and determinants of health.	Varies (Hospital, County, State, National, Region)	X	X	X	X	X	X	X		X	X	
County Health Rankings *Robert Wood Johnson Foundation, University of Wisconsin*	Ranks the health of nearly every county in the nation, with social determinants.	County	X	X	X	X	X	X	X				X
Dartmouth Atlas of Health Care *Dartmouth Institute*	Provides medical resource distribution, hospital care intensity, variations in care/ procedures, end-of-life care, and costs.	Hospital, County, State, Region	X	X	X	X		X	X			X	X
Community Health Profiles *Community Commons (CHNA)*	Provides data layer maps with demographic elements, SES, clinical care, health behaviors, and outcomes.	County, State	X		X	X		X	X	X	X		X

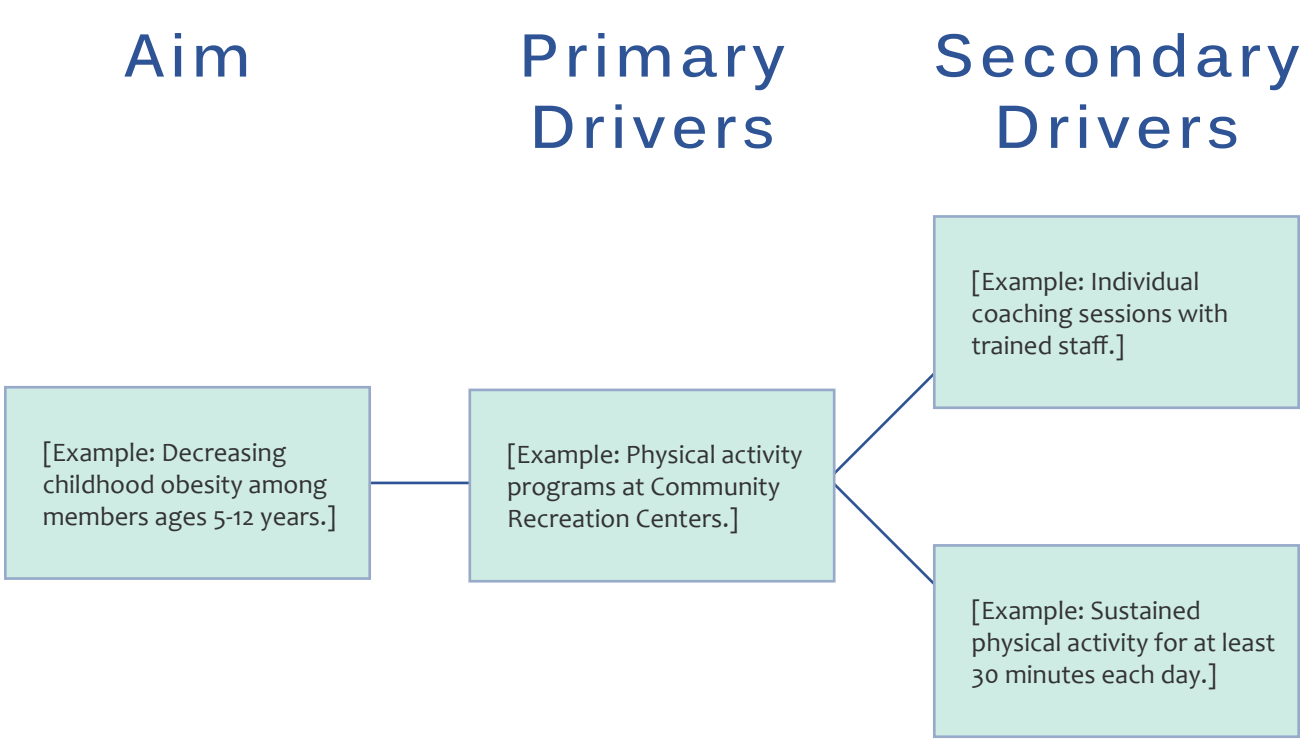
Additional local data sources:

State or Local Health Department Data, Local Community Health Needs Assessment (CHNA), Stakeholder Interviews, Administrative Claims, State Medicaid Data, American Communities Survey (ACS), Behavioral Risk Factor Surveillance System (BRFSS)

Key					
Q/Of	Quality & Outcomes	**P**	Prevalence of conditions / disease	**D**	Disability Status
C	Cost	**SES/SDH**	Socio-economic Status / Social Determinants of Health	**SO/GI**	Sexual Orientation & Gender Identity
A	Access	**R/E**	Race / Ethnicity	**R/U**	Rural / Urban
U	Utilization of care	**L**	Language		

AIMS AND DRIVERS FOR IMPROVEMENT

This tool was adapted in consultation with the Centers for Medicare & Medicaid Services from the Aims and Drivers for Improvement tool.



COMMUNICATION PLAN WORKSHEET

This document was adapted in consultation with the Centers for Medicare & Medicaid Services from the QAPI Communications Plan Worksheet.

Directions: Use this worksheet to plan your communications strategy with key stakeholders and community resources for any component of your childhood obesity prevention and treatment initiative. A communications plan should be revisited every three to six months to ensure it is still appropriate to meet the objectives of the initiative. Your CHOPT-AS lead may find it helpful to plan communications using this worksheet.

Date of Current Review: _____ **Next Review Schedules for:** _____

Step 1: State the purpose for the communication. *[Example: For a performance improvement project to reduce obesity rates among the health plan's pre-diabetic and diabetic pediatric population living in Area 1. The health plan needs to leverage a community food bank and nutrition assistance resources to improve access to healthy food options.]*

Step 2: Define Audiences. An effective communications plan targets messages and customizes tactics to specific audiences. To direct resources appropriately, you may choose to rank-order audiences as primary or secondary.

Primary Audiences: *[Example: Local health departments, WIC, community food bank.]*
Secondary Audiences: *[Example: Farmers markets, community groups assisting with healthy food for families.]*

Step 3. Define approach. Using the table below, define key aspects of the communication plan based on audience and timeframe.

	[Name of Audience]	Time Frame
Purpose Why is it important to communicate to this audience? What is the goal of your communications? Do you have a specific need or request (i.e., do you need approval, buy-in, involvement, support)?		
Values What does this audience most value when it comes to this topic? How will the content support these values? How will you express this in your messaging?		
Concerns What is this audience's greatest concern when it comes to this topic? How can the content alleviate these concerns or overcome them as barriers? How will you express this in your messaging?		
Message What is the key message you want to deliver to this audience at this time? Remember to tie in the audience's values and concerns. Also address the following: What successes are there at this point? What challenges need to be overcome? What is happening next?		
Messenger Who will deliver the message to this audience? You may assign the responsibility for delivering the message through each channel to different individuals.		
Evaluation How will you know you were successful? What output will you track (e.g., number of e-newsletters delivered and opened)? How will you monitor the effectiveness of the messages and channels used (e.g., surveys, key informant interviews, observations of changed behavior)?		

Sample Action Plan

Childhood Obesity Initiative Action Plan
Control or Improve Childhood Obesity among Health Plan participants
Opportunities: Utilize Data Analytics to Stratify members by reported BMI percentage • Sort members by BMI-highest to lowest • Include co-morbid conditions (asthma, hyperlipidemia, hypertension, high ED utilization) as part of the stratification

Action Plan

Target Population	2018 Interventions	Key Stakeholders*	Outcomes Monitored
Target members with BMI at or above the 95th percentile	Develop educational materials for use by health plan program staff focusing on nutrition and activity Identify health plan program staff who will provide support to identified members Develop newsletters for enrolled members with nutrition and activity topics Program newsletters contain education, resources and upcoming events pertaining to physical activity (for all members enrolled in program) Identify program intervention mode- Face to Face, group classes, telephonic, mailing, etc.	Identified Health Plan Staff- Curriculum Designers of Health Education Staff Health Plan Communications Team Case Management Leadership	Identified cohort of members to target for interventions

Of the targeted members, prioritize members with comorbid conditions (asthma, hyperlipidemia, hypertension, high ED utilization)	Develop educational materials focusing on identified topics Develop interventions specific to members with co-morbid conditions Develop program components to support healthy eating and physical activity. Develop materials that can utilize multiple delivery modalities (Face to Face, telephonic, mail, group classes, etc.)	Case Management Leadership Medical Management Leadership and Curriculum designer Research management of co-occurring diseases with childhood obesity Community Relations team,	Utilize materials already developed for management of co-morbid conditions or develop appropriate materials
Enroll identified target membership into program	Identify which members will receive intervention and mode of intervention	Identified health plan staff (Disease Managers, Case Managers, etc.)	Percent of identified members enrolled, BMI pre and post intervention and one year later, BMI pre and post intervention and one year later, Quality of Life Survey pre and post intervention and at one-year post intervention,
Pediatricians in the Health Plan network	Develop education topics to include in provider communications Develop Tip Sheet for provides on how to code for WCC interventions. Also develop tip sheet on proposed communication with affected members	Provider Communications Team Provider Services Team	WCC HEDIS Rate

Operational Table

SMART Aim	Primary Drivers	Secondary Drivers	Key Individuals and Organizations	Metrics	Measurable outcomes with Timeline
What are you trying to improve?	What is needed to achieve your aim?	What interventions will help you achieve the primary drivers?	Key staff, partners, stakeholders or members of the community leading the secondary drivers	What data will be used to track progress toward your aim and how often	Should align with aims
Control or Improve Childhood Obesity among Health Plan participants	Program focused on identified population incorporating nutrition and activity	Develop Educational materials for use by health plan program staff focusing on nutrition and activity Identify health plan program staff who will provide support to identified members Develop newsletters for enrolled members with nutrition and activity topics Program newsletters contain education, resources and upcoming events pertaining to physical activity (for all members enrolled in program)	Identified Health Plan Staff-Curriculum Designers or Health Education Staff Case Management leadership Health Plan Communica-tions Team Case Management Leadership Provider Relations Staff	Identified cohort of members to target for interventions Number of members with BMI at or above 95 percent Number of members with co-occurring conditions Presurvey and post survey Quality of Life Survey Percent of identified members enrolled WCC HEDIS Rate	Percent of total population with BMI at or above 95 percent who participate in program Percent of members with BMI stabilization or decrease after participating in program Percent of members with BMI stabilization or decrease after participating in program and improvement in co-occurring condition Improved Quality of Life Score after program participation

Operational Table (cont'd)

SMART Aim	Primary Drivers	Secondary Drivers	Key Individuals and Organizations	Metrics	Measurable outcomes with Timeline
What are you trying to improve?	What is needed to achieve your aim?	What interventions will help you achieve the primary drivers?	Key staff, partners, stakeholders or members of the community leading the secondary drivers	What data will be used to track progress toward your aim and how often	Should align with aims
		Identify program intervention mode- Face to Face, group classes, telephonic, mailing, etc. Develop education topics to include in provider communica-tions Develop Tip Sheet for providers on how to code for WCC inter-ventions. Also develop Tip Sheet on pro-posed com-munication with affected members			Percentage of targeted members that participated in program Increase in WCC HEDIS Rate

Community Engagement

Who will you engage?	When will you engage them?	Why did you choose them?	How will they contribute?	How will you ensure they are a continued part of ongoing monitoring/ improvement?
Childhood Obesity Work Group	Immediately	Participants from Health Plan and Community have role in creation of plan	Develop action plan, identify sponsors from each part of the team (health plan and community)	Schedule meetings at regular intervals
Medical Management, Provider Relations, External Partners (Community, Providers)	After Work Group Creates Timeline	Gain understanding of current partners in the community	Utilize already created interventions and enhance	Schedule meetings at regular intervals

Communications Plan

Audience
Health Plan Leadership, Pediatric Providers, Community Leadership
Time Frame of Communication
Within one month of development of Action Plan
Purpose: Why is it important to communicate to this audience? What is the goal? Do you have a specific need or request?
Gain Health Plan Leadership buy-in to support initiative. Gain Pediatrician buy-in to support initiative. Gain Community Partners buy-in to support initiative. Clearly articulate what you need from respective groups related to their participation.
Values: What does this audience most value when it comes to this topic? How will the content support these values? How will you express this in your messaging?
Health Plan Leadership, Pediatric Providers, Community Leadership
Concerns: What is the audience's greatest concern when it comes to this topic? How can the content alleviate these concerns? How will you express this in your messaging?
What resources do they need to supply to support the initiatives? What are the expectations for them?

Message: What is the key message you want to deliver to this audience at this time? Remember to tie in the audience's values and concerns. Address the following: successes to this point? Challenges to overcome? What is happening next?
Provide evidence of need for intervention (% of membership that are affected by childhood obesity, what are the health care costs associated with ignoring this issue?) Issues regarding importance on overall health of children
Messenger: Who will deliver the message to this audience? You may assign the responsibility for delivering the message through each channel to different individuals
Committee Members, Program Manager
Evaluation: What will success look like? What metrics will be tracked? How will the success of interventions be defined?
Percent of identified members enrolled, BMI pre and post intervention and one year later, Quality of Life Survey pre and post intervention and at one-year post intervention