Project COMPASS: Comprehensive Obesity Management Pathways Across Systems
Health System Partner Application

Deadline to submit: December 29, 2025

Purpose of Project COMPASS

Project COMPASS is a national quality improvement (QI) initiative designed by the American Association of Clinical Endocrinology (AACE) to improve the diagnosis and management of obesity across U.S. health systems. The project aligns with AACE's Global Education and Quality Improvement Priorities (2024–2028) . Endocrine practices selected for participation will engage in data-driven improvement cycles, education, and implementation support using the Institute for Healthcare Improvement (IHI) and Agency for Healthcare Research and Quality (AHRQ) methodologies.

Framework and Evaluation Plan

Project COMPASS will employ a structured QI framework grounded in the **Institute for Healthcare Improvement (IHI) Model for Improvement** and **AHRQ Science of Improvement** methodologies. Each participating health system will implement iterative **Plan-Do-Study-Act (PDSA)** cycles supported by AACE's QI faculty and consultants.

Project COMPASS will be a two-year national QI Collaborative with at least three diverse health systems (academic, community, and rural).

Strategy and Interventions:
Each health system will implement interventions within a unified QI framework:

1. **Standardized Screening & Diagnosis** – Embed EHR tools and workflows to improve BMI documentation and diagnostic coding.
2. **Provider & Patient Engagement** – Deploy conversation aids, SMART scripts, decision guides, stigma-reduction education, and patient-facing communication tools.
3. **Multidisciplinary Care Integration** – Strengthen referral pathways to nutrition, physical activity, behavioral health, pharmacotherapy, and bariatric surgery where appropriate.

Core Components:

- **Baseline assessment:** Evaluate current obesity care documentation, diagnosis rates, and treatment patterns.
- **Root cause analysis:** Use structured process mapping and fishbone analysis to identify barriers.
- **Intervention design:** Develop targeted solutions embedded within standardized frameworks.
- **Implementation support:** Facilitate webinars, peer learning, and individualized coaching.
- **Measurement and feedback:** Continuously track data and performance benchmarks.

Outcomes Measures

Outcomes will be assessed using objective data sources (EHR extracts, quantitative and subjective surveys, and QI tracking tools). Deidentified data will be collected.

Primary Measures:

- Increase in BMI documentation (target: 60% → 90%).
- Increase in obesity diagnosis (target: 45% → 75%).
- Increase in evidence-based care delivery: lifestyle and behavioral health counseling/referral, nutrition services, pharmacotherapy, and surgery referrals.

Secondary Measures:

- ≥5% BMI reduction or ≥5% weight loss in 25%–30% of enrolled patients at 12 months.
- Waist-to-height ratio <0.5 or waist-to-hip ratio <0.8 in some patients.
- Increased follow-up visits for obesity management.

Balancing Measures:

- Provider workflow burden.
- Patient satisfaction with obesity care.

The measures outlined in this proposal are not duplicative of CMS QI programs.

Initiative Timing

- **Pre-launch (Jan–Mar 2026):** Site recruitment, contracts, baseline data.
- **Onboarding (Apr–Jun 2026):** Root cause analyses, mapping sessions, baseline surveys.
- **Implementation (Jul 2026–Mar 2027):** Interventions deployed, QI cycles, monthly webinars. (monthly check ins)
- **Analysis & Reporting (Apr–Aug 2027):** Outcomes evaluation, dissemination, publication.

Award: $110,000 per Health System Partner

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Email completed application and required attachments to: qualityimprovement@aace.com

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Section 1. Practice Identifying and Contact Information

Practice name (applicant):

Health system name:

Practice TIN:

Practice service location address (street, city, state, zip):

Endocrinologist/Physician Champion name :

Applicant contact information (email, phone):

Clinic where the project will be implemented**:**

Practice/Clinic Type: ☐ Academic ☐ Community ☐ Rural

Project Team Members (please include name, title, email, and phone):

Clinician Champion (provides leadership and facilitates educational and improvement activities):

Project Manager (coordinates QI processes, data collection, communication, and deliverables):

IT/Data Liaison (supports EHR modifications, data extraction, and reporting):

Section 2. Organizational Capacity

Commitments

Do you agree to collect and submit relevant obesity care quality data as outlined below?

☐ Yes ■ No

Do you agree to designate a project coordinator or quality manager to oversee implementation and data submission?

☐ Yes ☐ No

Required Leadership Support

☐ Letter of support from health system leadership (CEO, CMO, CNO, or CQO) confirming commitment of institutional resources and protected time for staff participation.
(Include as attachment to email with application)

Section 3. Population Demographics

Patient Volume and Demographics within the Endocrine Practice/Clinic
Number of active adult patients with obesity served in the last completed calendar or fiscal year:

Time period:

Population Diversity and Access Indicators
Percentage identifying as non-White or Hispanic:

Percentage residing in rural areas:

Percentage residing in Medically Underserved Areas (MUA/MUP):

Section 4. Experience with Obesity Care and Quality Improvement

Describe your practice/health system's recent efforts to improve how your healthcare teams manage obesity with their patients. These efforts might include prior QI efforts, educational activities, and/or workflow redesign projects:

Please describe:

Current obesity care workflows and referral processes (nutrition, behavioral health, pharmacotherapy, surgery).

Use of standardized tools or algorithms (e.g., AACE Obesity Model Playbook).

Provider training or education in obesity management.

Past performance improvement projects using IHI/AHRQ or similar frameworks.

Section 5. Electronic Health Record (EHR) Capabilities

Do you use an EHR system? ☐ Yes ☐ No

Which EHR platform do you use? (e.g., Epic, Cerner, NextGen)

Does the EHR include functionality for obesity care tracking or an obesity module? ☐ Yes ☐ No

Describe current capabilities for:

Capturing BMI, diagnosis codes, and obesity care referrals:

Tracking counseling, medication, or surgical referrals:

Measuring patient weight trends and follow-up visits:

Extracting and submitting deidentified data for QI analysis:

Section 6. Quality Improvement Capabilities and Planned Interventions

QI Infrastructure
Describe your organization's capacity for data-driven improvement and its experience implementing Plan-Do-Study-Act (PDSA) cycles or equivalent QI methods:

QI Aims and Approach
Baseline and Target Metrics (check the metrics you are interested in measuring and any baseline data you currently have)

Metric	Baseline (%)	Target (%)	Data Source
☐ BMI documentation	_____	90	EHR extract
☐ Obesity diagnosis among eligible patients	_____	75	EHR extract
☐ Lifestyle/behavioral counseling referrals	_____	70	EHR/referral logs
☐ Pharmacotherapy utilization (when indicated)	_____	20	EHR prescribing data
☐ Bariatric surgery referrals (when indicated)	_____	10	Referral data
☐ ≥5% BMI reduction or ≥5% weight loss (12 months)	_____	25–30	Aggregate patient data
☐ Provider workflow satisfaction	_____	Improvement	Survey
☐ Patient satisfaction with obesity care	_____	Improvement	Survey

Describe your aims for improving obesity care within your system (diagnosis, management, or patient engagement) based on your current data and/or areas for improvement:

Describe your current challenges to improving obesity care within your system:

Select the Strategies you plan to address and describe:

☐ **Standardized Screening & Diagnosis:** Embedding EHR prompts/workflows.

☐ **Provider & Patient Engagement:** Implementing conversation aids, SMART scripts, stigma-reduction training, and patient materials.

☐ **Multidisciplinary Care Integration:** Enhancing referral pathways to nutrition, physical activity, behavioral health, pharmacotherapy, and surgery.

☐ **Evaluation and Reporting Plan**
Describe how you will measure and report progress on primary, secondary, and balancing measures. Include details on how you will share results with leadership, staff, and AACE (e.g., quarterly reports, dashboards, internal presentations):

Section 7. Health Equity and Patient Engagement

Describe how your clinic identifies and addresses barriers to obesity care, including bias, stigma, or social determinants of health:

Explain how culturally and linguistically appropriate resources will be developed and used:

Describe any existing or planned partnerships with health equity programs or community resources:

Section 8. Attestation

To the best of my knowledge, my health system is not applying with another professional society to participate in the AACE Project COMPASS Quality Improvement initiative.

Signature: Name & Title: Date:

Submission Instructions:

Please submit the completed application and required attachments to AACE Quality Improvement Programs at qualityimprovement@aace.com by the stated deadline. Include the leadership letter of support and any supporting documentation demonstrating QI or data capabilities. **Deadline for submission: 12-29-25**

☐ **Application (this document)**

☐ **Letter of Support from Practice/Clinic**