

# **Obesity Care Quality Improvement Tool Kit**

**Adapted from:  
ClinicalOptions.com**

## Introduction

This quality improvement (QI) tool kit is designed to serve as a guide for your practice as you work to improve obesity care. Many healthcare professionals (HCPs) may acknowledge that there is a need to improve obesity care but may not know where to begin and how to measure progress. This QI tool kit will help HCPs answer the following questions:

- How are we doing when it comes to providing obesity care?
- What proportion of my patients are achieving sustainable weight loss?
- What process and/or outcomes measure should we evaluate?
- What are some key opportunities for improvement?
- Who should be involved in our QI efforts?

## Domains of Healthcare Quality

Consider each of these domains of healthcare quality as your team evaluates how obesity care is provided to your patients:

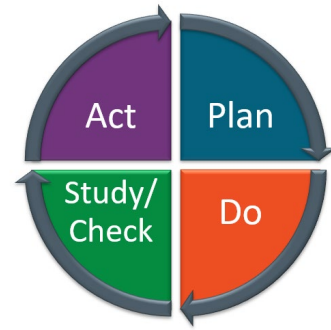
- **Safe:** Care is delivered safely. The risk of harm is minimized.
- **Timely:** Appropriate care is delivered without significant delays.
- **Effective:** Interventions are based on scientific evidence.
- **Efficient:** Reduce waste such as unnecessary tests, redundant processes, etc.
- **Equitable:** All patients are provided with the same type of care regardless of their personal characteristics (eg, gender, ethnicity, socioeconomic status).
- **Patient centered:** Care plans are developed through a shared decision-making process and reflect individual patient preferences, needs, and values.



## PDSA

Once the team has identified a problem statement, they are ready to use PDSA (Plan-Do-Study-Act) cycles to implement interventions and to track their progress.

PDSA may also be called PDCA (Plan-Do-Check-Act).



### P: Plan

During the Plan step, the team drafts an aim statement and lists the steps they will take to implement a process change. Identify the people who will be responsible for the process, when the new process will begin, and how the team will evaluate the impact of the change.

An aim statement should be written as a SMART (specific, measurable, achievable, relevant, and time-bound) statement.

- **Example:** The primary care clinic aims to ensure that 85% of new patients with obesity have a completed obesity care plan in their charts. The templated care plan will include sections for nutrition interventions, physical activity interventions, mental health services, and surgical evaluation. The clinic aims to achieve this goal over the next 5 months.

### D: Do

Describe what was done and what happened when the new process was implemented.

- **Example:** After launching the templated care plan, the QI team spends time at the next staff meeting informing everyone about the template. The team also sends weekly reminders to all staff members. The team asks several HCPs if they had any difficulty finding and using the template. They determine that the care plan is easy to use and takes approximately 10-15 minutes to complete.

### S: Study

After several weeks, the team regroups during the Study step to review whether the planned change achieved the intended result. Depending on the type of change that is implemented, the team may reach this step after several weeks (small change) or a few months (medium or large change).

The team should also consider balancing measures. Did the intended change cause new unanticipated problems in other areas? For instance, an aggressive intervention that combines low-calorie meal replacement plus injectable antiobesity medications may cause some patients to lose weight too quickly and develop gallbladder problems.

- **Example:** After 4 weeks, the team may find that the templated care plan was completed by 67% of HCPs; 5% forgot to use the template; and 28% only used portions of the template. The team may revise the template and make it shorter or easier to use. They may also find ways to automate portions of the template by pulling information from other parts of the patient record.

### **A: Act**

Now that the team has tested an intervention and evaluated its impact, the team must decide whether they will continue the intervention, modify the intervention, or develop a new intervention. Since the PDSA cycle is meant to be repeated, the Act step often leads back to the Plan step for a new intervention.

Depending on the scope of the QI project, the team may go through 2-5 PDSA cycles over 9-18 months before deciding that they are finished.

### **Continuous QI**

The philosophy behind continuous QI emphasizes that there are always opportunities for improvement. However, the team must prioritize and determine their capacity for effective interventions. If the team tries to fix too many problems at once, they may be ineffective without the proper resources.

## QI Case Examples

The following brief QI case examples are meant to illustrate how teams may develop interventions to address specific problems. The examples have been simplified and are reflective of the application of QI concepts and methods.

### Example 1

**Problem:** Patients report a lack of social support, which results in poor adherence to lifestyle modifications. Only 5% of these patients have achieved weight loss over the past 6 months.

**Intervention:** Create a virtual support group that meets monthly. Recruit a licensed mental health counselor to co-lead these sessions. Identify patient advocates who are willing to share their success stories during these meetings. Invite a motivational speaker for one of the sessions.

**Healthcare Quality Domains:** This intervention enables more equitable care for those who may have limited access to mental health resources. This also demonstrates efficiency by having a single intervention that affects multiple patients.

**Outcome:** After 6 months, the team finds that patients feel more motivated and empowered. Several patients receive antidepressant therapy after recognizing how their mental health affects their ability to make and sustain lifestyle modifications. After 9 months, your team finds that 64% of the patients who have been attending support group meetings have achieved weight loss over the past 3 months.

### Example 2

**Problem:** Your HCPs do not feel comfortable asking patients about obesity care. They report feeling unprepared to answer sensitive questions. They have encountered angry and hostile patients when they have introduced the topic. Because of their hesitancy, HCPs have frequently missed opportunities to document an obesity care plan for each new patient.

**Intervention:** Offer motivational interviewing training sessions for your staff. Use a templated approach with the 6 “A’s” Model (Ask, Assess, Advise, Agree, Assist, Arrange). Providing coaching and feedback can help to empower HCPs.

**Healthcare Quality Domains:** This intervention enables a patient-centered approach and demonstrates the application of effective communication skills (motivational interviewing).

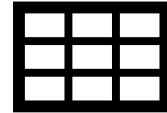
**Outcome:** After 3 months, your HCPs report feeling more comfortable and confident discussing obesity care with patients. Although some patients may not wish to discuss obesity care, many are eager to try some of the newer therapies. After 6 months, these HCPs complete obesity care plans for every new patient.

## Appendix

The following QI resources may guide the team as they work through specific steps of their QI project. Additional QI tools and resources may be found on websites like [www.ihl.org](http://www.ihl.org) and [www.ahrq.gov](http://www.ahrq.gov).

### Baseline Assessment

One way to perform a baseline assessment is to review patient charts and see how your HCPs are providing obesity care.



- Create a list of 30 adult patients with obesity seen in the past 12 months in your outpatient clinical practice.
- Fill out a baseline data collection spreadsheet.
- Review the data and answer the following questions listed below.

#### [Baseline Assessment Spreadsheet](#)

Questions that the baseline data will answer:

- What proportion of our patients with obesity have “obesity” listed on their problem list?
- What proportion of our patients with obesity have an obesity care plan documented in their charts?
  - What proportion of those obesity care plans include referrals to other specialists or HCPs (eg, nutrition, surgery, mental health)?
  - What proportion of those obesity care plans include having patients returning at regular intervals for weight checks and/or counseling?
- What proportion of our patients with obesity have been prescribed antiobesity medications?
  - What types of antiobesity medications have been prescribed?
  - How often do patients have trouble obtaining antiobesity medications?
- What proportion of our patients with obesity have lost weight over the past 6 months?
  - How much weight have they lost?

## Priority Matrix

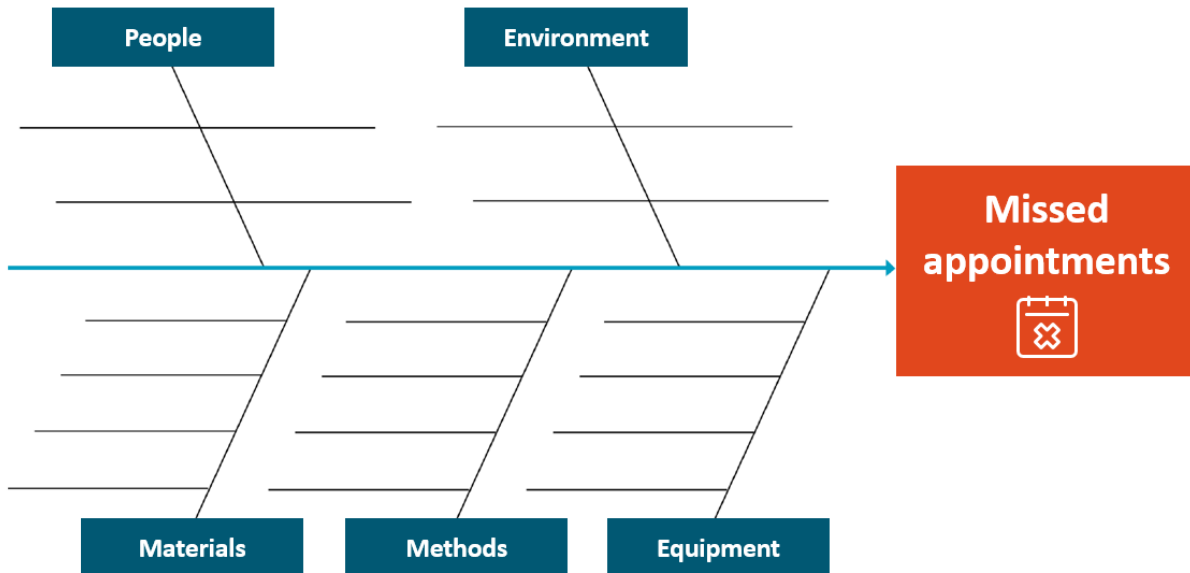
After the team has brainstormed a list of possible interventions, place each idea in one of the quadrants based on its potential clinical impact (high vs medium or low) and its feasibility (easy vs difficult to implement). This may help the team prioritize short-term interventions that are most likely to benefit patient care.

**Priority Matrix**

<b>Clinical Impact</b>	<b>High</b>		
	<b>Medium or Low</b>		
		<b>Easy</b>	<b>Difficult</b>
		<b>Feasibility (ease of implementation)</b>	





## Root Cause Analysis

A fishbone diagram may be used to identify potential root causes behind a problem. This tool may also be called a “cause and effect diagram” or an “Ishikawa” diagram. The root causes for a problem (eg, “missed appointments”) may be grouped into different categories such as people, environment, materials, etc.



## Process Mapping

A process map (or flowchart) is a visual representation of steps in a process. This tool can help identify when steps may cause variations in care or when unnecessary work may be occurring. The most common symbols used in a process map are shown below:

Symbol	Name	Function
	Oval	Start/End of a process
	Arrow	Connector/directional relationship
	Rectangle	A process
	Diamond	A decision



## PDSA Worksheets

**PDSA Worksheet (short version)**  
1. Define your aim, the overall goal you wish to achieve. 2. Plan the first (or next) test of change toward achieving the aim. 3. Do the test. 4. record and study the results. 5. Act to modify the plan for your next test.

**Aim:**

**Plan**  
Describe your first (or next) test of change:

Who is responsible:      When is it to be done:      Where is it to be done:

List the tasks needed to set up this test:      Who:      When:      Where:

Predict what will happen when the test is performed:      List measures for assessing the predictions:

**Institute for Healthcare Improvement**  
Copyright © 2008 Institute for Healthcare Improvement (IHI). All rights reserved. IHI welcomes the use of this tool, based at ihq.org. Language, field names, and the IHI logo and copyright language must remain intact. Using this form does not imply IHI endorsement. This form may not be reproduced for commercial use without the written permission of IHI.

**Do**  
Describe what actually happened when you ran the test:

**Study**  
Describe the measured results and how they compared to the predictions:

**Act**  
Describe what modifications to the plan you'll make for the next cycle, based on what you learned:

**Institute for Healthcare Improvement**  
Copyright © 2008 Institute for Healthcare Improvement (IHI). All rights reserved. IHI welcomes the use of this tool, based at ihq.org. Language, field names, and the IHI logo and copyright language must remain intact. Using this form does not imply IHI endorsement. This form may not be reproduced for commercial use without the written permission of IHI.

[https://www.ihq.org/education/IHIOpenSchool/resources/Assets/PDSA\\_Worksheet\(short\).pdf](https://www.ihq.org/education/IHIOpenSchool/resources/Assets/PDSA_Worksheet(short).pdf)

## Obesity Resources

AGA Clinical Practice Guideline on Pharmacological Interventions for Adults With Obesity

[https://www.gastrojournal.org/article/S0016-5085\(22\)01026-5/fulltext](https://www.gastrojournal.org/article/S0016-5085(22)01026-5/fulltext)

AMGA Obesity Care Model Playbook

[https://www.amga.org/AMGA/media/Store/Products/AMGA\\_OCMC-PlaybookFINAL.pdf](https://www.amga.org/AMGA/media/Store/Products/AMGA_OCMC-PlaybookFINAL.pdf)

Building Successful Models in Primary Care to Improve the Management of Adult Patients with Obesity

<https://www.liebertpub.com/doi/10.1089/pop.2020.0340>

Obesity Definition, Diagnosis, Bias, Standard Operating Procedures (SOPs), and Telehealth: An Obesity Medicine Association (OMA) Clinical Practice Statement (CPS) 2022

<https://www.sciencedirect.com/science/article/pii/S2667368121000048>

Obesity Medicine Association 2023 Abridged Obesity Algorithm

[https://obesitymedicine.org/wp-content/uploads/2023/02/Final-OMA-Algorithm\\_Abridged-Version\\_2023.pdf](https://obesitymedicine.org/wp-content/uploads/2023/02/Final-OMA-Algorithm_Abridged-Version_2023.pdf)

Weight Can't Wait

<https://stoppublichealth9.drupal.gwu.edu/sites/g/files/zaxdzs4356/files/2022-02/wcw-guide-for-the-management-of-obesity-in-the-primary-care-setting.pdf>