Weitzman Institute
inspiring primary care innovation

The France Foundation

Weight MANAGEMENT

in Community Health:

Bridging Systems & Care Coordination

Patient/Family Engagement

Learning Collaborative Session #5

Today's Agenda

- Welcome
- Overview of Technology and Reminders
- Patient/Family Engagement
- PDSA
- Next Steps and Q & A

Technology: Your Zoom Window

Sound

- Muting/Unmuting
- Press *6 to unmute phone audio

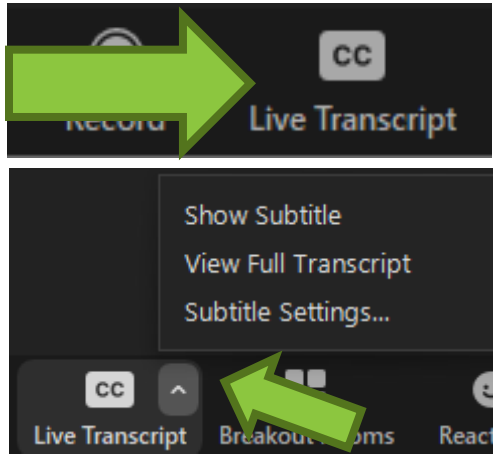
Webcam

- Please share!

Chat

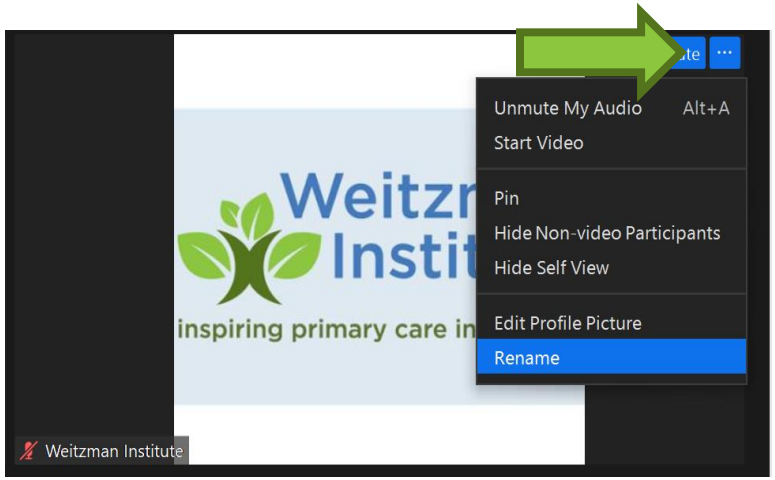
- Questions
- Sharing resources/ideas

Technology: Your Zoom Window



Closed Captioning and Live Transcript

- Click on the caret or icon
- Select ‘Show Subtitle’ for closed captioning on screen
- Select ‘View Full Transcript’ for live transcript pop-out window



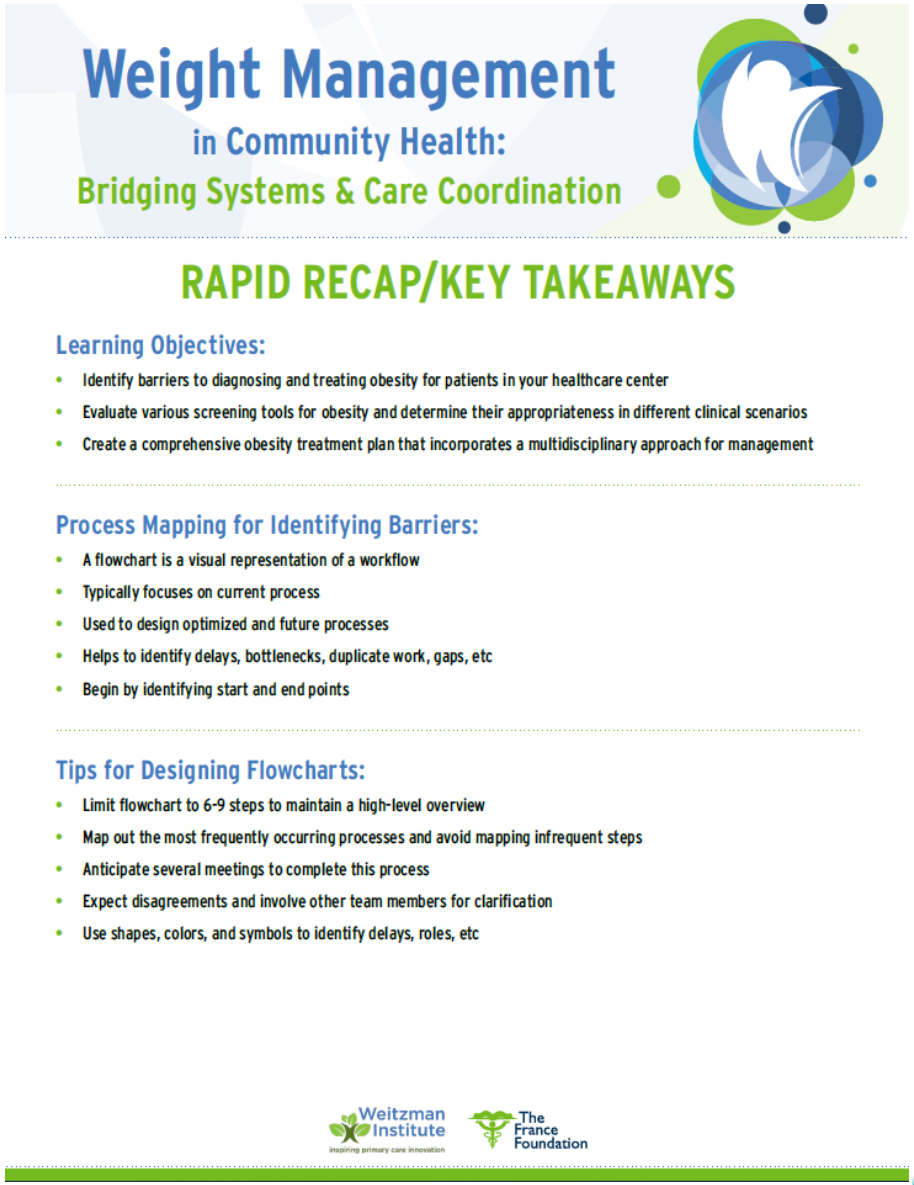
Change Your Name

- Click on the three dots
- Click ‘Rename’
- Type in your name

Rapid Recaps

- Return to the **Overview tab** of the live activity, *Live Session–Module 4: Prevention, Management, and Treatment*
- Scroll down to the **Rapid Recap** header

You will then be able to click on **Rapid Recap** listed below the headers to access the resources



Continuing Education Credits

In support of improving patient care, this activity has been planned and implemented by The France Foundation and Moses/Weitzman Health System, Inc. and its Weitzman Institute. The activity is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION

This series is intended for clinical leadership, primary care providers, behavioral health providers, dietitians, nurses, QI/technical teams, and other members of the care team

Please complete the post-session survey and claim your CE certificate on the WeP after today's session

Disclosure

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (or spouse) and any for-profit company in the past 12 months which would be considered a conflict of interest
- The views expressed in this presentation are those of the presenter and may not reflect official policy of Moses/Weitzman Health System and its Weitzman Institute
- We are obligated to disclose any products which are off-label, unlabeled, experimental and/or under investigation (not FDA-approved) and any limitations on the information that I present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion

Acknowledgements

- This activity is supported by an independent medical educational grant from Lilly

The Weitzman Institute is Committed to Justice, Equity, Diversity & Inclusion

At the Weitzman Institute, we value a culture of equity, inclusiveness, diversity, and mutually respectful dialogue. We want to ensure that all feel welcome.

If there is anything said in our program that makes you feel uncomfortable, please let us know.

Series Learning Objectives

- Ascertain metrics of your healthcare center against key performance measures related to the obesity care
- **Identify barriers to diagnosing and treating obesity for patients in your healthcare center**
- Formulate an improvement plan for establishing diagnostic and treatment plans for patients with obesity in your healthcare center
- Develop an improvement plan for managing holistic care of patients with obesity in your healthcare center

Session Learning Objectives

- Describe the impact of weight stigma on health-related outcomes for patients
- Explain the core components of successful primary care models for managing patients with overweight/obesity
- Implement strategies to improve the holistic care of patients with overweight/obesity

What Is Weight Stigma?

- Assuming health status based on weight
- Discussions about weight loss
- Belief that weight is in one's control
- Personal responsibility narrative about health
- Complimenting weight loss

Pathologizes the body

Weight loss is NOT a behavior

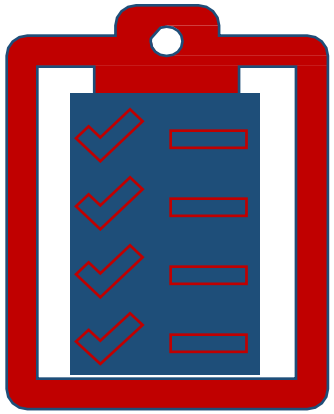
Tomiyama AJ. *Appetite.* 2014;82:8-15.

Impact of Stigma

Adapted from Nourishing Minds Nutrition: https://www.nourishingmindsnutrition.com/home

Internalizing Weight Stigma

When people with obesity internalize weight stigma, they apply harmful weight-related stereotypes to themselves

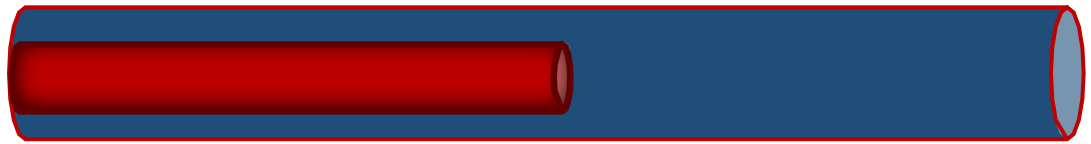


The **most-cited reason** that those with obesity gave for not seeking medical help was perceived personal responsibility for their weight

82% of people with obesity surveyed believed they alone were responsible for weight loss

82%

Over half of participants who identified as "struggling with their weight" were found to have high levels of internalized weight bias



52%

Adapted from: https://stop.publichealth.gwu.edu/fast-facts/weight-bias-stigma

Effects of Weight Stigma in Medical Care

- Independent health risk factor, even when controlling for BMI
- Reduced engagement in health behaviors
- Reduced engagement in health care
- Medical care is sited as most frequent source of weight stigma

Puhl RM, et al. *Obesity (Silver Spring)*. 2006;14(10):1802-1815.

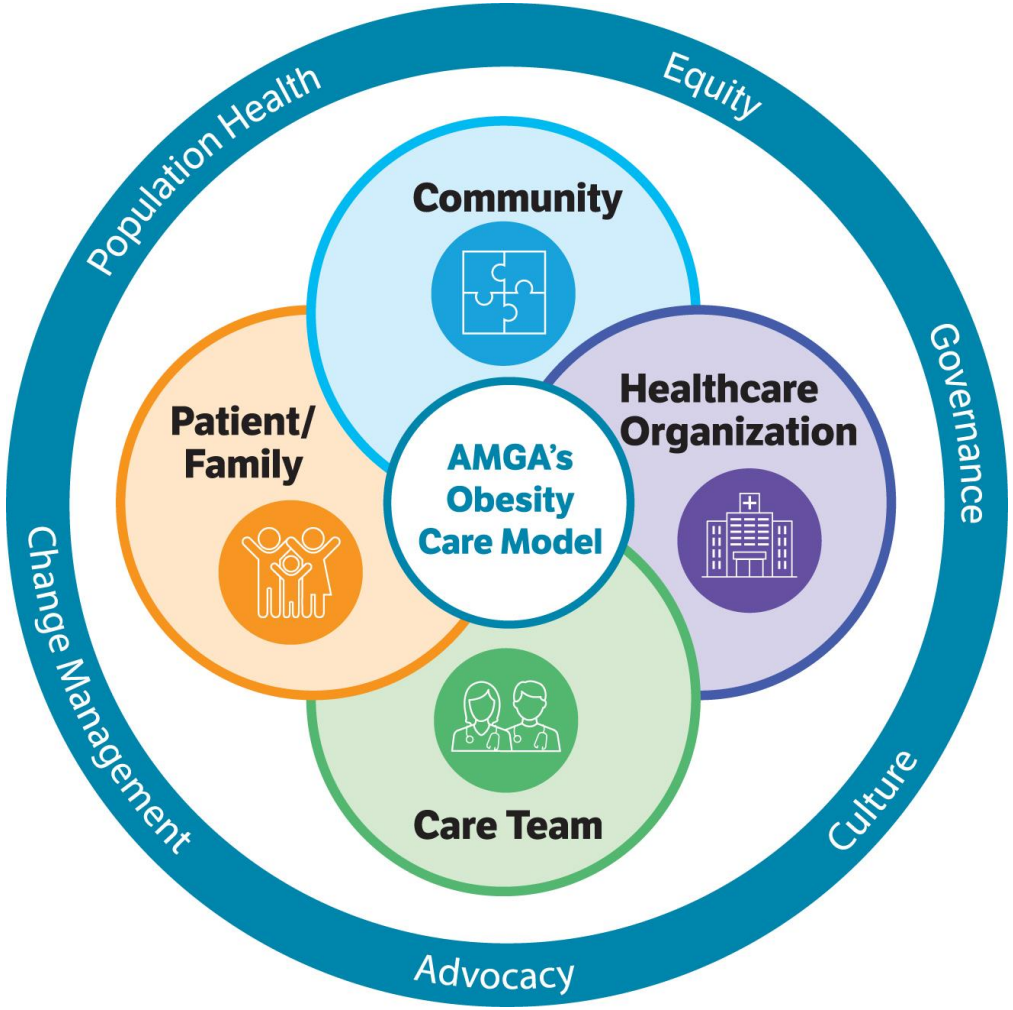
Weight Stigma Can Lead to Misdiagnosis

- Weight stigma creates disparities in healthcare
- The patient is often prescribed weight loss instead of offered research-based treatments; e.g. knee pain, hernia, HTN
- Patients delay coming to appointments due to the pain of stigma and wait until there are medical complications
  - Turned away for services (weight loss is required for treatment)
  - Patients are shamed, lectured, etc
  - Providers are not prepared to care for patient in larger bodies

Ramos Salas X, et al. *Front Psychol*. 2019;10:1409. Fulton M, et al. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan. Available from: https://www.ncbi.nlm.nih.gov/books/NBK554571/

Successful Models for Primary Care

- **Community** focuses on engaging and building relationships with patients and organizations
- **Organization** focuses on administrative, financial, and clinical initiatives in a medical institution
- **Care team** focuses on health system care teams implementing initiatives that directly impact patient care
- **Patient/family** focuses on creating partnerships between clinician, patients, and their families



American Medical Group Association. AMGA Obesity Care Model Collaborative; 2024.

Essential Role of Community

- Identify and establish community partnerships and select "community champions" to facilitate partnerships
- Secure leadership support for the creation of community outreach services
- Compile and distribute existing community resource lists for the care team and patients
- Pilot community outreach programs
- Use patient experience, effectiveness, and utilization patterns to adjust care and services

American Medical Group Association. AMGA Obesity Care Model Collaborative; 2024.

Essential Role of Healthcare Organizations

- Assess and develop business case
- Provide staff education
- Assess bias and stigma in the culture of the organization
- Conduct educational meetings
- Develop patient-reported outcomes
- Establish an insurance verification team to determine insurance and patient reimbursement
- Ensure appropriate coding for diagnosis and level of service
- Develop and integrate tools into EHRs
- Develop referral process for providers for new or existing obesity/weight management programs

American Medical Group Association. AMGA Obesity Care Model Collaborative; 2024.

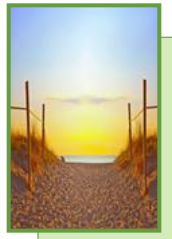
Essential Role of the Care Team

Create and support a multidisciplinary team

Determine types of care delivery services offered

Develop referral networks

Provide education for clinicians and staff



Assess patient referral services to gauge clinic access

Develop a patient support group or refer to an existing support group

Create and maintain an obesity registry or dashboard

Understand the reimbursement landscape

American Medical Group Association. AMGA Obesity Care Model Collaborative; 2024.

Essential Role of Patients and Their Families

The picture can't be displayed.

Include a patient/family member or patient advisory group during planning

Provide education for patients

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American Medical Group Association. AMGA Obesity Care Model Collaborative; 2024.

Factors That Influence Patient Engagement

- Culture of inclusion
- Unconscious bias
- Microaggressions
- Systemic racism
- Institutional racism
- Access to quality care

Simon M, et al. *NAM Perspectives*. 2020:10.31478/202007a.

Importance of Engaging Patients in Healthcare

Improves patient satisfaction and motivation

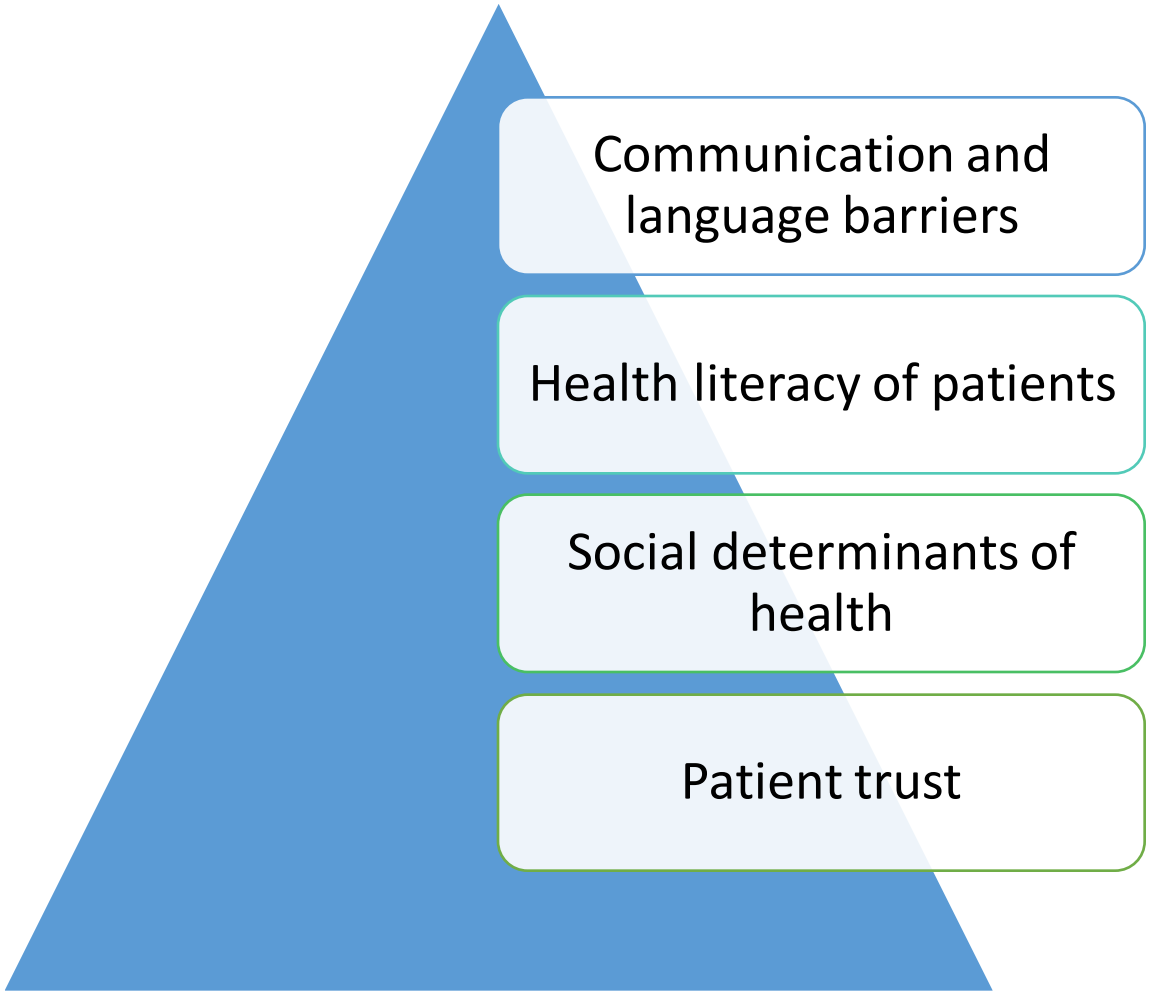
Improves long-term health and well-being of patients

Reduces waste and overall costs

Patient Outcomes

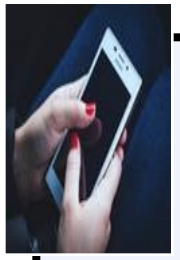
Simon M, et al. *NAM Perspectives*. 2020:10.31478/202007a; Greene J, et al. *Health Aff (Millwood)*. 2015;34(3):431-437; Nijman J, et al. *J Health Commun.* 2014;19(8):955-969.

Challenges and Barriers to Patient Engagement



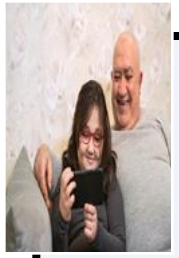
Woodward EN, et al. *BMC Health Serv Res*. 2024;24(1):29.

Strategies to Improve Communication

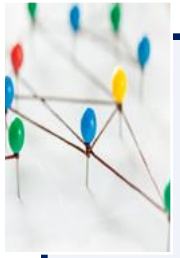


Telehealth

Translation services



Incorporation of caregivers into communications



Offering training on how to improve interpersonal communication (avoiding medical jargon, slowing down, assuring understanding, asking the right questions, etc.)

Emphasize nonverbal communication and body language

https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-communication

Trauma-Informed Care

- Shifts focus from “What's wrong with you?" to “What happened to you?"
- Principles of trauma-informed care:
  - Safety
  - Trustworthiness and transparency
  - Peer support
  - Collaboration and mutuality
  - Empowerment voice and choice
  - Cultural, historical, and gender issues

https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

Nutrition and Physical Activity Advice Considerations

- "Window of tolerance“
  - Notice body language and degree of engagement
  - Ask permission/consent before offering advice
- Relative safety
  - Stay present
  - Actively listen
  - Challenge from state of curiosity (in non-confrontational way)
  - Check in (ie, “does this feel ok?”)

Corrigan FM, et al. *J Psychopharmacol.* 2011 Jan;25(1):17-25. National Institute for the Clinical Application of Behavioral Medicine. https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance/; Geller SM, et al. *J Psychother Integr*. 2014;24(3):178-192.

Strategies to Improve Health Literacy

Agency for Healthcare Research and Quality. Accessed July 25, 2024. https://psnet.ahrq.gov/primer/strategies-improve-organizational-health-literacy

Strategies to Address SDoH

- Leverage SDOH screening tools
- Recommend affordable food options
- Connect patients with food and affordable housing options through partnerships
- Offer medical transportation
- Provide alternatives to in person care with telehealth
- Combat social isolation

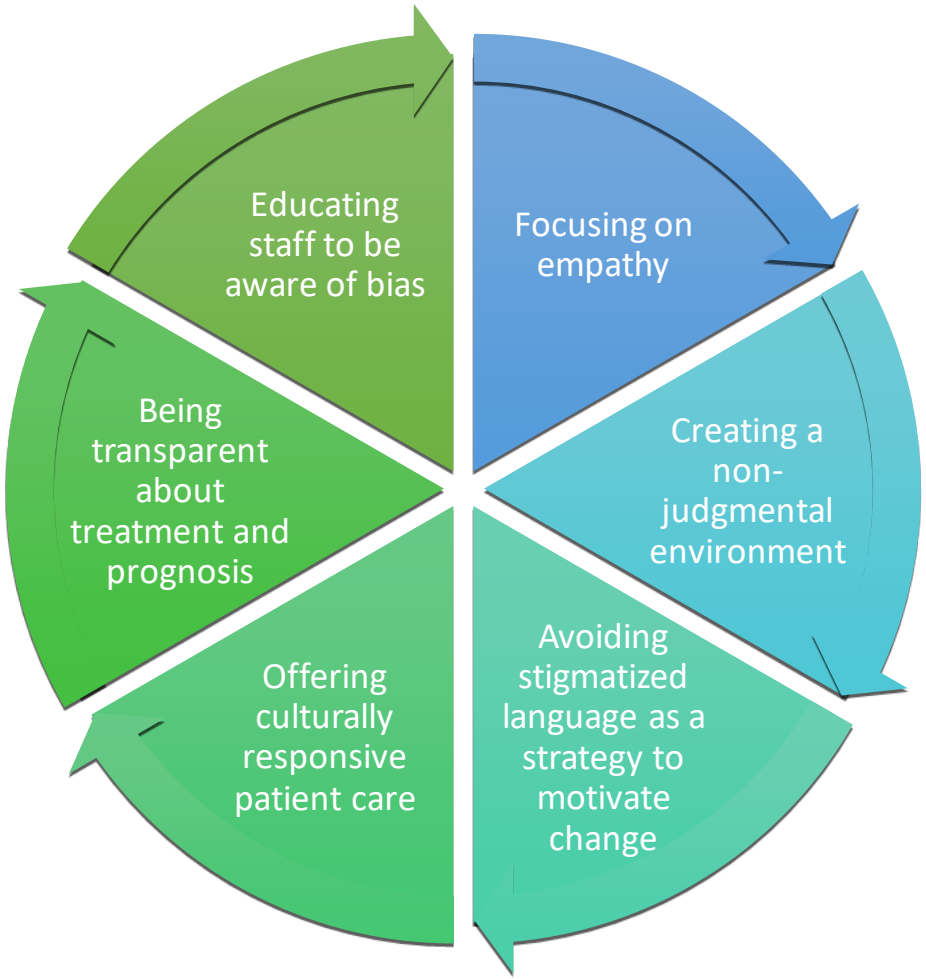
White-Williams C, et al. *Circulation*. 2020;141(22):e841-e863; https://www.uspreventiveservicestaskforce.org/

SDOH Screening Tools

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE)	• National Association of Community Health Centers • Can be directly uploaded into EHRs
The EveryONE Project	• American Academy of Family Physicians
Health-Related Social Needs Screening Tool (AHC-HRSN)	• Centers for Medicare and Medicaid Services Accountable Health Communities

O'Gurek DT, et al. *Fam Pract Manag*. 2018;25(3):7-12.

Strategies to Improve Patient Trust



Stubbe DE. *Focus (Am Psychiatr Publ).* 2020;18(1):49-51; Moudatsou M, et al. *Healthcare (Basel).* 2020;8(1):26; https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol

Logistical Strategies for Engaging Patients

Considerations for the Clinic Environment

Furniture	• Wide-base, higher-weight-capacity chairs in the waiting and patient areas • Specialized bariatric chairs, where possible • Pedestal toilets, rather than wall-mounted • Wheelchair-accessible bathrooms
Equipment	• Large-sized or thigh-sized blood pressure cuffs • High-capacity weighing scales • Extra-large gowns
Staff	• Educated about obesity and weight bias

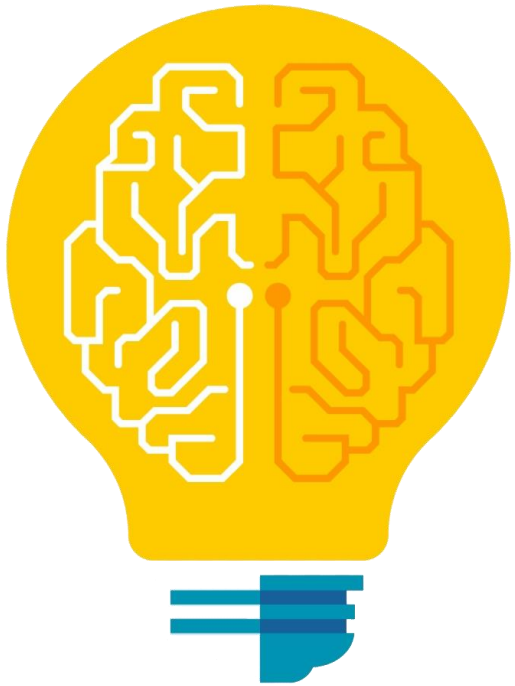
Kahan SI. *Mayo Clin Proc*. 2018;93(3):351-359.

Obesity-Related Programs in the US

- Healthy Food Financing Initiative
- New Markets Tax Credit
- Federal Hunger and Nutrition Assistance: WIC, School/Child Nutrition Programs, SNAP, and Nutrition Incentive Programs
- Diabetes Prevention Program (DPP)
- Double Up Food Bucks at Farmers Markets (state-dependent)

WIC, Special Supplemental Nutrition Program for Women, Infants, and Children; SNAP, Supplemental Nutrition Assistance Program

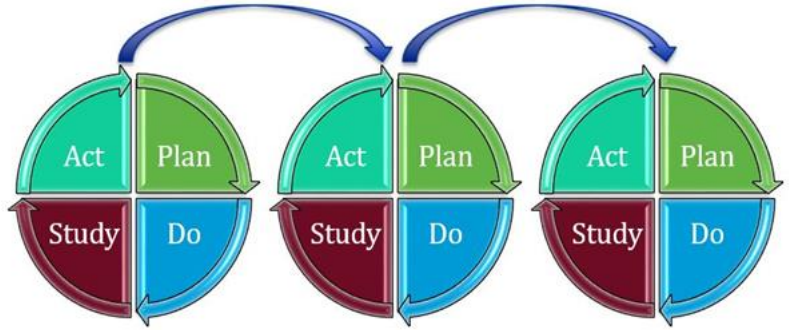
Questions?

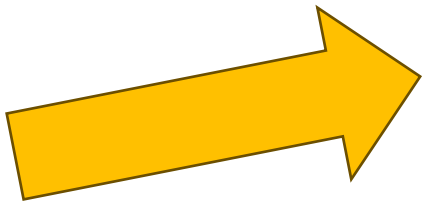


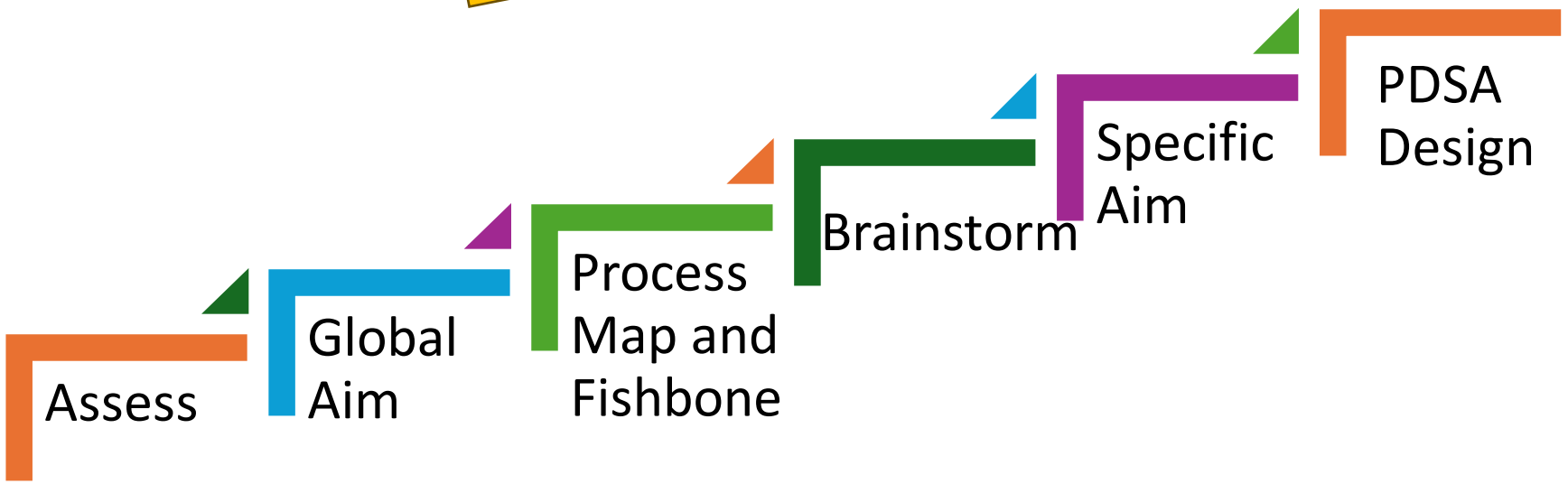
Key Takeaways

- Weight stigma (both internalized and external) influences the level of care a person receives and is an independent risk factor for chronic disease
- Patient engagement improves when trust is built, trauma is accommodated for, and barriers are acknowledged
- Look to create inclusive environments and utilize national resources to address SDOH barriers

QI Improvement Ramp





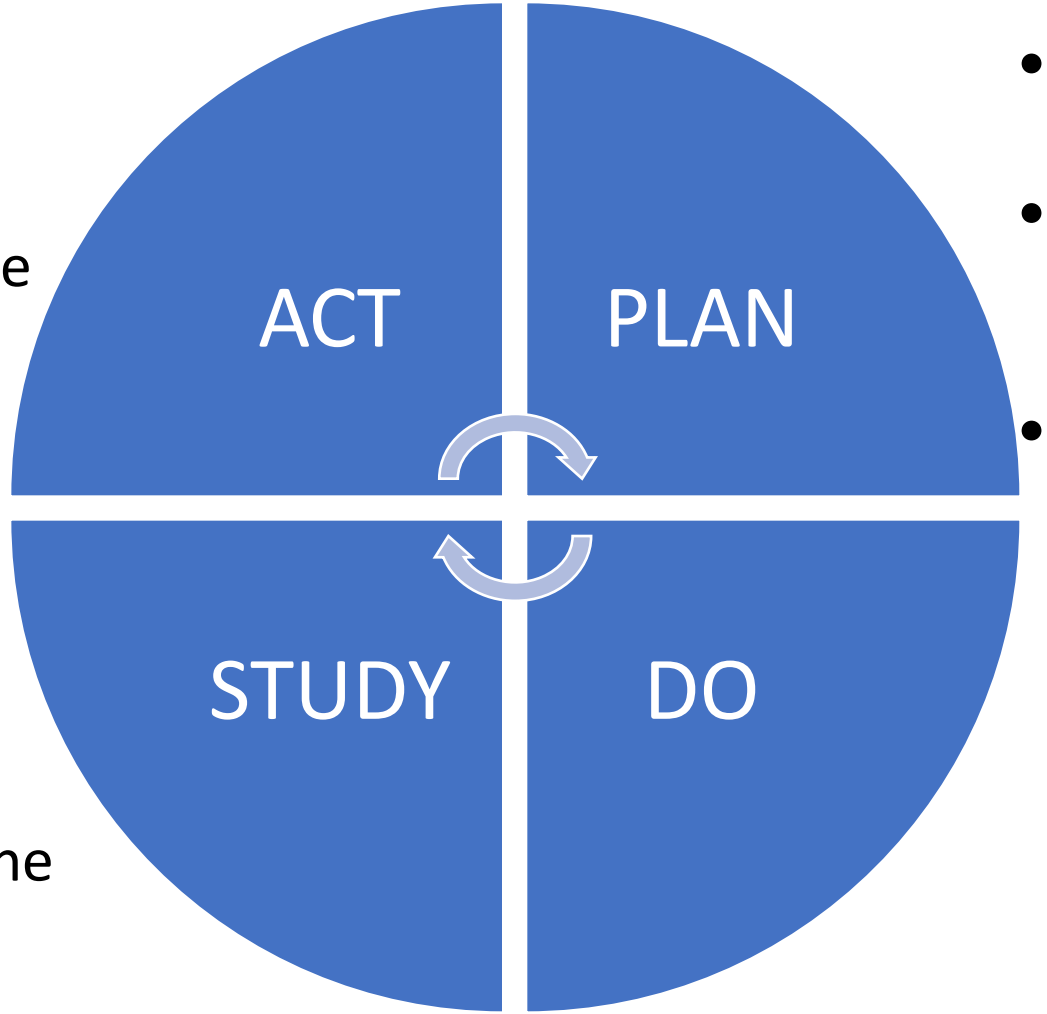


PDSA: Plan, Do, Study, Act

- The backbone of quality improvement work
- Answers the question, “Has our change resulted in an improvement?”
- Series of small, rapid tests of change
- It is aka: DMAIC, PDCA, and small tests of change

PDSA Cycle for Change

- Adopt, adapt, or abandon cycle
- What changes are to be made?
- Next cycle?



- Set improvement goals–Predictions
- Plan–small scale (who, what, where, and when)
- What data will be gathered?

- Fully analyze
- Compare results/ data to predictions
- Summarize and examine learning

- Carry out the plan
- Document challenges and observations
- Gather and record data

STRUCTURE

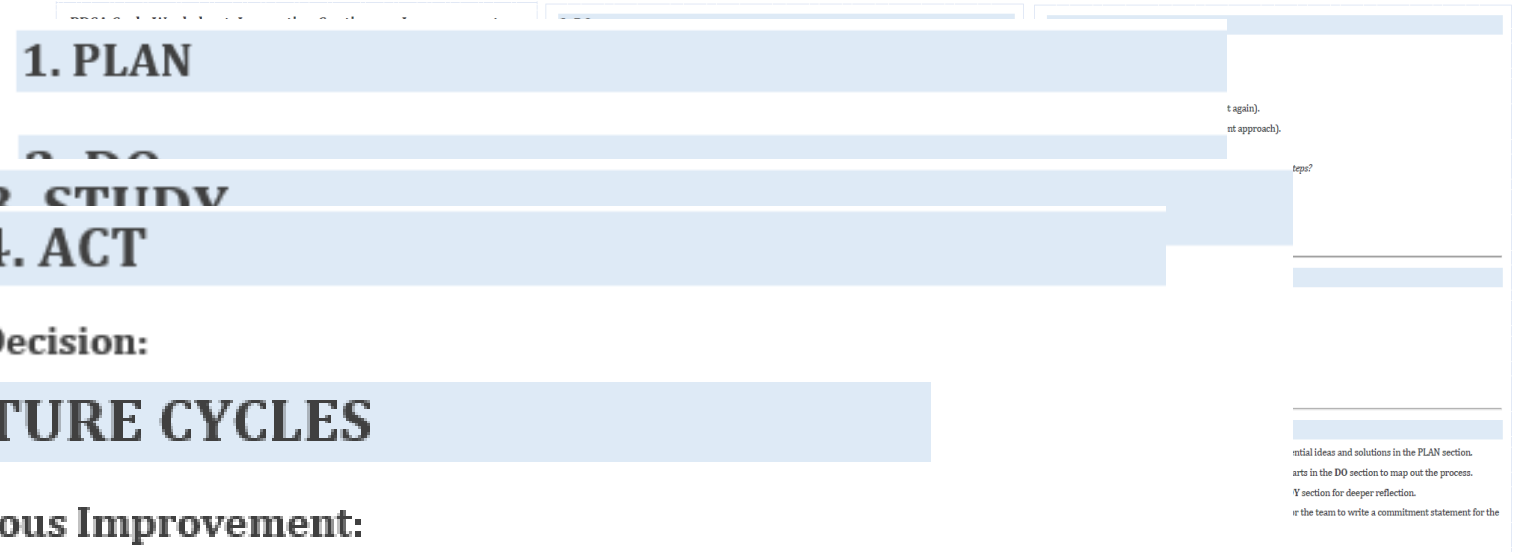
- PDSA Title
- **Detailed Description and Type** (continuation, revised, or new cycle)
- Date
- **Plan–**With tasks (who, when, tools needed, and measures)
- **Do**–What are we learning? Collect Data.
- **Study**–What happened? What do the measures tell us?
- **Act**–Abandon idea? Tweak/Adjust? Continue test? Implement?

PDSA Case Study

- **Problem:** Prescription refills not being addressed at time of patient appointments, resulting in multiple phone calls for refills, back and forth with provider, delays in refills, and stress on support staff and unhappy patients
- **Solution:** Have patients fill out prescription paperwork at appointment check in, listing their medications and when they need a refill. Provider can quickly review during appointment and process refills as needed.
- **PDSA Cycle #1:** Try out for one morning with two provider teams
- **Findings**: Patients could not accurately list their medications, and did not have time to complete paperwork before being called for their appointment. [illegible] mation that was already in the EMR.

What might have happened if this was rolled out across the entire clinic without a small test of change? How would it have impacted the healthcare staff? The clinical operations? The patients?

PDSA Worksheet



1. PLAN

4. ACT

Decision:

5. FUTURE CYCLES

Continuous Improvement:

How will you continue to improve on this process?

Ideas for Next Cycle:

What's the next area or process you want to focus on?

Celebration:

How will you celebrate your successes, big or small?

Which idea will you test first, and why?

PDSA Benefits

- Eases tension when resistant/anxious about change
- Increases confidence in the team and the process
- Helps build evidence for change, engages stakeholders, and increases buy-in
- Contributes to culture of continual improvement
- Fosters curiosity, teamwork, and innovation
- Empowers staff
- Provides safe space for staff to design and test improvement theories without fear of failure
- Allows for rapid testing results
- Reduces unnecessary delays, wasted resources, and frustration

PDSA Pro Tips

- Tests of change = Rapid and as small as possible
- Ensure team: “These are TESTS of change; nothing fully implemented without input and feedback.”
- Don’t get stuck in the “doing” phase (very common)
- Document observations and insights–a PDSA team journal, end of cycle huddle, etc.
- Remind team: “There is much to be learned in what does not work. Expect multiple PDSA cycles until goals are achieved.”
- Have fun and **celebrate success**!

References

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The improvement guide: A practical approach to enhancing organizational performance* (2nd ed.). Jossey-Bass.

Institute for Healthcare Improvement. (n.d.). *Plan-Do-Study-Act (PDSA) worksheet.* Institute for Healthcare Improvement. http://www.ihi.org

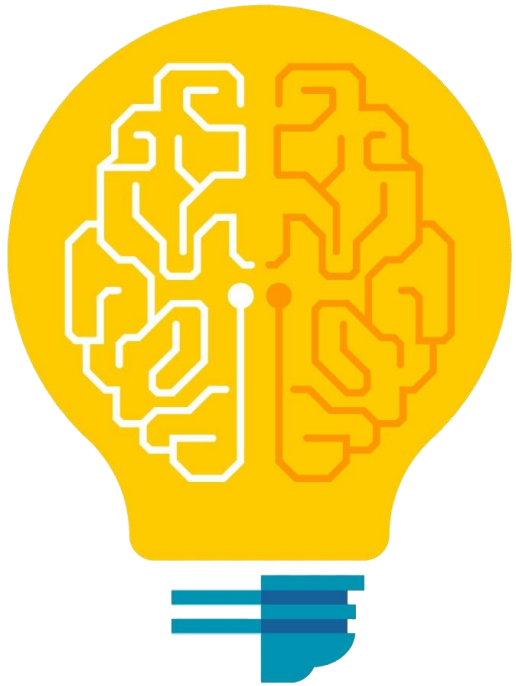
Deming, W. E. (1986). *Out of the crisis.* MIT Press.

NHS Education for Scotland. (n.d.). *PDSA worksheet.* Quality Improvement Zone. https://learn.nes.nhs.scot/

American Society for Quality. (n.d.). *Plan-Do-Check-Act cycle (PDCA).* American Society for Quality. https://asq.org

Thank You

- Continuous learning and application throughout program
- Office hours (we are here for you!)



Questions?

QI Coaching Office Hours

- **QI Coaching Office Hours for Module 4:**
  - September 24, 2024
  - October 8, 2024
- **Please come prepared to the session…**
  - Pick **one** of the following to report on:
    - What is one success your team has experienced? Please explain and show it in detail so others can try it with their groups.
    - What is one challenge your team is facing?
    - What is one question you have?

Post-Work Overview

- Post-work completed as a team:
  - Complete the Working with People: Stakeholder Analysis Exercise worksheet and work your way through the instructions to create your own stakeholder analysis on the writeable template.
    - » After creating your stakeholder analysis, discuss with your team your design for an effective participatory process with stakeholders.
  - Review the PDSA Cycle Worksheet with your team in conjunction with your Session 1 Data Collection table.
    - » Use this tool throughout the remainder of the series and as you are implementing your QI plan.
    - » This worksheet does NOT need to be submitted as post work.
  - Submit your stakeholder worksheet (only team leads need to submit)