

Weight MANAGEMENT

in Community Health:

Bridging Systems & Care Coordination

**System/Clinic
Transformation and
Sustainability**

Learning Collaborative Session #7



Today's Agenda

- Welcome
- Overview of Technology and Reminders
- System/Clinic Transformation and Sustainability
- Standardizing What Works
- Next Steps and Q & A



Technology: Your Zoom Window

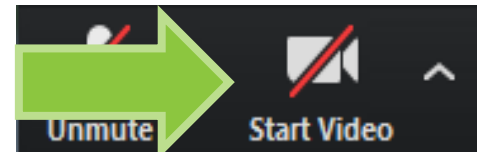
Sound

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



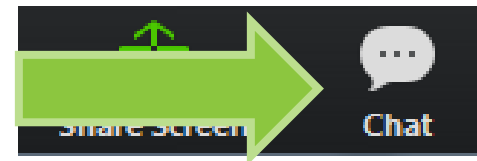
Webcam

- Please share!

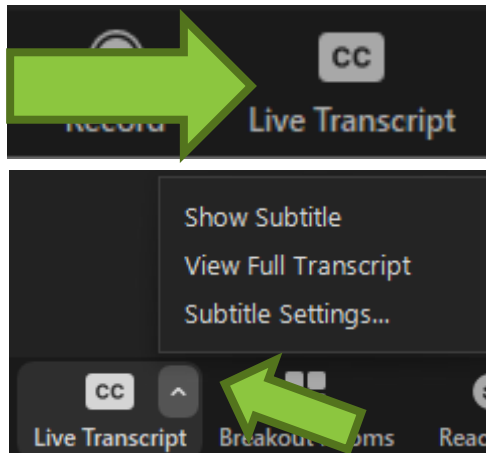


Chat

- Questions
- Sharing resources/ideas

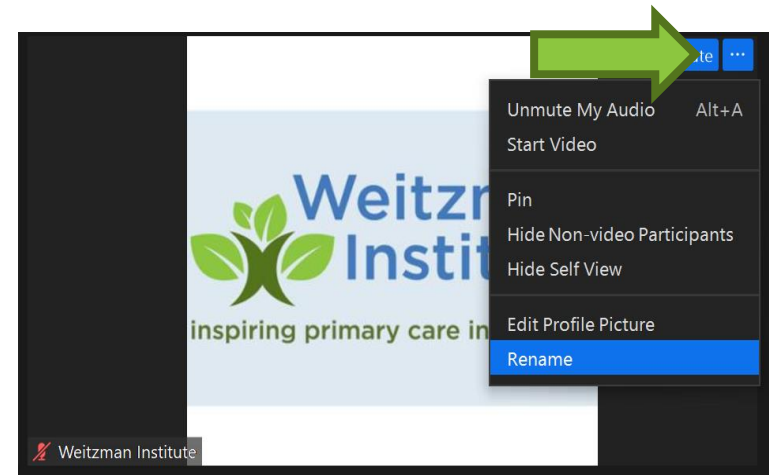


Technology: Your Zoom Window



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 6: Motivational Interviewing*
- 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

Weight Management in Community Health: Bridging Systems & Care Coordination



RAPID RECAP/KEY TAKEAWAYS

Learning Objectives:

- Identify barriers to diagnosing and treating obesity for patients in your healthcare center
- Evaluate various screening tools for obesity and determine their appropriateness in different clinical scenarios
- Create a comprehensive obesity treatment plan that incorporates a multidisciplinary approach for management

Process Mapping for Identifying Barriers:

- A flowchart is a visual representation of a workflow
- Typically focuses on current process
- Used to design optimized and future processes
- Helps to identify delays, bottlenecks, duplicate work, gaps, etc
- Begin by identifying start and end points

Tips for Designing Flowcharts:

- Limit flowchart to 6-9 steps to maintain a high-level overview
- Map out the most frequently occurring processes and avoid mapping infrequent steps
- Anticipate several meetings to complete this process
- Expect disagreements and involve other team members for clarification
- Use shapes, colors, and symbols to identify delays, roles, etc



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.

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.

You will be able to claim a comprehensive certificate on the WeP at the end of the series, December 2024.



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Disclosure

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the faculty listed above or other activity planners and any ineligible company in the past 24 months which would be considered a relevant financial relationship.
- The views expressed in this presentation are those of the faculty and may not reflect official policy of Moses Weitzman Health System.
- 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 are presented, 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



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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

- Define metrics of your health care center against key performance measures related to the obesity care
- Identify barriers to treating obesity for patients
- Formulate an improvement plan for establishing treatment plans for patients with obesity
- Develop a holistic care plan for patients with obesity



Session Learning Objectives

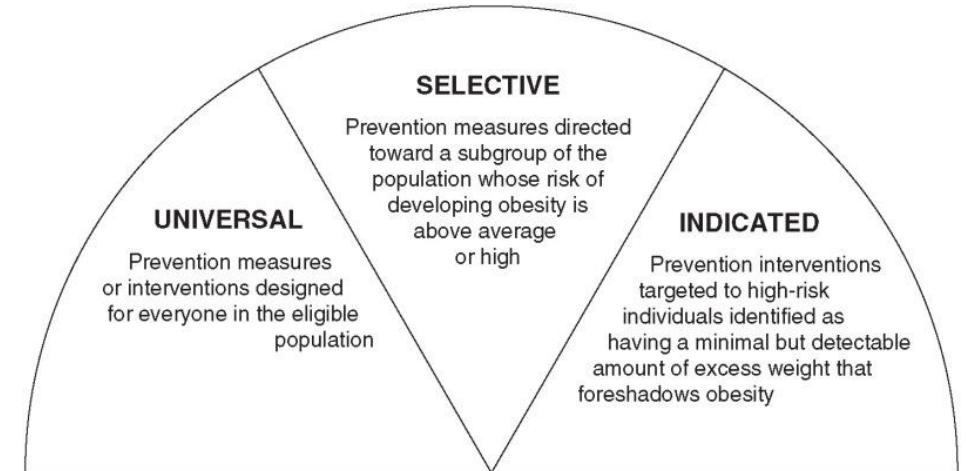
- Formulate an improvement plan for managing holistic care of patients with obesity in your health care center
- Identify the components of a comprehensive interdisciplinary approach to obesity treatment
- Evaluate the effectiveness of interventions in improving outcomes for patients with obesity



Strategies for Preventing/Managing Obesity Are Multifaceted

- Obesity is a complex issue and can be addressed through multiple types of interventions
 - Consider a multilevel approach
 - What is in your span of control?
- Systemic change can be initiated by:
 - Policy and legislative approaches
 - Organizational policies, environments, and practices
 - Fostering changes in communities and neighborhoods
 - Health communication and social marketing approaches
 - Interventions in health care settings

Types of Interventions



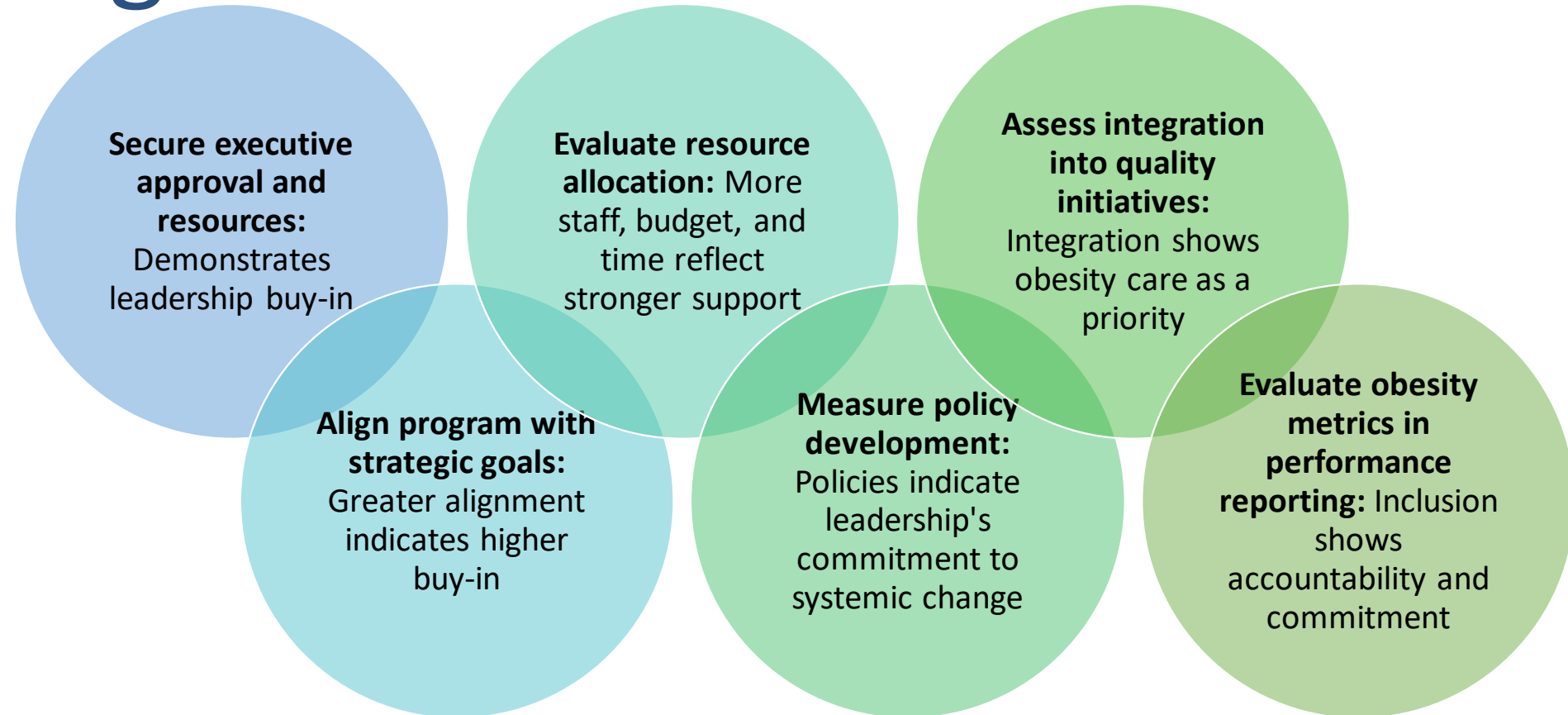
A Sustained Portfolio of Initiatives Is Necessary to Overcome Obesity



Dobbs R, et al. Overcoming obesity: An initial economic analysis. McKinsey Global Institute. November 2014.
<https://www.mckinsey.com/industries/healthcare/our-insights/how-the-world-could-better-fight-obesity>.



Steps for Implementing Systemwide Change



AMGA. Obesity Care Model Playbook. 2020. https://www.amga.org/getmedia/3cc7d6f4-b60e-4938-bb26-b3a4bb1f152b/ocmc_playbook_v9_links.pdf;
Chambers E, et al. Cultivating a comprehensive obesity program in primary care. AMGA Obesity Care Model Collaborative. White Paper. October 2020.
https://www.amga.org/getmedia/eb970f0e-1ebe-4e51-8e26-a77d9eab5cc5/AMGA_OCMC_White_Paper_FINAL.pdf



Engage Key Players Early

- To successfully implement a holistic obesity care program, it's crucial to gain engagement from key stakeholders
- Key stakeholders
 - Leadership team
 - Healthcare providers (physicians, nurses, dietitians, etc.)
 - Support staff
 - Patients

Engagement strategies should focus on educating stakeholders about the benefits of a holistic approach and addressing potential concerns



Gaining Engagement: Connect to Center Initiatives

- Demonstrate how the program contributes to improved patient outcomes and satisfaction

Aligning with quality metrics



- Highlight the program's role in addressing a major public health concern

Supporting population health initiatives



- Position the center as a leader in comprehensive obesity care

Enhancing reputation



- Use the program as a platform for research and continuous improvement in obesity treatment

Fostering innovation



AMGA. Obesity Care Model Playbook. 2020. https://www.amga.org/getmedia/3cc7d6f4-b60e-4938-bb26-b3a4bb1f152b/ocmc_playbook_v9_links.pdf;
Chambers E, et al. Cultivating a comprehensive obesity program in primary care. AMGA Obesity Care Model Collaborative. White Paper. October 2020.
https://www.amga.org/getmedia/eb970f0e-1ebe-4e51-8e26-a77d9eab5cc5/AMGA_OCMC_White_Paper_FINAL.pdf



Comprehensive Interdisciplinary Care



Developing a Comprehensive Playbook

Define

- Define clear goals, timelines, and metrics for success

Outline

- Required resources
- Financial considerations
- Staffing and training needs

Develop

- Patient flow
- Protocols for documenting patient care: identification, referral, care coordination, management

AMGA. Obesity Care Model Playbook. 2020. https://www.amga.org/getmedia/3cc7d6f4-b60e-4938-bb26-b3a4bb1f152b/ocmc_playbook_v9_links.pdf;
Chambers E, et al. Cultivating a comprehensive obesity program in primary care. AMGA Obesity Care Model Collaborative. White Paper. October 2020.
https://www.amga.org/getmedia/eb970f0e-1ebe-4e51-8e26-a77d9eab5cc5/AMGA_OCMC_White_Paper_FINAL.pdf



Assess the Current State to Inform Goals, Timeline, and Metrics

- Review existing obesity care protocols and services offered
- Evaluate staff knowledge and training on holistic obesity management
- Assess current multidisciplinary team structure and roles
- Analyze patient outcomes and satisfaction data related to obesity care



Resource Needs

- Assess current resources and identify additional needs (e.g., equipment, space)
- **Ensure availability of appropriate-sized equipment such as:**
 - Scales that can accurately weigh patients up to 500 lbs or more
 - Blood pressure cuffs in various sizes, including extra large
 - Examination tables and chairs rated for higher-weight capacities
 - Wider doorways and hallways to accommodate larger patients and mobility aids
- **Consider allocating a dedicated area for obesity management services, which may include:**
 - Private consultation rooms for sensitive discussions
 - Exercise rooms for physical activity assessments and demonstrations
 - Kitchen facilities for nutrition education and cooking demonstrations

Sheer AJ, Lo MC. Counseling Patients With Obesity. [Updated 2023 Feb 9]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK589679/>; Medical office equipment designed for patients with obesity. https://www.amga.org/getmedia/c326b344-257a-4014-8312-909c13baae75/medical_office_equipment_designed_for_patients_in_obesity.pdf; VHA CEOSH. Bariatric Safe Patient Handling and Mobility Guidebook. <https://asphp.org/wp-content/uploads/2011/05/Baraiatrice-SPHM-guidebook-care-of-Person-of-Size.pdf>



Financial Considerations

Engage finance team in creating a pro-forma

Analyze which personnel and equipment costs have a payor source and which don't

Consider bundling non-reimbursable services with other services that generate revenue

Create efficiencies to optimize billable services while ensuring regulatory compliance

Ensure staff are working at top of license

Know payor requirements—for example, how many different types of providers can bill on the same day, are group visits billable, and is obesity a covered diagnosis?

Ask

Is grant or research funding available?

Are interventions like medications, RD visits, and surgery affordable for patients?

Are community resources available, such as discounted gyms and healthy food?



Staff Training



Train staff on **proper use of specialized equipment** like larger blood pressure cuffs and scales



Train on proper **coding and documentation** for obesity-related visits



Educate on **capturing quality measures** related to obesity care



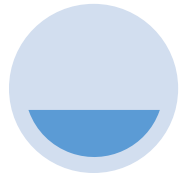
Create procedures for **identifying and addressing** equipment needs in advance



Provide training on using **person-first, non-stigmatizing language** when discussing weight



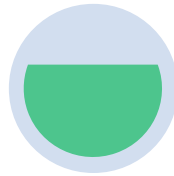
Patient Flow



Initial Assessment:

Conduct comprehensive evaluations during the first visit

Use standardized questionnaires to gather patient-reported outcomes

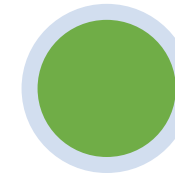


Treatment Planning:

Set realistic weight-loss goals with the patient

Develop an individualized care plan

Include other specialists as needed



Follow-up process:

Schedule regular follow-up appointments

Monitor and document:

- Weight changes
- Improvements in comorbidities
- Adherence to treatment plan
- Side effects of any medications

Reassess and modify treatment plan as needed



Patient Care Documentation



Implement a comprehensive EHR system that allows all team members to access and update patient information



Create standardized templates for obesity-related visits to ensure consistent documentation across providers



Schedule regular multidisciplinary team meetings to discuss complex cases and coordinate care; use secure chat group or email group for questions



Patient Communication

Provide patients with access to a secure online portal where they can:

- View their care plan and goals
- Message their care team
- Access educational resources
- Log self-monitoring data (e.g., weight, food intake)

Designate a primary point of contact (e.g., care coordinator) or process that fits your organization to streamline patient communication:

- Schedule appointments with various team members
- Relay messages between patients and providers
- Ensure patients understand their care plan



Team Members and Responsibilities

	Clinical	Lifestyle	Community	Data/IT	Operations/Finance
Responsibilities	Identify and treat the medical needs of patients with obesity	Address the behavioral, physiological, nutritional, and physical activity aspects of patients with obesity	Establish and maintain relationships with external facilities for patient referrals	<p>Implement, test, and refine success metrics: Continuously improve performance measures</p> <p>Use patient portal (if available): Enhance communication with patients through the portal</p> <p>Develop or utilize a patient registry: Track and monitor patient progress effectively</p>	Ensure compliance with billing and coding; manage insurance; focus on business development, marketing, staffing, and operations; and address physical space requirements
Team Members to Consider	Primary care physician Specialist Advanced practice clinician Nurse, care manager QI specialist Bariatric surgeon (or access)	Social worker Nutritionist Behavioral health specialist Exercise physiologist Certified health coach	Community health nurse, Case manager, Certified health coach, Nurse, Referral specialist	Data/IT analyst	QI specialist Billing and coding manager Project manager Process improvement

AMGA. Obesity Care Model Playbook. 2020. <https://www.amga.org/performance-improvement/best-practices/collaboratives/obesity-care-model/>



Evaluating Effectiveness of Interventions



Tracking Clinical Outcomes for Adults With Obesity

Weight

- If using medical or surgical approach
- Percent weight loss from maximum weight
- Percent weight loss from weight at start of program
- Weight maintenance

Change

- Blood pressure
- HbA1c
- ALT
- LDL
- Triglycerides
- Abdominal circumference
- Fitness testing (grip strength, get up and go, step test, etc.)

Screening

- PHQ-2, PHQ-9
- GAD-7
- Perceived Stress Scale
- Epworth Sleepiness Scale
- STOP-Bang Questionnaire

AMGA. Obesity Care Model Playbook. 2020. <https://www.amga.org/performance-improvement/best-practices/collaboratives/obesity-care-model/>; The New Hampshire Department of Administrative Services. Perceived Stress Scale: <https://www.das.nh.gov/wellness/docs/percieved%20stress%20scale.pdf>; Epworth Sleepiness Scale: <https://www.cdc.gov/niosh/work-hour-training-for-nurses/02/epworth.pdf>; Chung F, et al. *Anesthesiology*. 2008;108(5):812-821; STOP-Bang Questionnaire. <http://www.stopbang.ca/osa/screening.php>.



Measuring Satisfaction and Engagement



Patient
satisfaction scores



Self-assessment of
confidence with
lifestyle change or
chronic disease
management



Number of visits
or group sessions
completed

Measuring Satisfaction and Engagement

AMGA. Obesity Care Model Playbook. 2020. https://www.amga.org/getmedia/3cc7d6f4-b60e-4938-bb26-b3a4bb1f152b/ocmc_playbook_v9_links.pdf; Chambers E, et al. Cultivating a comprehensive obesity program in primary care. AMGA Obesity Care Model Collaborative. White Paper. October 2020. https://www.amga.org/getmedia/eb970f0e-1ebe-4e51-8e26-a77d9eab5cc5/AMGA_OCMC_White_Paper_FINAL.pdf



Future Directions

Plan

- Plan for scalability

Consider

- Additional interventions
- Special populations
- Age groups

Improve

- Clinical outcomes
- Patient experience
- Revenue
- Community perception



Key Takeaways

- Take time to plan for
 - Data
 - Finances
 - Clinical outcomes
 - Scalability upfront
- Engage stakeholders and partners
- Create a multidisciplinary team
- Don't let perfect be the enemy of good in getting started
- Work on efficiencies

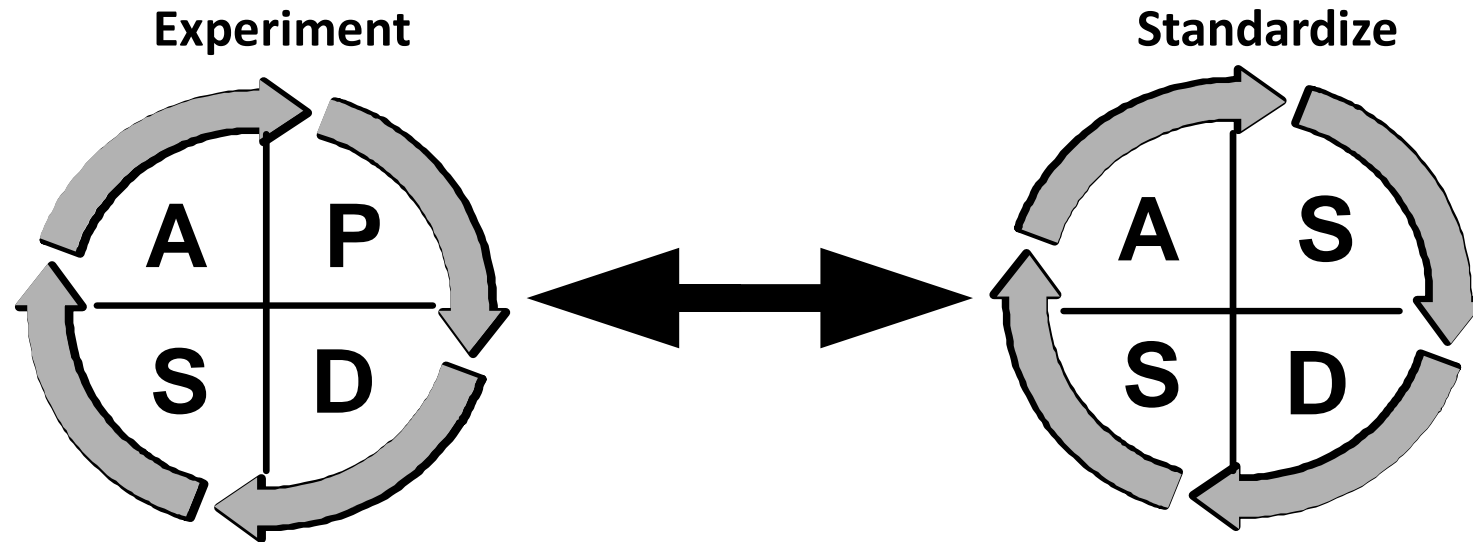


Standardizing What Works

Sustaining Quality Improvement



PDSA → SDSA



PDSA

Plan Do Study Act

Small tests of change. Experiment & test new workflows to identify if changes are resulting in an improvement.

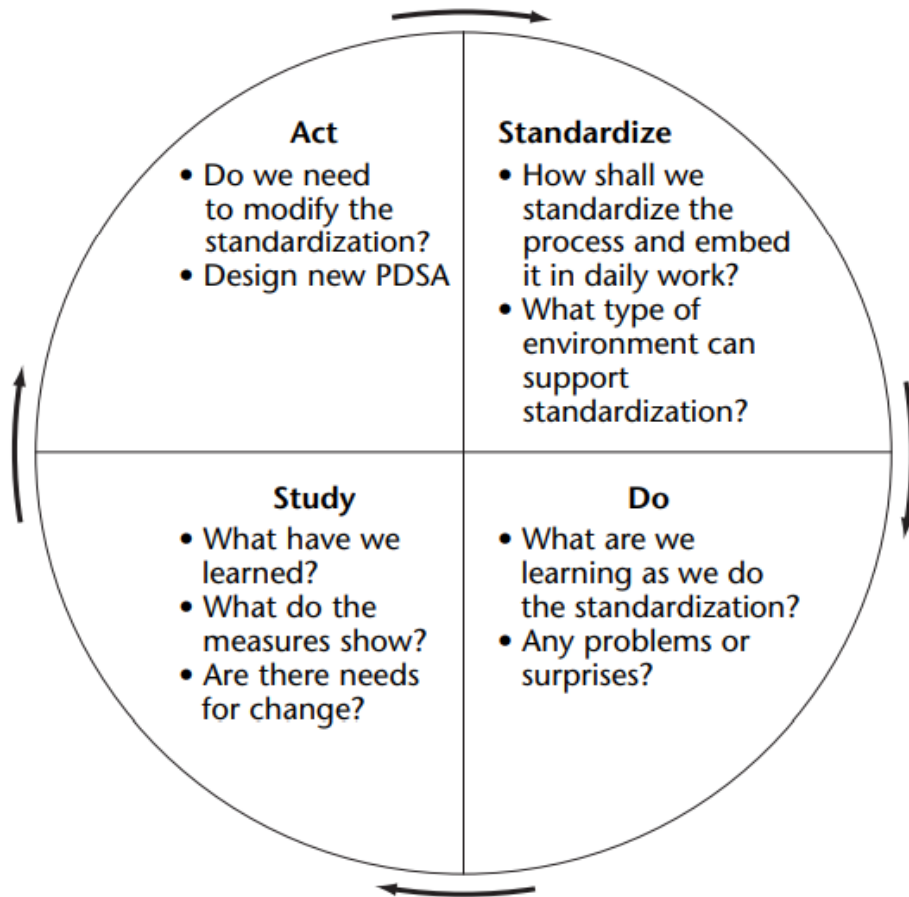
SDSA

Standardize Do Study Act

Ingrain and sustain positive results. Across providers, practices, and teams.



The SDSA Cycle



Standardizing Gains— Deciding When

Identify when it's time to standardize your gains

- The improvement team has achieved stated objective
- Stakeholders are supportive of initiative
- You've celebrated your success!



Standardizing Gains—Approaches



Share, Spread, and Celebrate Success

- Connect to your “why”
- Multiple messages, multiple ways (email, meetings, newsletters, story boards)
- Provide data to support your work



Add to your Playbook/SOPs

Clinical workflows of who does what, and when
Integrate into new employee training



Audit the Process

Decide who will do the audit– leadership, or staff who are semi-compliant (!)
Adjust audit schedule based on results (weekly, quarterly, annually)





Sustaining Gains Clinical Example



PDSA–SDSA Example

PDSA Goal

- Improve management of patients with HTN

Findings

- MAs not properly trained on taking BP measurement results in false-positive HTN diagnosis

Improvement Plan

- Train all MAs on BP measurement

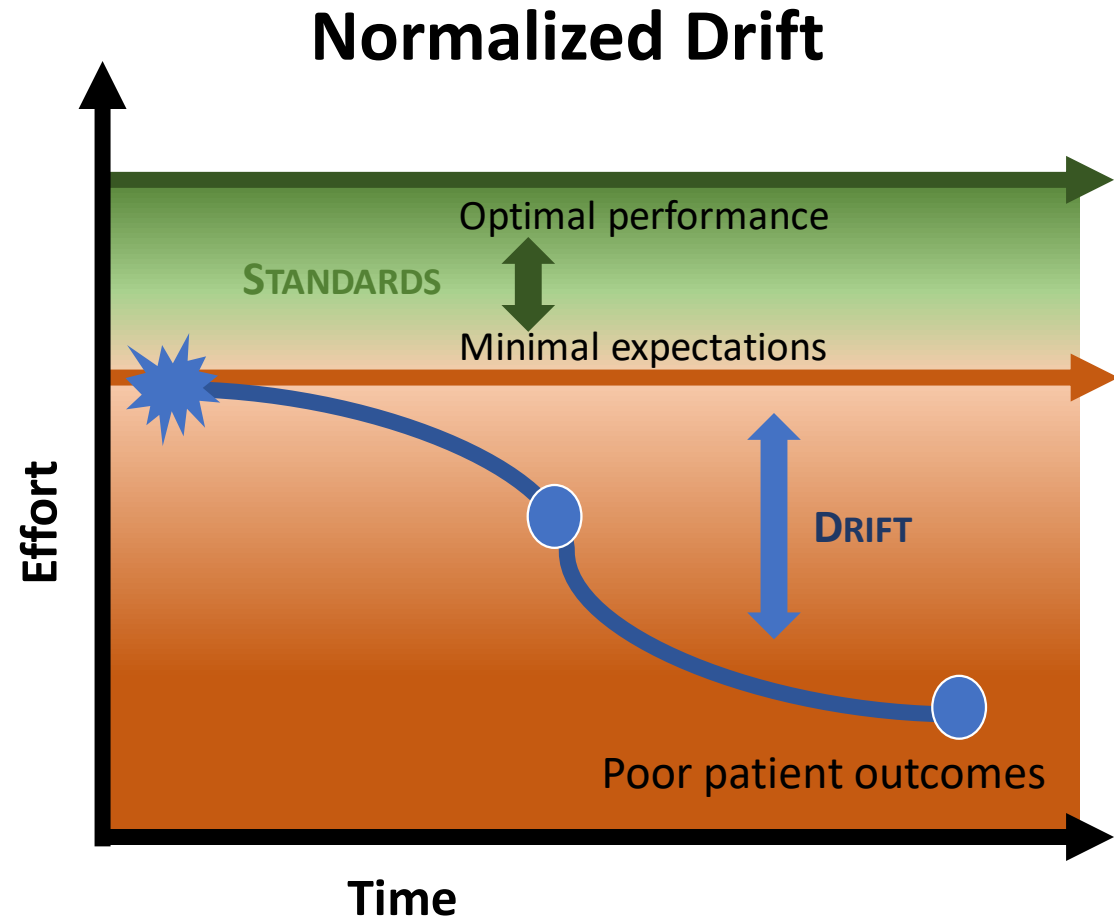
Results

- Excellent buy-in, support, and results!



Sustainability Plan: Why?

Without a plan to sustain gains, what would happen 3 years down the road?



Sustainability Plan: Developing a Plan

Determine:

- Who will audit?
- How often would you audit?
- How would you know that the change is being sustained?



And the Cycle Continues...

- SDSA today will be a springboard for further improvement initiatives down the road
- Nothing is carved in stone—even best practices change and develop over time

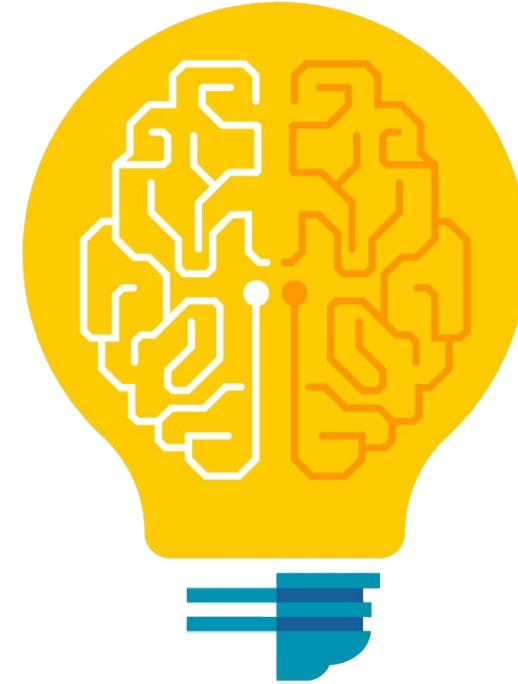
How to sustain momentum
and engagement with
continuous change?

Post work has a PDSA cycle worksheet template
that can be used for each iteration



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 7:**
 - November 26, 2024
 - December 10, 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:
 1. Review and complete the provided PDSA template with the plan for your team's QI initiative.
 - A. Use the example provided as a resource when filling out the template.
 2. Ensure that your plan is clear and comprehensive as each health center team will present specific highlights from their plan in a 3-minute presentation during the Learning Collaborative Live Session 8 on 12/18/2024.
 - A. Be sure to focus on the questions highlighted in red text with the note "your response from this section will be used for LC 8 presentation," as these will be the key points for your presentation.
 3. Submit your template as post-work (only the team lead needs to submit). Your completed PDSA template will serve as post-work for module 7 and preparing your presentation from this PDSA plan will serve as pre-work for module 8.

Post-work due by December 11, 2024

