Integrating Primary Care Practices and Community-based Programs to Manage Obesity (TO #21 Clemente)

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Workshop Agenda

- Welcome and overview
- Context
  - Why do linkages matter?
  - Personal experiences with linkages
- Highlights from Clemente Project
  - Background and study aims
  - Baseline assessment findings
  - Lincoln County Case Study
- Discuss findings and strategize next steps
- Take home lessons: What will you apply in your community?

Question:

What is the importance of creating linkages between primary care clinics and community-based resources?

The Realities of Primary Care for Office-based Physicians in the US

- 994 millions visits/yr - reason for visit [1]
  - 40% chronic conditions - follow up/flare-up
  - 33% new problems
  - 20% preventive care

- Based on typical panel 2,500 patients [2,3]
  - Care for chronic diseases = 10.6 hr/day
  - Recommended preventive care = 7.4 hr/day
  - (not including care for acute conditions, filling in forms, being outside exam room, phone calls, etc)

[1] National Ambulatory Medical Care Survey 2005/6
[2] Yarnell Am J Pub Health 2003
[3] Østbye Ann Fam Med 2005

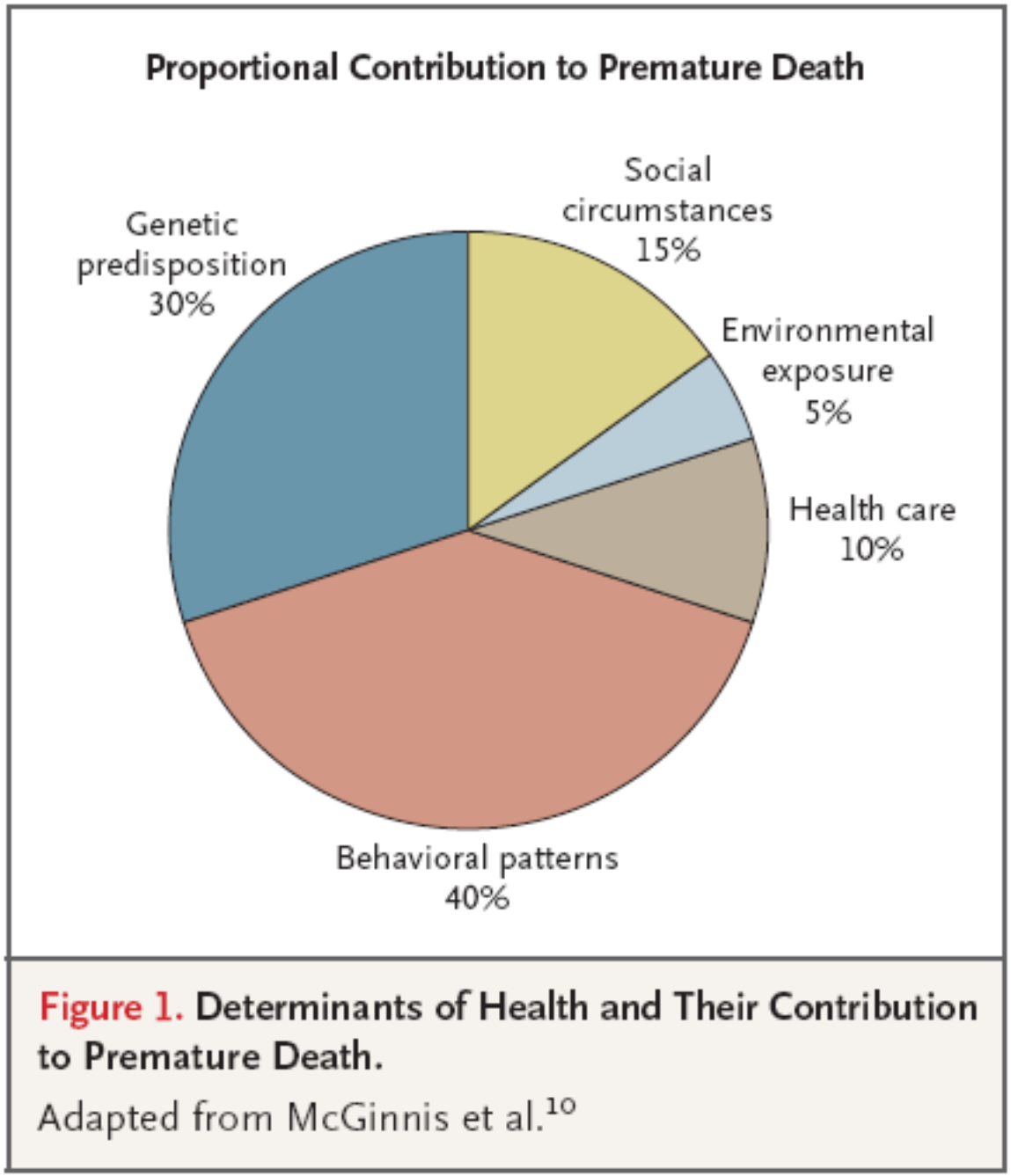


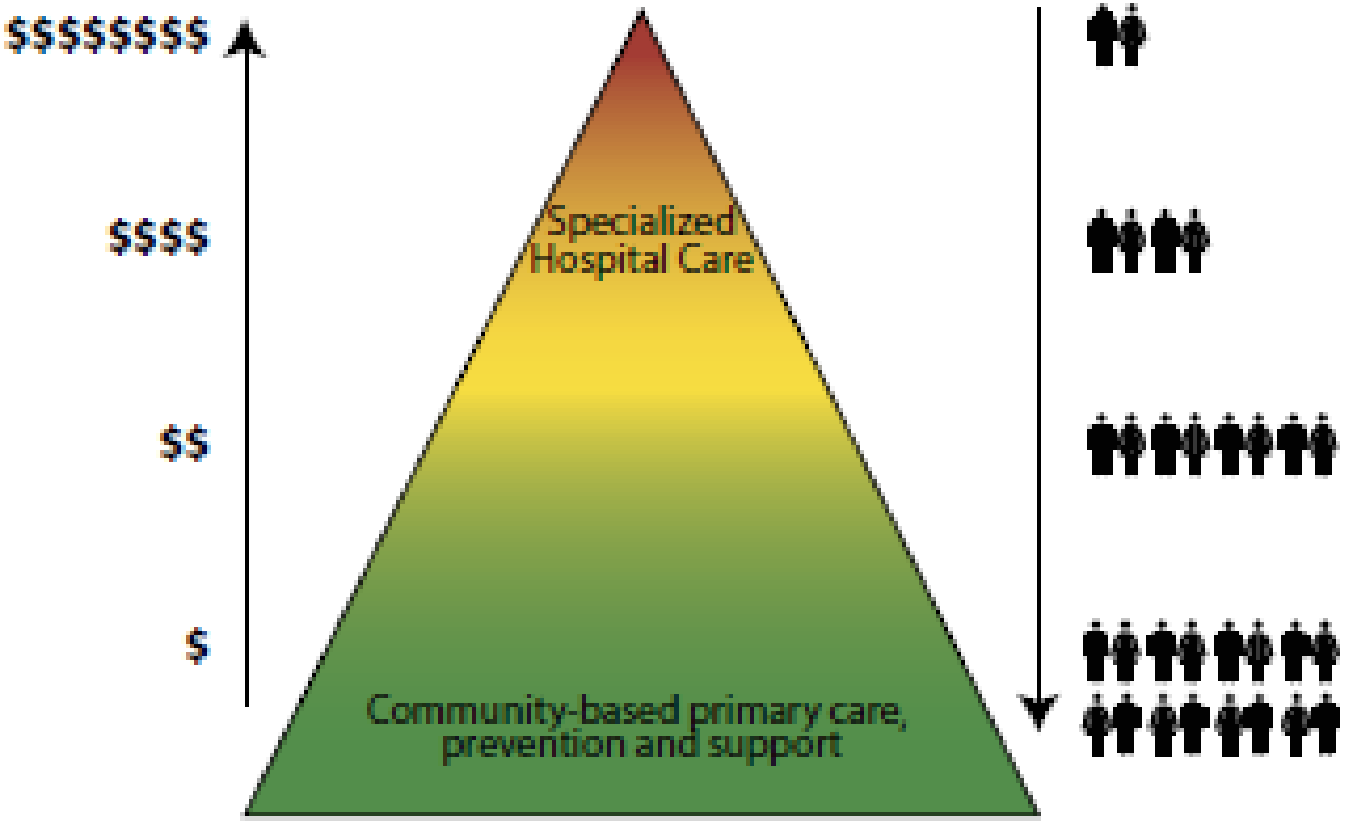
Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.[10]

Schroeder. N Engl J Med 2007; 357:1221-8.

McGinnis et al. Health Aff (Millwood) 2002; 21(2):78-93.

Community-Based Health Service Capacity



Most people get most of their care, most of the time, in the community. The cost of care increases the more specialized it becomes.

There is a basic need for linkages

- Health Reform/Practice Change Initiatives
  - The Patient Centered Medical Home (and care coordination)
  - Accountable Care Organizations (or Coordinated Care Organizations in Oregon)

- Examples of linkages
  - Specialist referral
  - Preventive Services (colonoscopy, mammography, cholesterol screening…)

Small-Group Breakout – Referral Personal Experiences

- Reflect on the following 3 questions:
  - As a patient, have you ever had a health-related referral to an organization outside the clinic? How did the referral work and what was the outcome?
  - How would you respond if you receive a referral from your primary care clinic to a community-based resource for weight management or health behavior change?
  - What characteristics are necessary in order to create and sustain effective linkages between primary care clinics and community based resources (e.g., Awareness? Feedback? Referral process?)

- Have one individual give a brief report out

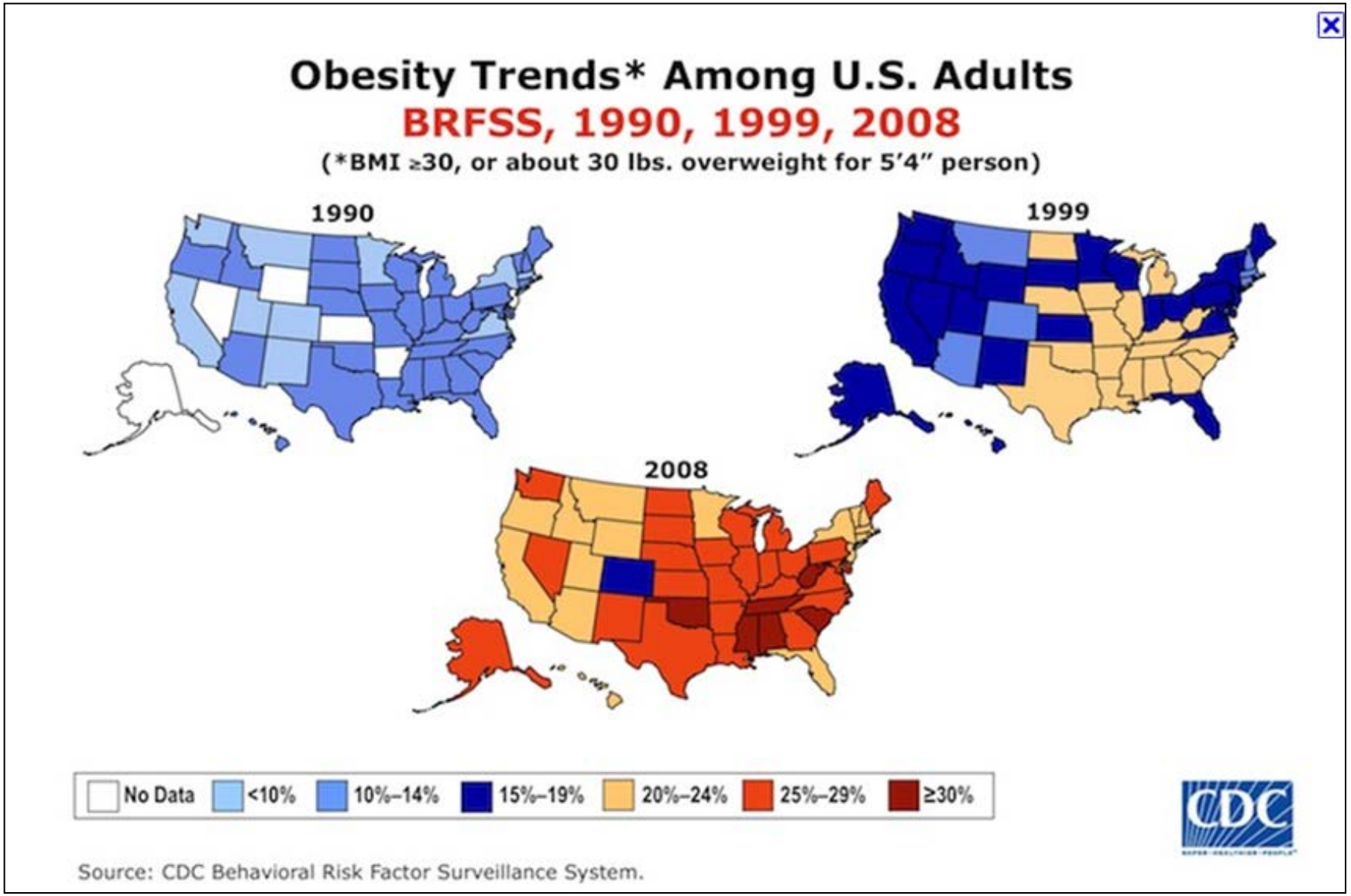
Highlights from the Clemente Project

Clemente Aims

- Use an iterative, participatory research approach to develop, describe, and disseminate *a process* to facilitate sustainable linkages between clinics and communities in the management and treatment of obese patients.

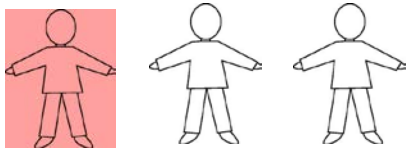
- To meet these goals, we propose the following aims:
  - AIM 1: Determine the **predisposing, reinforcing and enabling factors** necessary to develop sustainable linkages between primary care and community resources for obesity management.
  - AIM 2: **Design, implement and evaluate** an adaptable, reproducible, and sustainable process for developing linkages between primary care clinics and community resources to manage obese patients in diverse rural communities.
  - AIM 3: **Develop, evaluate and widely disseminate an implementation guide** to improve clinic and community partnerships for obesity management based on findings from aims 1 and 2.

Background/Context

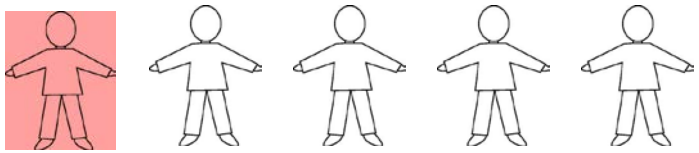


Obesity rates and health

- One in three adults are obese



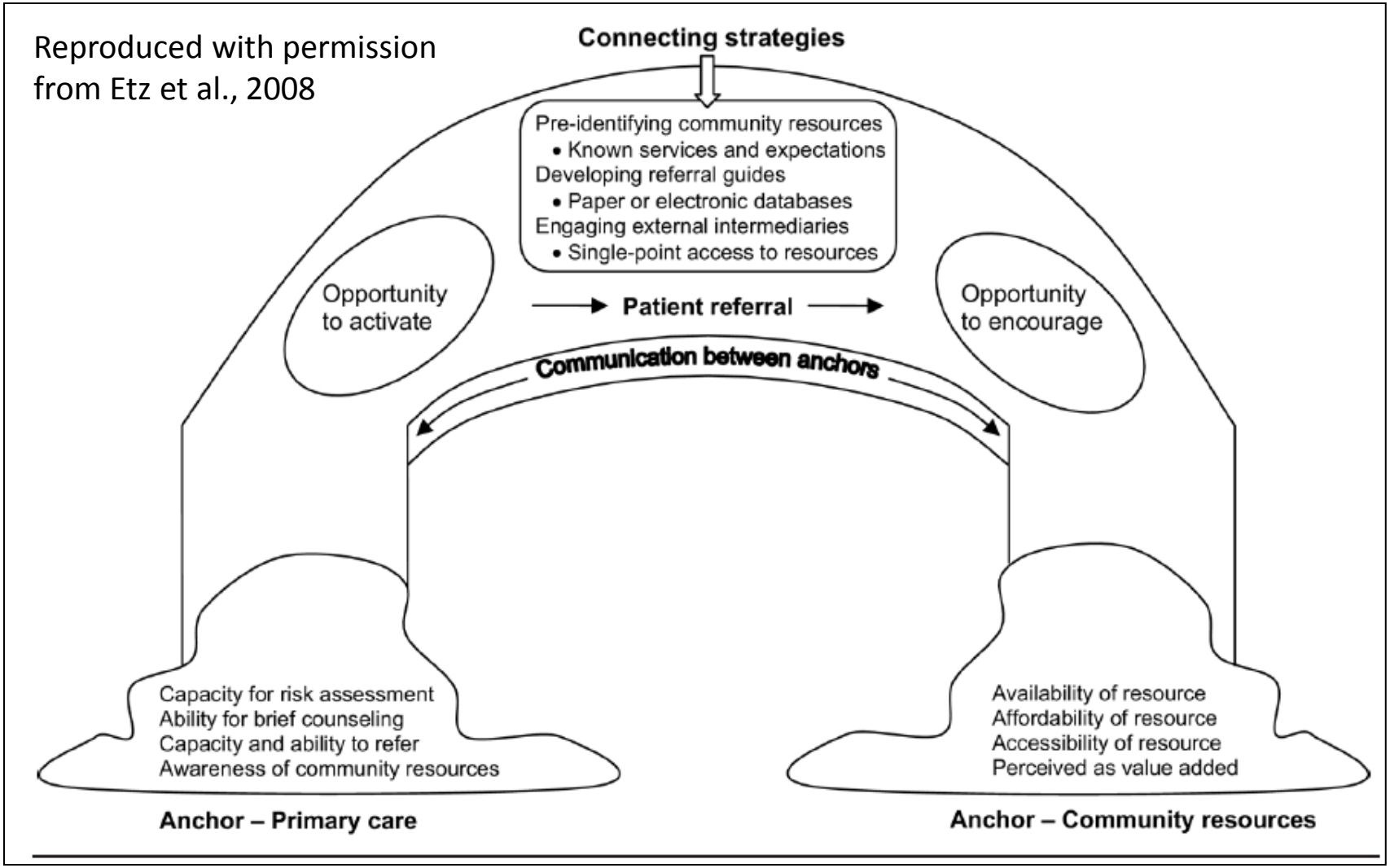
- One in five children and adolescents are obese



- The epidemic may be especially severe in rural areas!!
- Obesity is associated with…
  - leading causes of morbidity and mortality in the US
  - stigmatization, discrimination → emotional problems
- Primary care presents important opportunity to treat obese patients (and encourage prevention)

Bridging Primary Care with Community Resources: Model Elements

Reproduced with permission from Etz et al., 2008

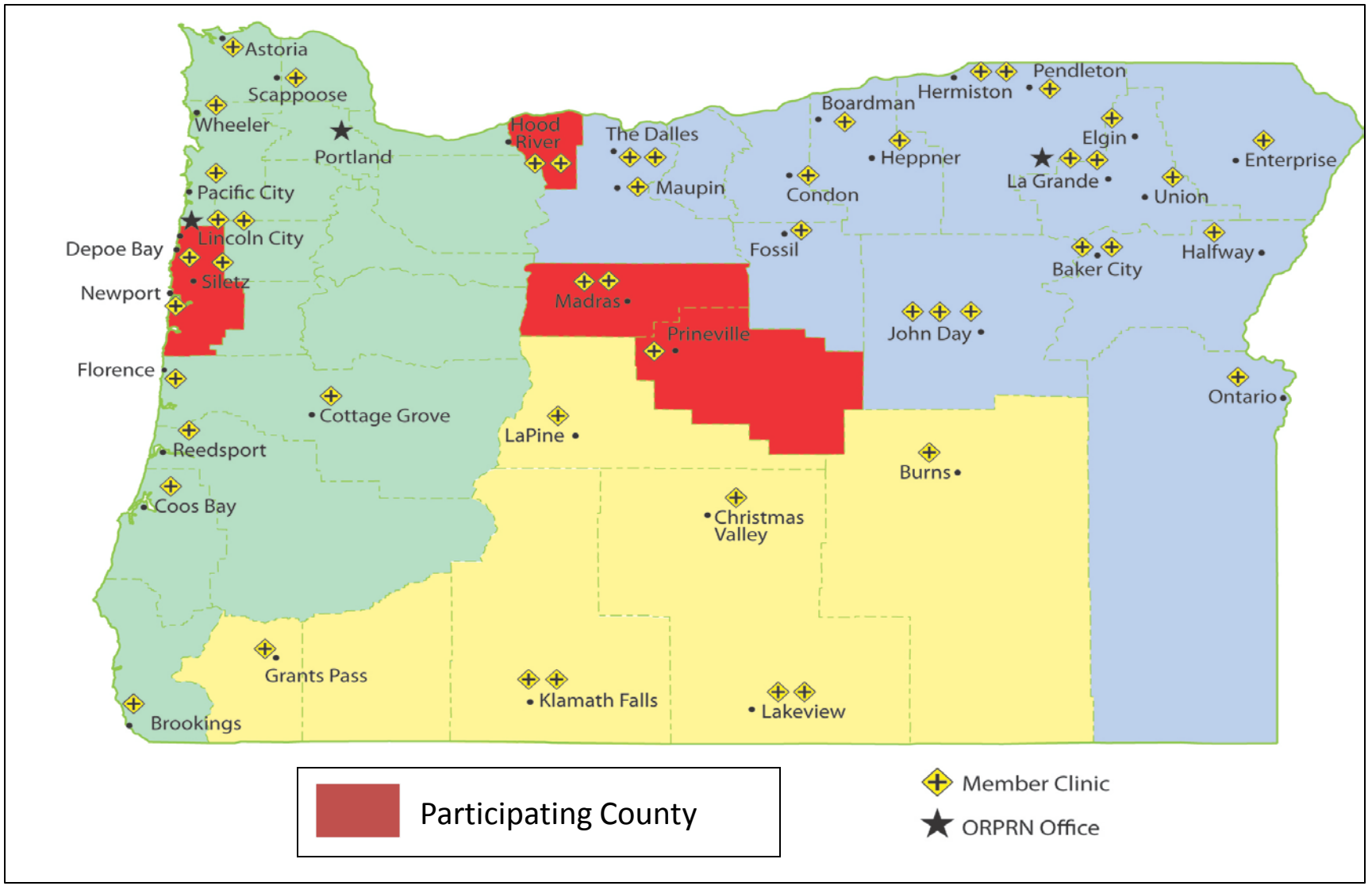


Clemente Project Steps

- Phase 1: Stakeholder Engagement and Randomization
- Phase 2: Baseline Assessment
- Phase 3: Intervention Alignment
- Phase 4: Intervention Implementation
- Phase 5: Maintenance

Overarching: Evaluation and Reflection

Phase 1: Stakeholder Engagement & Randomization



Phase 2: Baseline Assessments

- **Focus Groups**
  - Community Group Participants (*N* = 36)
  - Clinic Group Participants (*N* = 44)
- **Waiting Room Patient Survey (*N* = 382)**
  - To all presenting patients (adult patients <90 years; parents of children 6-18 years) prior to project initiation
- **Clinic Chart Audits (*N* = 799)**
  - Random selection of patients, age 6 – 89 years, seen at each clinic between 3/1/2010 – 8/31/2010

Focus Group Results: Key Findings

Focus Group Results – Part 1

- Overweight and obesity as significant regional health concerns
- Weight falls along a continuum – people who are overweight or obese generally “know it”
- Primary care as a potential resources for weight related conversations
  - Sensitive topic
  - Focus on “healthy lifestyles” and “healthy weight”

Focus Group Results – Part 2

- Views regarding weight discussions varied
  - Clinicians felt they addressed weight
  - Community members felt they addressed the disease
  - Clinic staff said patients initiate the conversation
- Weight related discussion may not happen because: limited time, clinicians lack a ready solution, and the potential to lose a patient
- Behavior change requires support – just saying “lose weight” is not enough, patients may need to be shown “how to do something”

Focus Group Results – Part 3

- Community members wanted time with their doctor – but would accept referrals or help from staff – if handled smoothly
  - Tailored referrals necessary
  - “one size doesn’t fit all”
- Lack of insurance coverage and community-based resource awareness as barriers for referral

Waiting Room Survey Results (*N* = 382)

Demographic Characteristics	Overall
Male Gender	35%
Mean Age in years	48

- 29.4 Mean BMI
- 64% % overweight or obese (BMI ≥ 25 kg/m^2)
  - 81% % report they are “somewhat” or “very” overweight
  - 87% % currently or intend to start losing weight
  - 38% % are “interested” or “very interested” in getting help from primary care to connect with weight management resources.
  - 57% % “Never or rarely” had conversations with clinicians about weight in the past year

Chart Audit Results (*N* = 799)

- Demographic Characteristics

Characteristic	Overall
Male Gender	34%
Mean Age (SD)	47 ± 21
<19	27%
20-49	25%
50-64	24%
65-74	14%
>75	10%

- % of patients with any recorded BMI:
  - Males 25% (Range 0 – 61)
  - Females 24% (Range 1 – 74)
- Why???
  - Weight present but height missing in 70-80% of patient charts
  - Like the insurance companies say: *"If it's not in the chart…it didn't happen."*

Chart Audit Results

- Patients with Documented Medical Problems
  (select conditions)

Condition	Overall
Hypertension (High Blood Pressure)	32%
Dyslipidemia (High Cholesterol)	24%
Depression	18%
Diabetes (Type I & II)	14%
Asthma	11%
Arthritis	6%
Overweight	6%
Obese	12%

- **Recall:** Although not accurately available from the chart audit, based on waiting room survey data ***64% of patients have a BMI ≥25 (overweight or obese)***.

Chart Audit Results

- Percent of Patients Receiving Health Behavior Change Counseling During Any Visit (as documented) Data excluded from Jefferson & Crook County for BMI>30 because of missing scores
  - Weight: 16% (45% BMI ≥30)
  - Diet: 25% (41% BMI ≥ 30)
  - Exercise: 21% (44% BMI ≥ 30)

- Documented weight management referral
  (includes any referral for diet, exercise, or weight)

	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Overall
N (% of all patients)	2 (2%)	4 (3%)	1 (1%)	3 (2%)	1 (1%)	0	11 (1%)
N (% BMI ≥ 25)	1 (2%)	4 (6%)	1 (2%)	1 (17%)	0	0	7 (3%)

Phase 3: Intervention Alignment

First - A meeting (in the local community) with clinic and community representatives to review baseline assessment data and discuss next steps

Second - Follow-up by ORPRN PERCs and community partners with the clinics to “do the work”

Phase 4: Intervention Implementation

- Case study of Lincoln County - Lessons from the field…
  - Community resource list
  - “Academic detailing” of resources
  - Improving clinic screening, brief counseling approaches
  - Developing/streamlining referral process

It’s a process (practice) not a home run!

Lessons From the Field: Lincoln County Case Study

1st Pitch: Community Resource List

- 1st Base: Recruiting volunteers
- 2nd Base: Connecting with Resources
- 3rd Base: Engaging with Resources
- Home Plate: Resource List Developed!
- **Ideal* Home Run: Full Participation & Playing Nice

2nd Pitch: *Academic Detailing* of Resources

- 1st Base: Clinic Review of Resource List
- 2nd Base: Clinic Choice of Resource
- 3rd Base: Presentations to Clinic Staff
- Home Plate: 2 Presentations!!
- **Strike-Outs*: scheduling, interest & commitment, comfort

3rd Pitch: Improving Clinic Screening, Brief Counseling Approaches

- 1st Base: Need to Collect ***both*** Height & Weight at Each Visit
- 2nd Base: Changing Height Measurements at Each Appt.
- 3rd Base: Document Everything!!
- Home Plate: Document Referrals to Community Resource
- **HOME RUN*: Clinics realized what they need to do to efficiently collect BMI data.

4th Pitch: Developing/Streamlining Referral Process

- 1st Base: Referral System ***Not*** in Place
- 2nd Base: Lack of Coordination
- 3rd Base: Limited ***New*** Referrals
- Home Plate: Referrals are Taking Place
- **HOME RUN*: Dialogue is Beginning!!

Reflections

- What are strategies to overcome challenges or build on successes in Lincoln County?

- How might building these linkages be similar or different in your community?

Take Home Lessons

- Based on this workshop - What will you apply in your community?