

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

Proportional Contribution to Premature Death

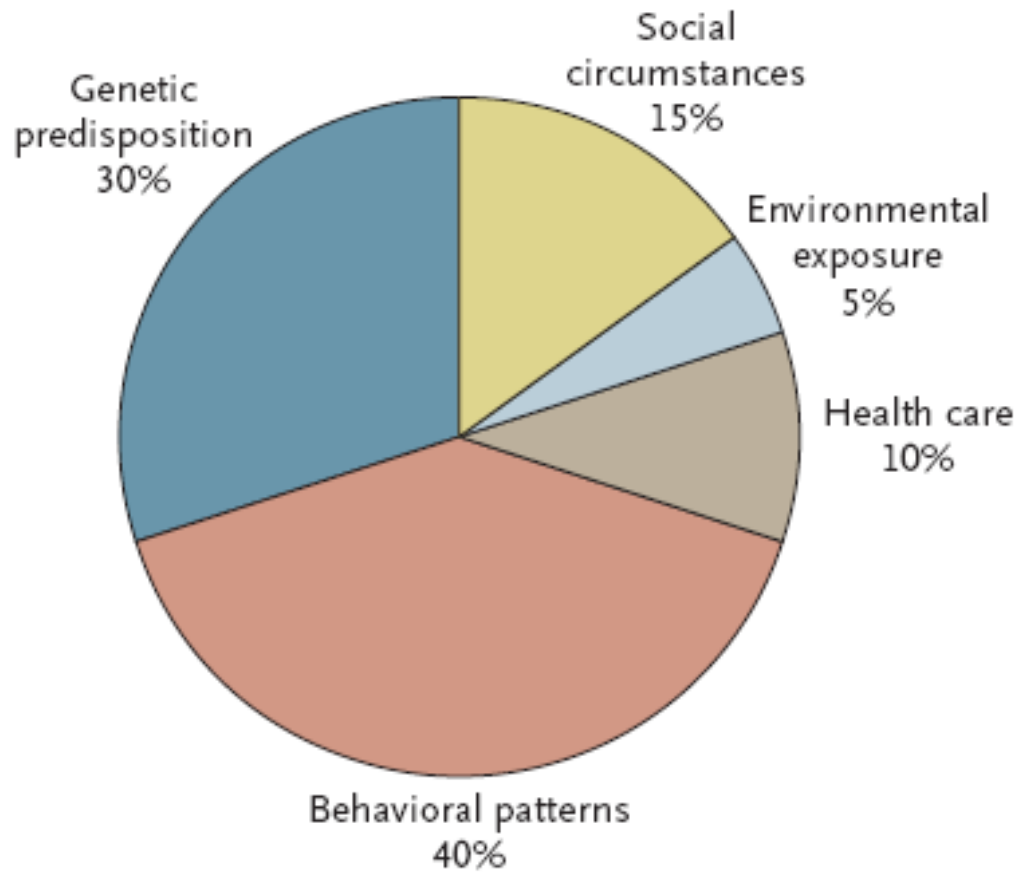


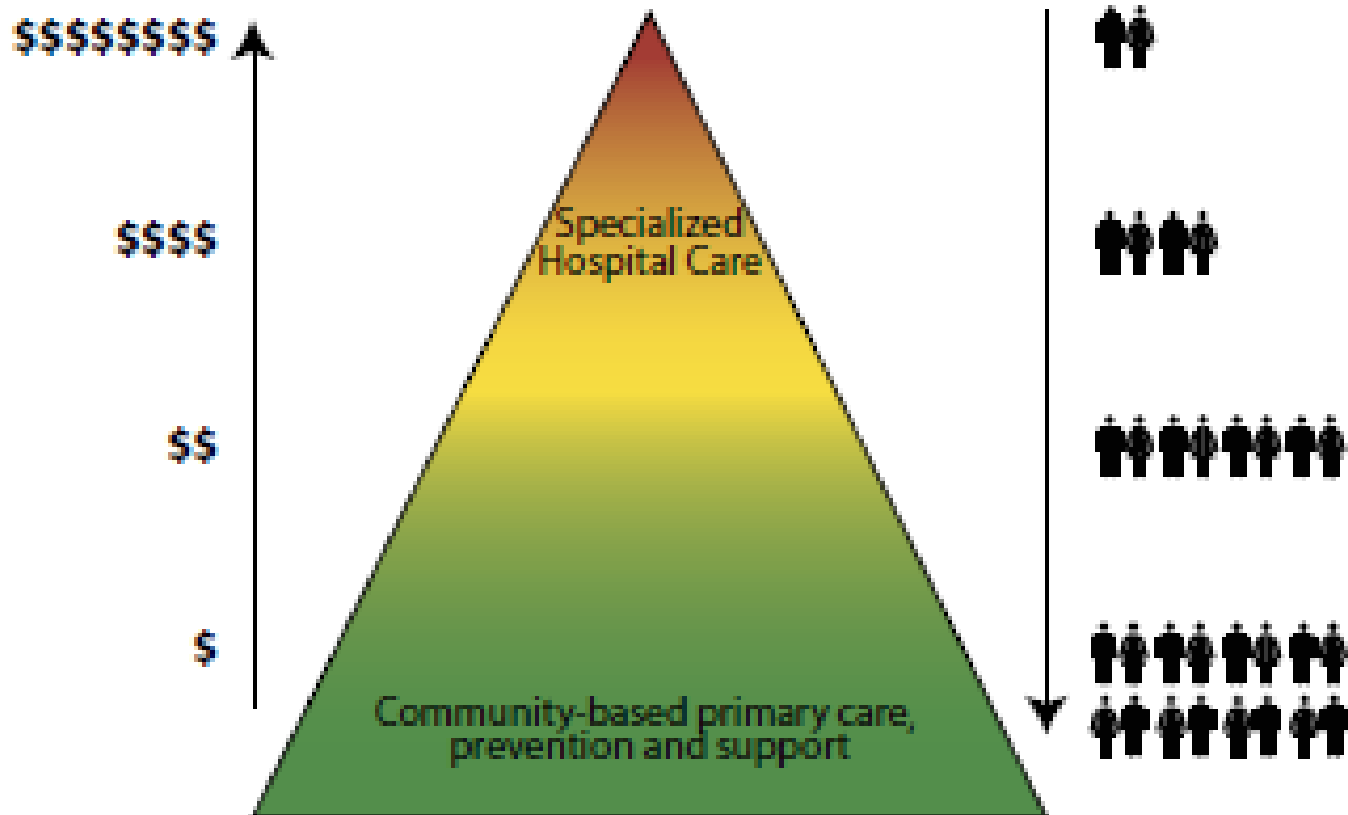
Figure 1. Determinants of Health and Their Contribution to Premature Death.

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

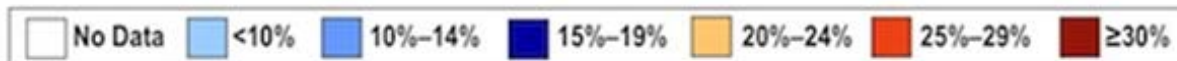
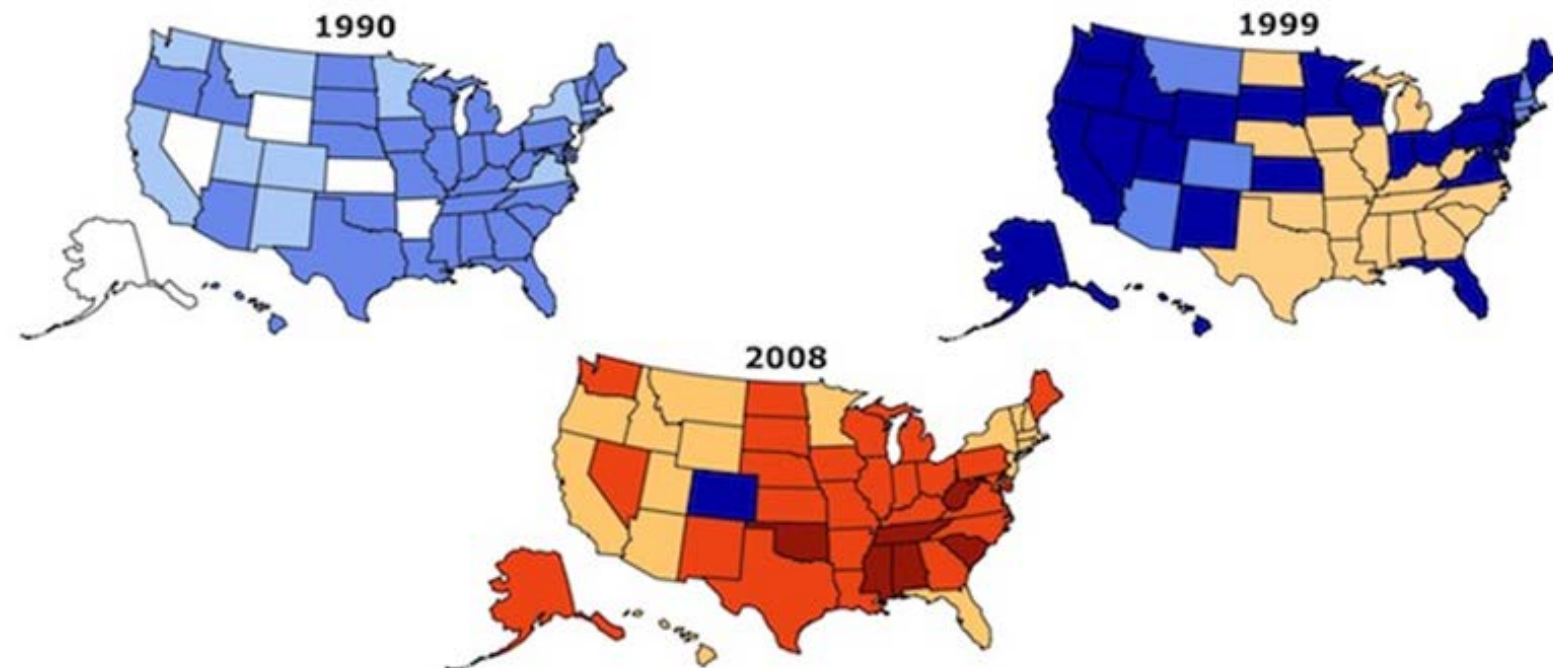
- Use an iterative, participatory research approach to develop, describe, and disseminate *a process* to facilitate sustainable linkages between clinics and communities in the management and treatment of obese patients.
- To meet these goals, we propose the following aims:
 - AIM 1: Determine the **predisposing, 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 Trends* Among U.S. Adults

BRFSS, 1990, 1999, 2008

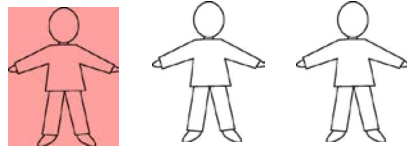
(*BMI ≥ 30 , or about 30 lbs. overweight for 5'4" person)



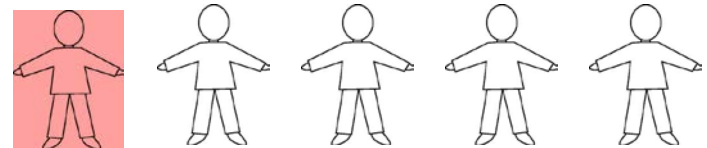
Source: CDC Behavioral Risk Factor Surveillance System.

Obesity rates and health

- One in three adults are obese



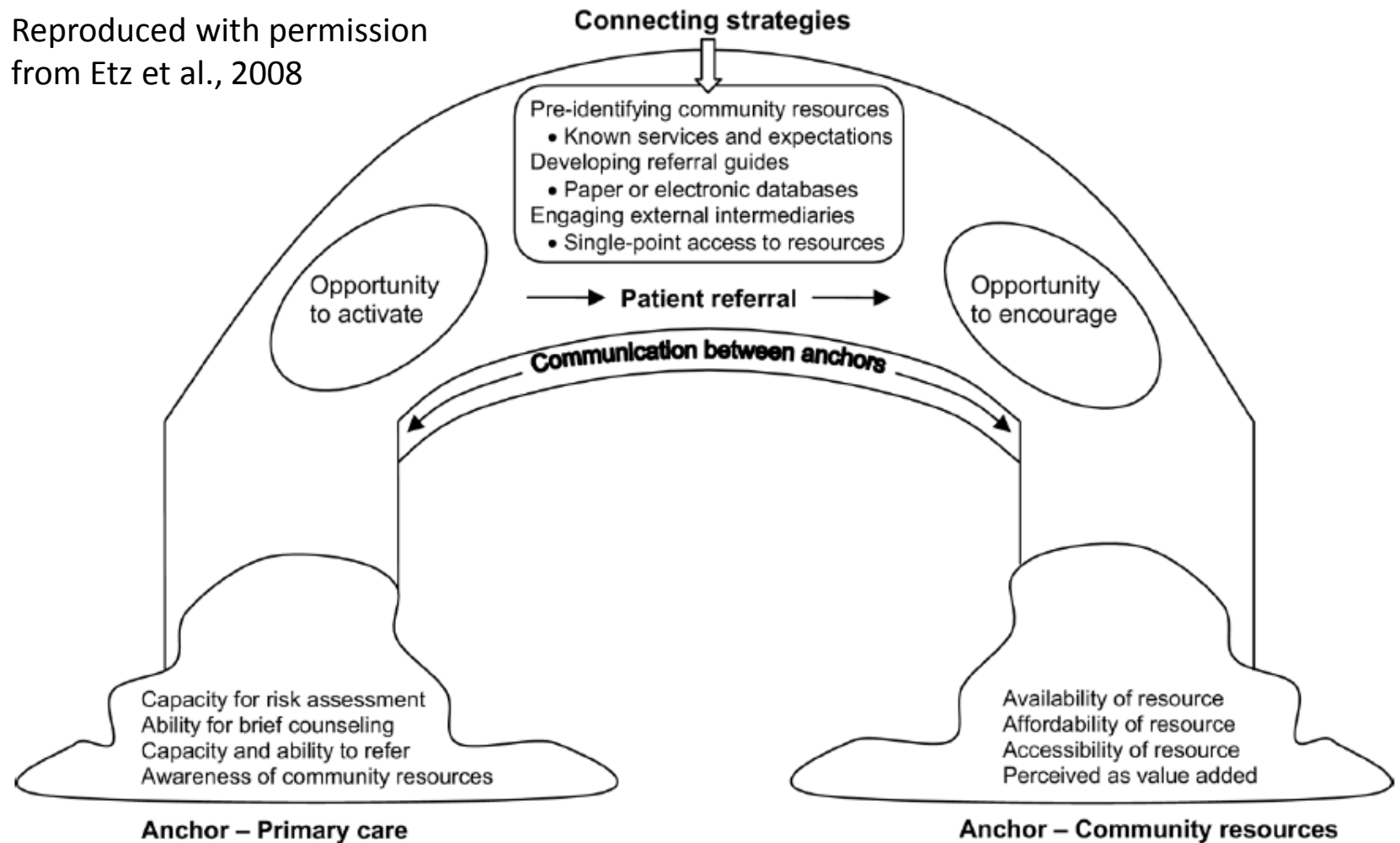
- One in five children and adolescents are obese



- 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

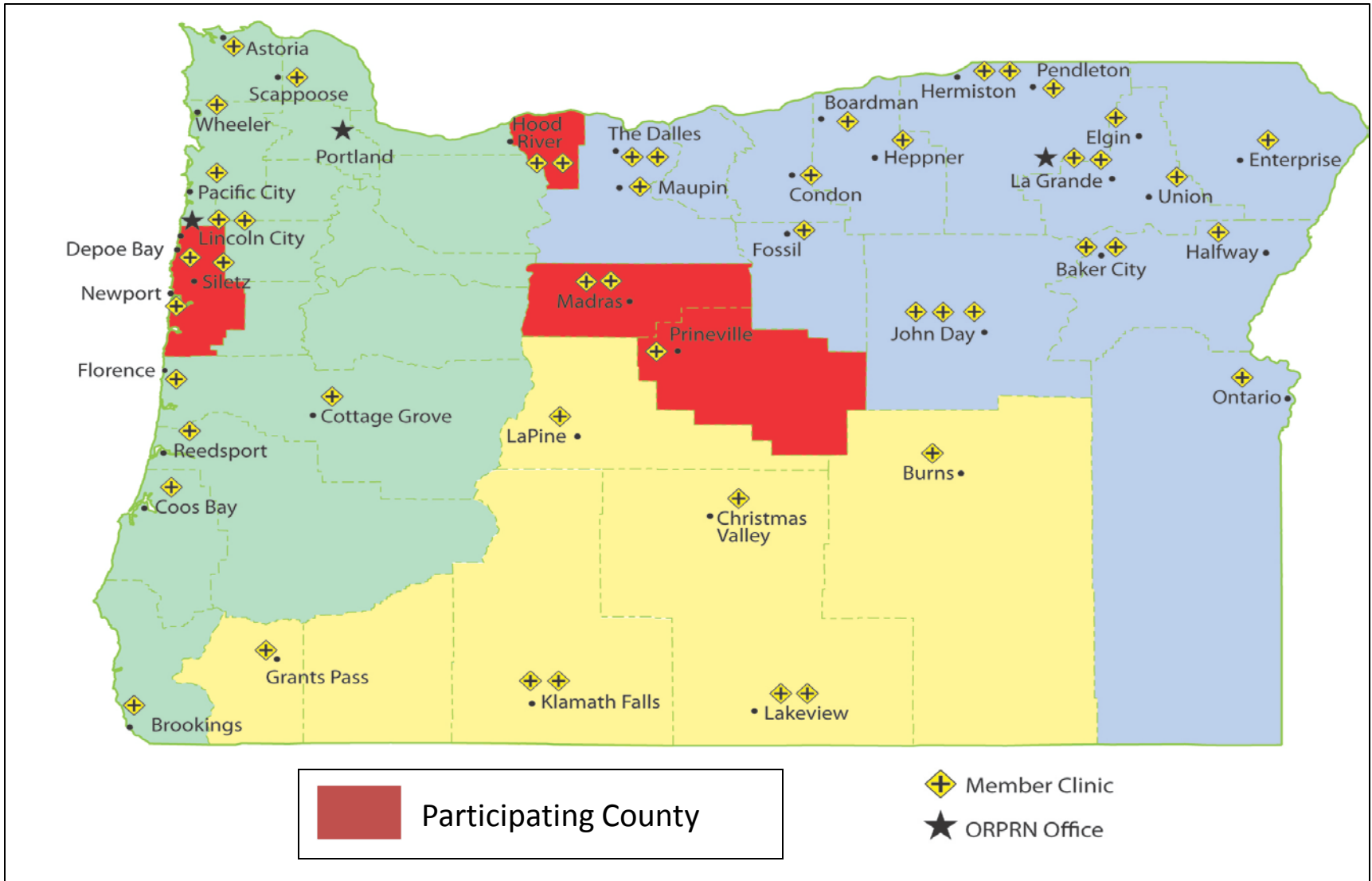


Clemente Project Steps

- 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 ($BMI \geq 25 \text{ kg/m}^2$)
 - 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 \geq 30)
- Diet: 25% (41% BMI \geq 30)
- Exercise: 21% (44% BMI \geq 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 \geq 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?

