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Is it Possible to Have a Financially Viable, Evidence-Based, Weight Management Program in a Patient Centered Medical Home?

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Background

Problem: Obesity is an expensive and preventable public health issue that requires persistence and innovative strategies to address.

Role of a Patient Centered Medical Home (PCMH) in treating obesity: Medicare developed guidelines for delivering Intensive Behavioral Therapy (IBT) for obesity in primary care,[1] based on US Preventive Services Task Force (USPSTF) recommendations:[2]

- First Month: One session/week
- Months 2-6: Two sessions/month
- Month 6: Reassess progress and readiness to change
- Months 7-12: One session/month if lost ≥ 3kg (6.6lbs) in 1st 6 months

IBT Content:
- 5As (Assess, Advise, Agree, Assist, Arrange) to promote sustained weight loss focused on diet and exercise interventions

Setting

UNC Family Medicine Center, Chapel Hill, NC

- Large academic family medicine center
- Patient centered medical home (PCMH)

Drivers of Program Development

- **Primary care providers (PCPs) have little training or time** to adequately deliver weight management interventions
- **Collaboration with interprofessional providers and resources** utilizing clinical social workers (LCSW), nutritionists, behavioral health specialists, and Family Medicine and Preventive Medicine residents to provide IBT

Methods

Intervention design: Pilot, single-site feasibility study

Eligibility Criteria:
- Established PCMH patients
- BMI ≥ 30 or BMI ≥25 with obesity-related comorbidity
- ≥18 years of age
- Completed ≥ 1 weight management visit between Sept 2015 and Aug 2018

Measures:
- Program reach
- Demographics
- Clinical outcomes (weight loss & blood pressure (BP)): calculated comparing first and last available values between start date (SD) and SD+18 months
- Financial sustainability

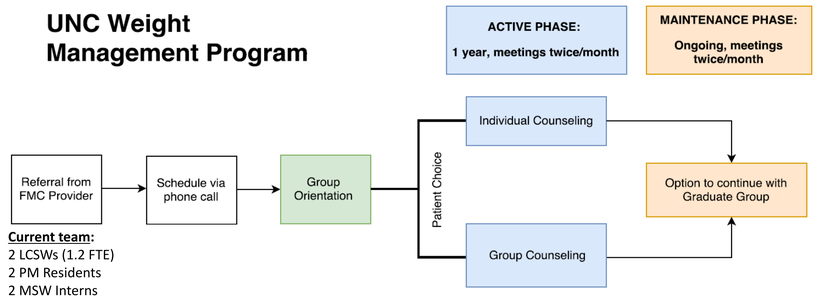
This study has been reviewed and approved by the UNC Institutional Review Board - IRB:18-0358

Program Evolution

Phase 1 (September 2015 – June 2016):
- 1 LCSW provided individual counseling, 6 hours/week (open to 25% of patients)

Phase 2 (July 2016– April 2017):
- Involved MSW interns and PM residents to increase capacity (open to all patients)
- Added option for 6-week group counseling

Phase 3 (May 2017 - August 2018):



Current team:
2 LCSWs (1.2 FTE)
2 PM Residents
2 MSW Interns
21 hours/week individual counseling
2 groups/week

Results

Reach:
- >2700 completed sessions since inception
- >500 unique patients served
- 222 patients have completed ≥ 4 visits

Demographics: See **Table 1**

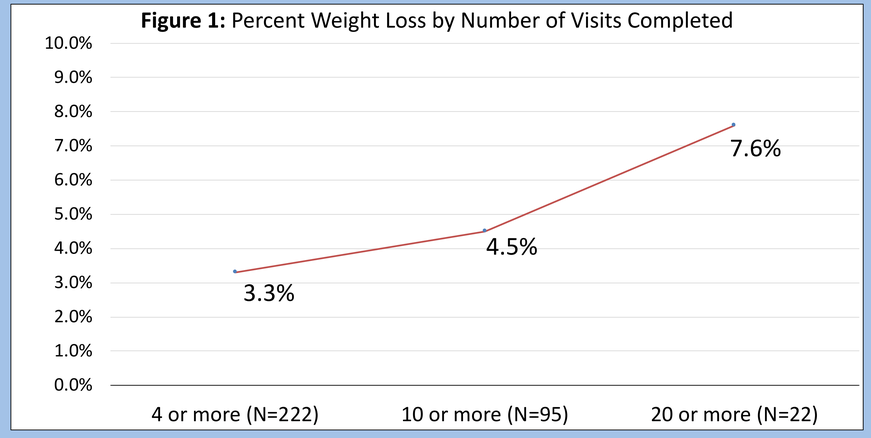
Patients who completed ≥ 1 visit and had at ≥ 2 weight values (N=485):
- Average weight loss was 2.5%
- 26% achieved clinically significant weight loss, defined as ≥5% of initial weight

Patients who completed ≥ 4 visits (N=222), greater weight loss observed with greater number of visits (Figure 1):
- 32% achieved clinically significant weight loss

Blood Pressure for patients starting with BP ≥ 140/90:
- Average decrease in SBP was 14.7mmHg and DBP was 9.8mmHg at 6 months (N=21)
- Average decrease in SBP was 14.3mmHg and DBP was 11.7mmHg at 18 months (N=20)

Financial Sustainability (See Figure 2):
- Building self-sustaining program through patient cost-sharing and billing receipts

Figure 1: Percent Weight Loss by Number of Visits Completed

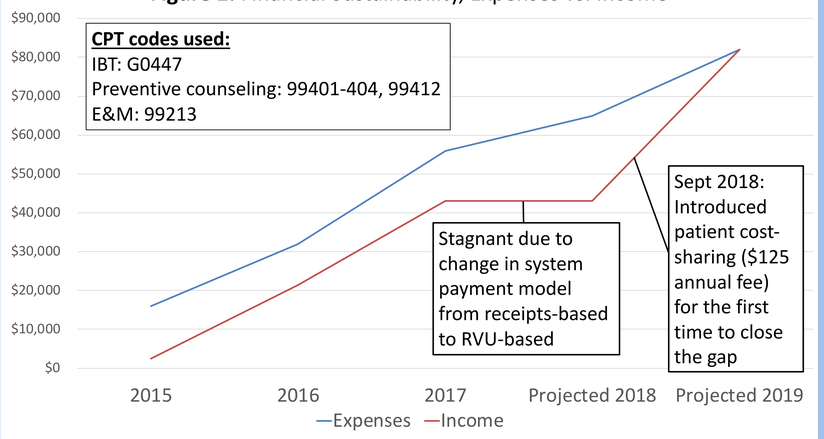


Results (continued)

Table 1: Demographics (N=505)

Race	Black/African American	45%
	White/Caucasian	45%
	Other/unknown	10%
Ethnicity	Non-Latino/Hispanic	91%
	Latino/Hispanic	5%
	Other	4%
Gender	Female	78%
	Male	22%
Comorbidities	Hypertension	55%
	Diabetes Mellitus, Type 2	25%
	Depression	25%
	Obstructive Sleep Apnea	22%
	Osteoarthritis	20%
	Polycystic Ovarian Syndrome	5%

Figure 2: Financial Sustainability, Expenses vs. Income



Discussion

This evidence-based interdisciplinary, intensive behavioral weight loss program
- Helps many patients achieve clinically significant weight loss
- Improves BP among those with uncontrolled hypertension
- Augments PCPs' ability to treat obesity
- Will be financially viable with introduction of minimal patient cost-sharing

Limitations include
- Lack of standardization in practices hampers efforts to collect data
- Change in data collection over time complicates reporting trends
- Great variability in patient retention
- Demographics not fully representative of PCMH patients

Next steps:
- Increase financial sustainability
- Increase reach and scalability
- Diversify population served – Latino population, men

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References: [1] Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N) https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253
[2] *Final Recommendation Statement: Obesity in Adults: Screening and Management*. U.S. Preventive Services Task Force. December 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-management