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Advancing High Performance Health

Obesity Care Model Collaborative: Case Study

The Iowa Clinic

Organizational Profile

The Iowa Clinic, P.C. (TIC) was formed in 1994 and today is the largest physician-owned, multispecialty group in Central Iowa. TIC employs over 160 physicians and 60 advanced practice providers (APPs) in 40 specialties. TIC's Primary Care Provider (PCP) division includes Internal Medicine and Family Medicine and consists of 48 physicians and five APPs. TIC partners with local medical centers and hospitals in Central Iowa and the capital city of Des Moines to provide leading-edge health care to a population of 1.1 million, averaging 600,000 patient visits each year. Outreach specialty clinics are located in 14 outlying rural areas throughout Iowa, serving the cardiology, vascular, pulmonology, urology, podiatry, and other healthcare needs of these communities.

Pilot Profile

The Iowa Clinic does not have a dedicated department of Obesity Medicine or Bariatrics. In formulating its strategy for participation, it was decided to include all primary care patients in TIC's efforts. TIC understands as a clinic that overweight and obesity are chronic medical problems that affect a large portion of its patients. To be successful in improving care for a vast number of patients requires meaningful effort in the patients' primary care home.

Executive Summary

The target of TIC's intervention was its entire primary care population. Tools were needed to help physicians update their internal pictures of what quality care of the obese patient looks like.

To start with, champions were solicited broadly. The Obesity Project Champions met quarterly and had members from primary care, cardiology, cardiovascular surgery, OB-GYN, physical therapy, and executive health, along with many other departments. This generated energy for the topic within the Clinic.

Obesity was added as a problem to the problem list. The clinic is already oriented to accurately assessing HCC codes as the clinic participates in shared savings programs where full and accurate risk coding is key to appropriately setting budgets for TIC patients. Morbid obesity or obesity with a comorbidity are both HCC codes and show up in red on the problem list until assessed. In order to assess these codes, a conversation needs to occur. This made providers hungry for tools to make that conversation effective.

These tools were provided in a spring continuing medical education (CME) seminar and in the provider toolkit. For the spring seminar, TIC brought in Dr. Robert Kushner to explain how to address obesity effectively with patients and local physician champions in order to address pharmacology, as well as discuss how to access the toolkit and educate people about the new Walk with a Doc program, where there are select dates for providers and patients to meet as a group and walk on a determined route to foster engagement and physical activity. Embedded in the toolkit are community resources for dieticians and counseling, such as a guide for taking a weight loss history, a one-page handout on prescribing medications for obesity, and referrals for patients to develop an exercise program with a therapist at a local gym.

Acronym Legend

APP: Advanced Practice Providers
BMI: Body Mass Index
CME: Continuing Medical Education
EMR: Electronic Medical Record
PCP: Primary Care Provider
TIC: The Iowa Clinic, P.C.

Program Goals and Measures of Success

TIC goals and measures of success were to raise organizational awareness to treat obesity as a disease, create community connections, and educate providers of tools available.

Population Identification

The population targeted for intervention were all primary care patients, based on body mass index (BMI) assessment.

Interventions

1. **Background:** TIC identified need and formed a multi-disciplinary Obesity Project Champions Taskforce.
2. **Community:** A sub-committee identified community resources for the provider toolkit. Representatives from

the 5-2-1-0 Program, Iowa Dept of Public Health, and a local Behavioral Health partner were all guests at Obesity Project Champions Taskforce meetings. The American Heart Association attended the Spring Seminar and TIC has partnered with them.

3. **Care Team:** Many members of TIC nursing staff and care managers attended the Spring Seminar and have access to the provider toolkit.
4. **Patient/Family:** Started a Walk with a Doc program to create patient and family engagement and promote activity.

Outcomes and Results

Over the course of the collaborative, significant gains on assessing obesity in patients and on completing the appropriate/recommended lab work were made. Because TIC focused on its entire population, it was believed the system was successful in creating organizational awareness/change.

TIC's focus on capturing and assessing obesity in patients was further bolstered by AMGA's sharing of the positive impact across all three obesity classes for patients with an obesity DX vs. those without (see Appendix).

TIC has managed to move the needle in a meaningful fashion in documentation of Obesity Diagnosis from the start of the collaborative to the final data submission. The below table shows the percent of patients with an obesity diagnosis within a 12-month lookback period:

Obesity Class	2018 Q1	2019 Q1
Class 1	26.6%	32.7%
Class 2	47.8%	52.7%
Class 3	75.2%	83.7%

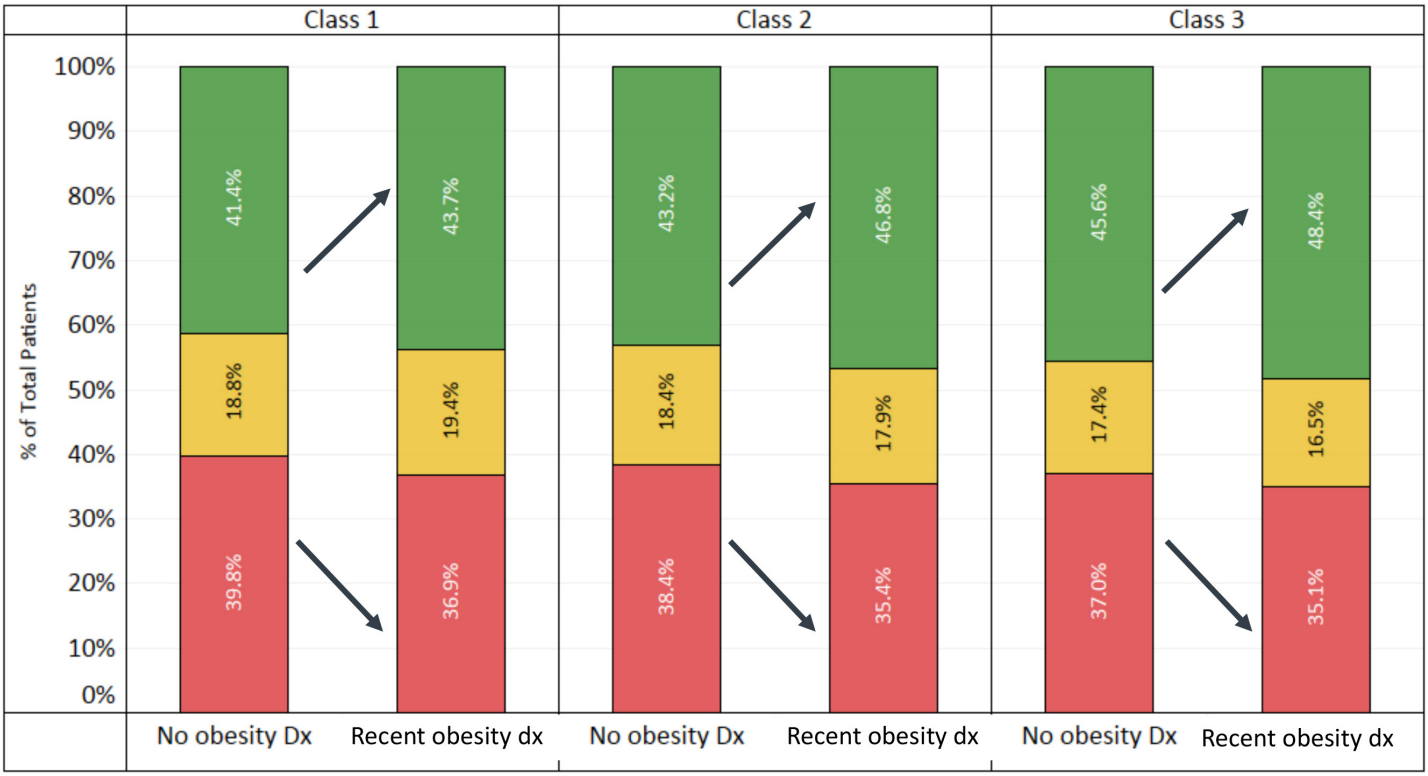
In addition to the importance of proper risk scoring, and the positive weight loss outcomes shown above, keeping this issue top of mind had benefits on TIC's completion of lab results as well (see Appendix).

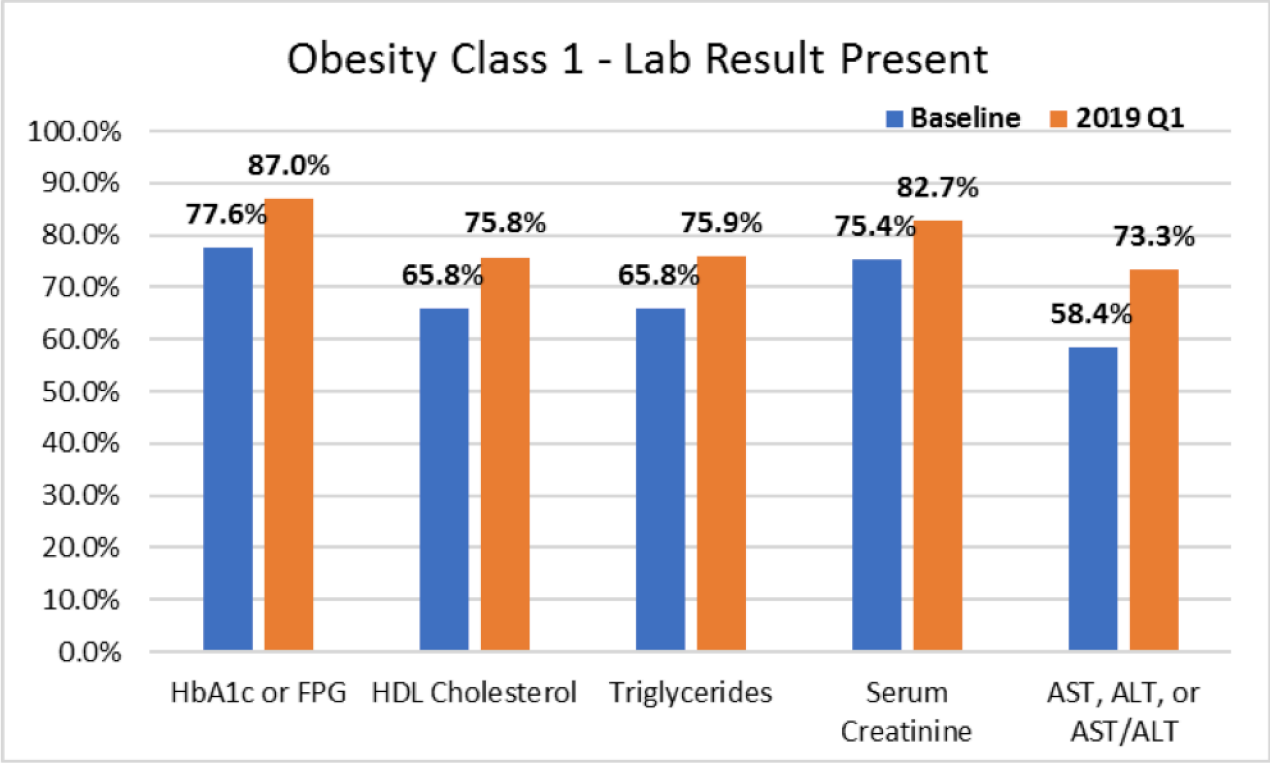
Lessons Learned and Ongoing Activities

Having an active Obesity Project Champions Taskforce was key, as was the need to continue to work on shared medical appointments. Continuing to work with payers would also help support the effort. Challenges included the additional demand of time on administration, clinical staff, and providers.

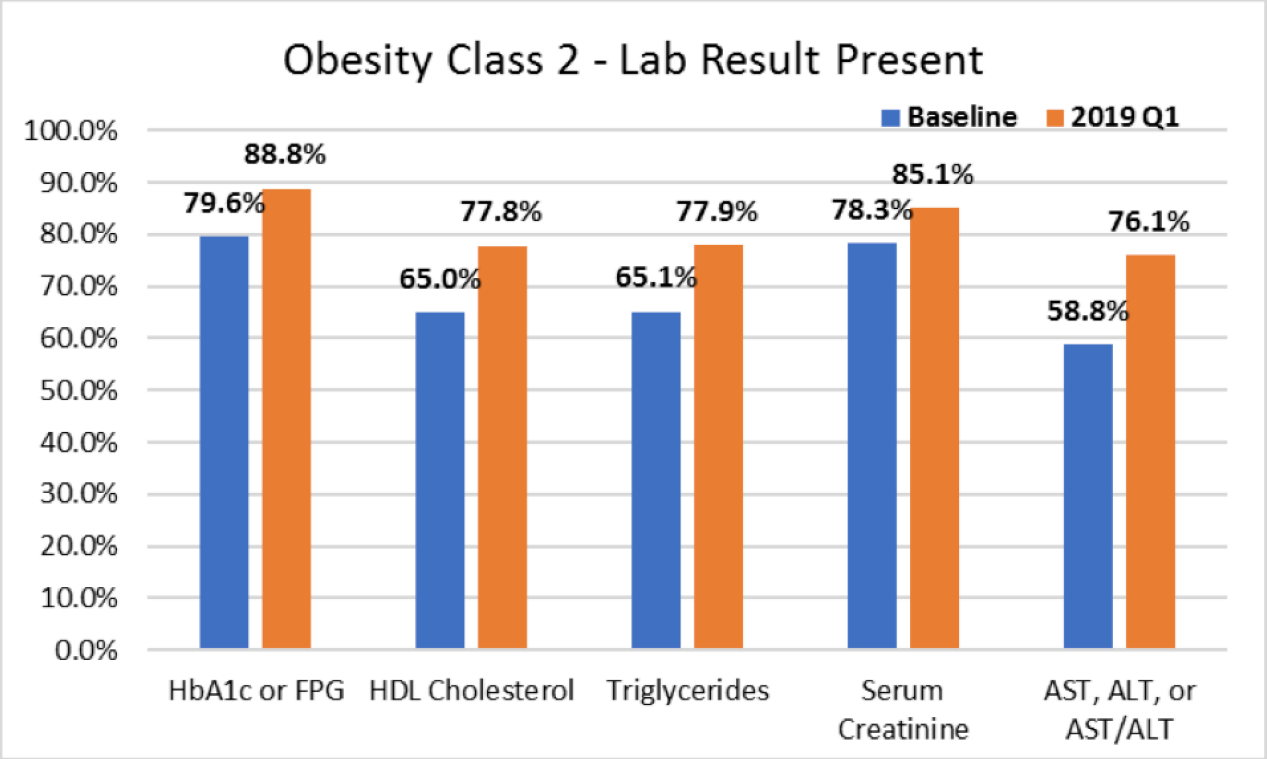
Appendix

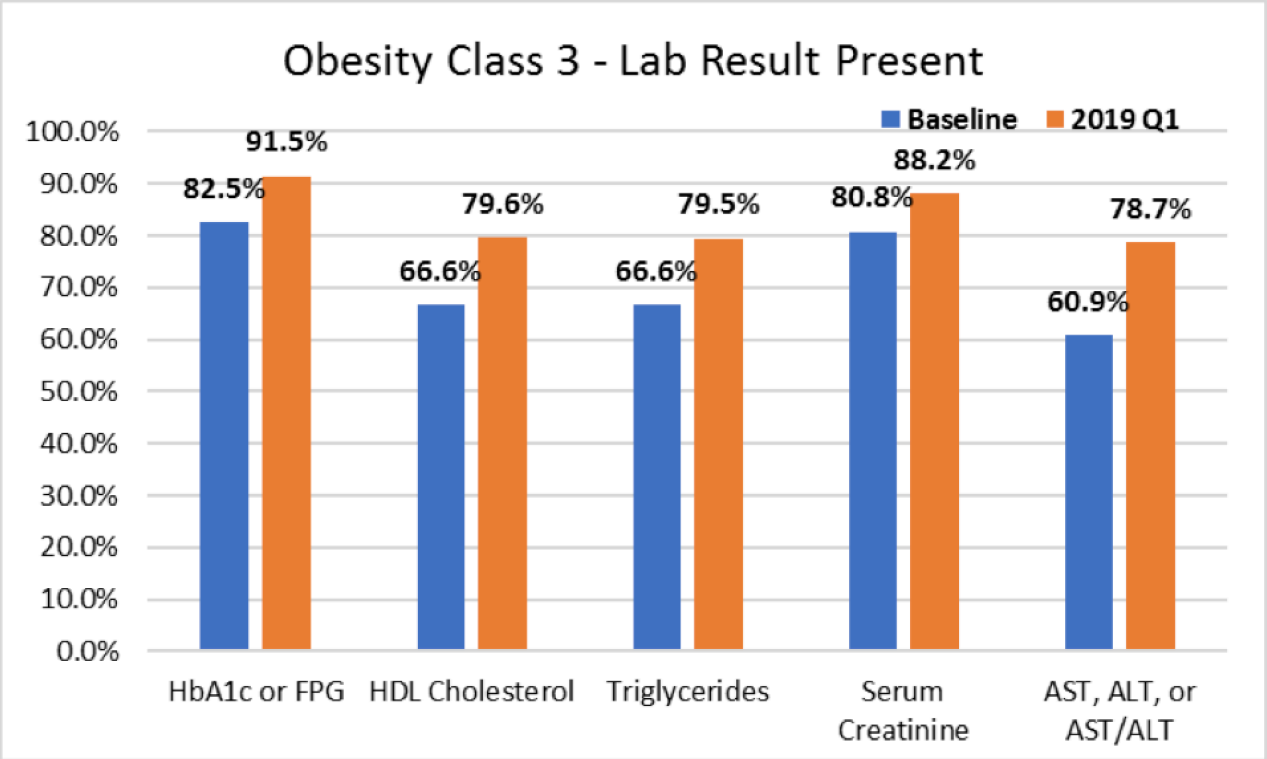
Percent of patients who experienced weight gain (red); weight maintenance (yellow); or weight loss (green) over 9-15 months





Appendix


Obesity Class 2 - Lab Result Present
Baseline
2019 Q1
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
79.6%
88.8%
65.0%
77.8%
65.1%
77.9%
78.3%
85.1%
58.8%
76.1%
HbA1c or FPG
HDL Cholesterol
Triglycerides
Serum Creatinine
AST, ALT, or AST/ALT


Obesity Class 3 - Lab Result Present
Baseline
2019 Q1
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
82.5%
91.5%
66.6%
79.6%
66.6%
79.5%
80.8%
88.2%
60.9%
78.7%
HbA1c or FPG
HDL Cholesterol
Triglycerides
Serum Creatinine
AST, ALT, or AST/ALT

Appendix

Obesity Toolkit available to all providers and clinical staff within the electronic medical record (EMR):

Internally created toolkit items are pharmacotherapy and Physical Therapy.

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Treatment of Medical Weight Management

Dosing & Tips

Combo	Drug	Dosing: *off label usage discussed	Tips
Qsymia		3.75/23mg: Increase at 2 week intervals to top dose of 15mg/92mg.	
	Phentermine & other Sympathomimetic amines (Schedule 4)	15-37.5mg.	- Counsel to take 15-30 min before a meal for better effect - EKG prior to use is consensus good practice
	Topiramate	25mg. Increase by 25mg weekly until desired effect is reached without excessive side effects. Max dose 300mg. - In practice have not seen doses > 100mg to be effective unless BED is present.	- Consider in pts with hx of eating disorder but watch for potential paradoxical response - Consider in patients with prior alcoholism - Very good at helping maintain a weight after loss.
	Liraglutide (low dose) (high dose)	Week 1: 0.6mg Week 2: 1.2mg Week 3: 1.8 Max DM dose Week 4: 2.4mg Week 5: 3.0mg	- Up to 1.8 usually covered for Hyperglycemia & impaired fasting glucose - injectable
Contrave		8/90mg: Week 1: 1qAM Week 2: 1 BID Week 3: 2qAM, 1qPM Week 4: 2 BID	
	Naltrexone	50mg: Week 1-2: ¼ tablet Week 3: ½ tab Week 4: 1 tablet	Add in sober patients with hx of alcoholism when starting weight loss. Iowa Compounding will compound lower dose if intolerance occurs
	Bupropion	**12 ER: 100mg** Week 1: 1 daily Week 2: 1 BID Week 3: 2qAM, 1qPM Week 4: 2 BID **24hr ER: 150mg** Week 1-2: 1 daily Week 3-4: 2 daily or 1 BID.	- Contrave has 12hr ER medication in script but in practice have not seen differences in weight loss/appetite suppression in 24hr - ER version
	Orlistat OTC	60mg TID if meal contains fat.	- Consider in statin intolerant pts for improved LDL
	Lorcaserin (Schedule 4)	IR Version: 10mg BID ER: 20mg daily	
	Lisdexamfetamine Dimesylate (Schedule 2)	30mg. Increase by 20mg increments weekly to target dose of 50-70mg.	Clearly doc BED behaviors in note for standard of care use

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Exercise Recommendations

Aerobic Activity

Duration: Start with 10 min increments, working up to 30 min continuously.
Intensity: Moderate (5-6) or vigorous (7-8), on a scale of 0-10 for level of physical exertion.
Goal: 150-300 min per week
Examples: Walking, biking, swimming, elliptical

Resistance Training

Frequency: 2x/week, 24-48 hour rest between sessions
Intensity: Moderate (5-6), on a scale of 0-10 for level of physical exertion.
Progressing: Move to the next level intensity once you reach 5 sets.

Intensity	Low	Moderate	High
Repetitions	5 sets of 5 repetitions. Start with 1 set and work up to 5 as tolerated		
Squats	Sit to stand	Sit to stand adding weight	Goblet squats
			
Step Ups (may use stairs or a sturdy box)	Use 1 arm	No arms	Add weight in opposite arm and increase step height
			
Push Ups	At wall	Counter top	Knee or full push ups
			
Reverse Lunges	1/4 lunge with arms	1/2 lunge with or without arms	Full lunge without arms
			

Flexibility Exercise:

Frequency: 2x/week
Intensity: Comfortable stretch
Repetitions: 2 sets holding 30 seconds.

Hamstrings

Quad Muscles

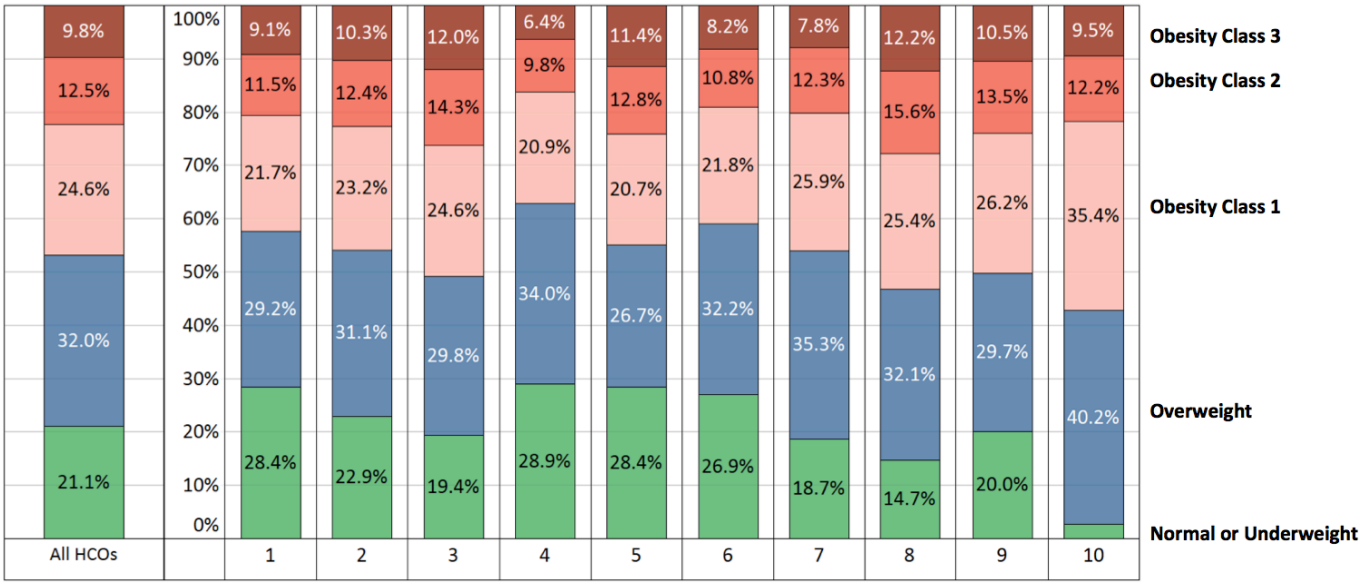
Calf Muscles

Prayer Stretch

Final Data Report from AMGA Obesity Care Model Collaborative

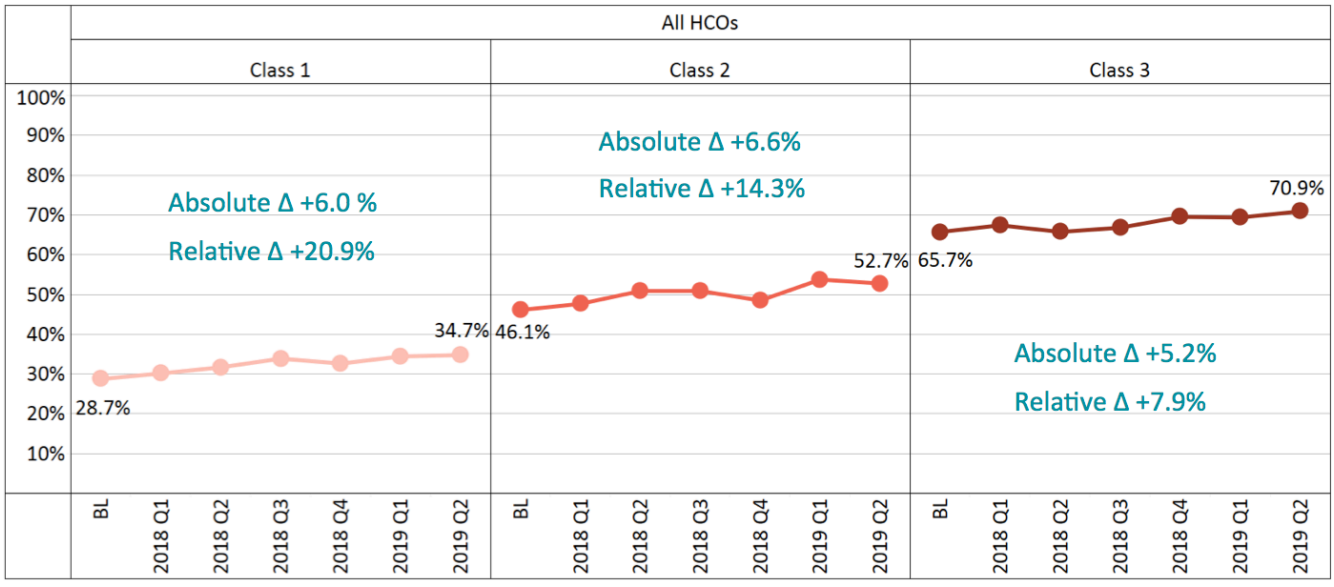
Prevalence of Overweight and Obesity: 2019 Q2

Targeted clinics for OCMC (~122,000 total patients)



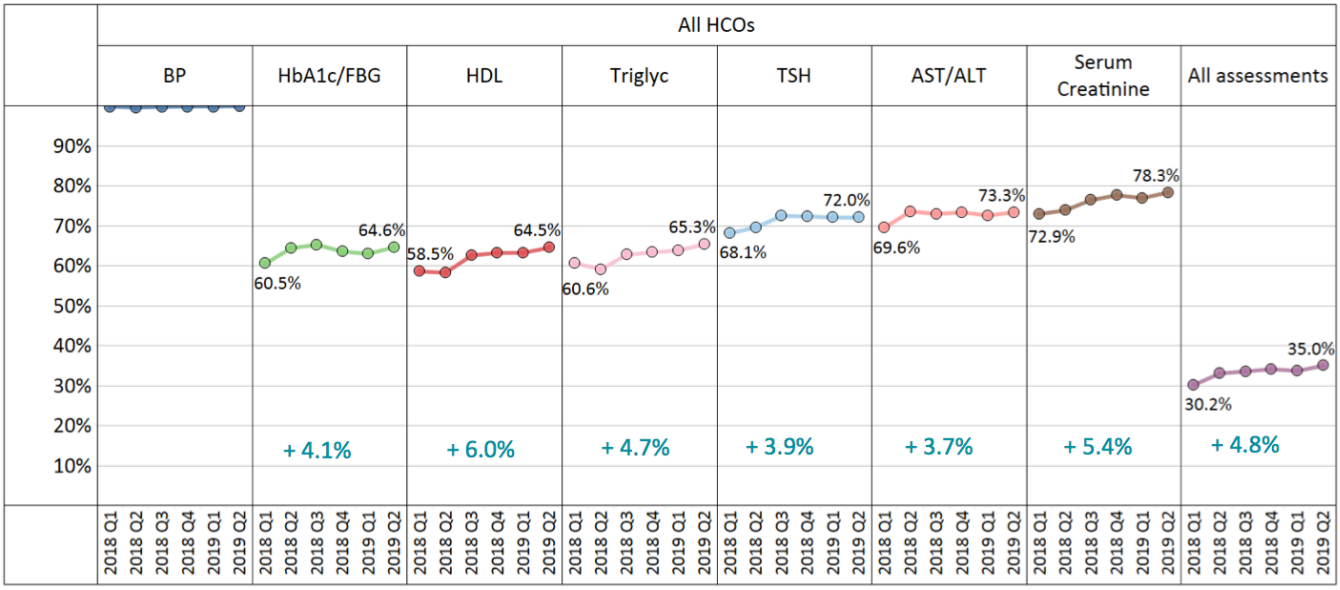
Collaborative Performance: Documentation of Obesity Diagnosis

- Proportion of patients with **BMI ≥ 30** who have a documented obesity diagnosis **in Targeted Clinics**
- ICD10: E66.01, E66.09, E66.2, E66.8, E66.9



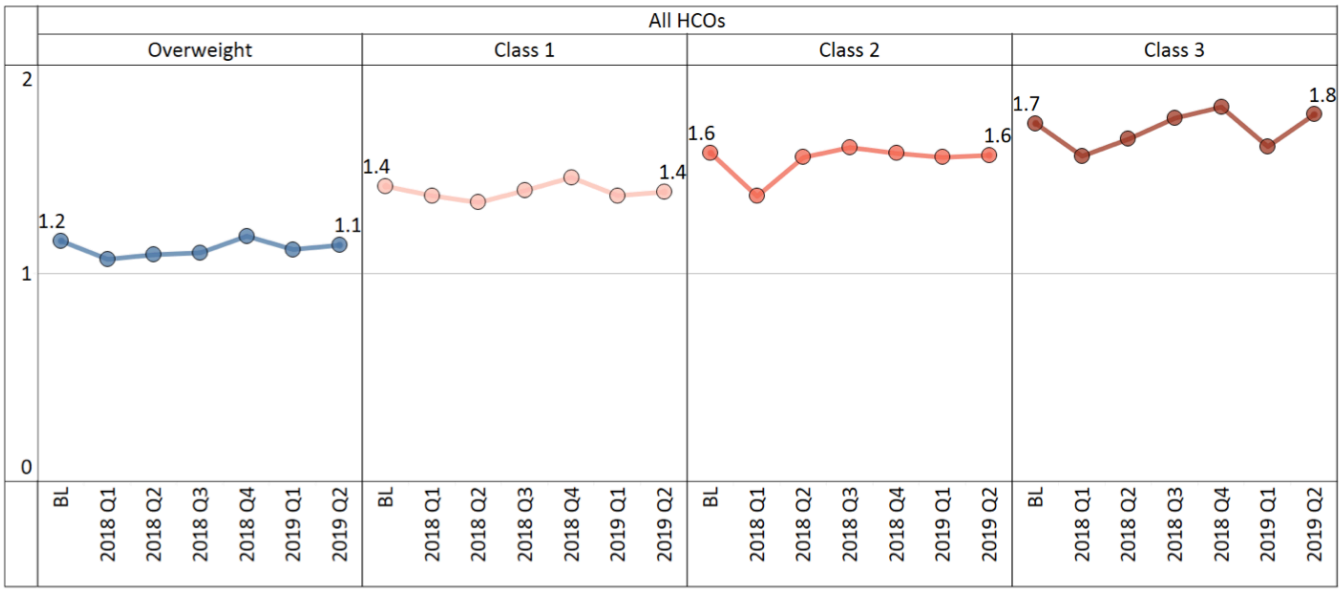
Assessment for Obesity-Related Complications

- Proportion of patients (BMI ≥ 25) with select laboratory assessments by reporting period, in Targeted Clinics
- ALL assessments remain low but overall improvement since 2018 Q1
- HDL and Serum Creatinine demonstrated some of the largest absolute improvements; 6% and 5%, respectively



Average Number Obesity-Related Complications Per Patient

- Average Number of obesity-related complications per patient (BMI ≥ 25) by weight class and reporting period
- 6 complications: Type 2 Diabetes, Dyslipidemia, Hypertension, Obstructive Sleep Apnea, Osteoarthritis, Nonalcoholic Fatty Liver Disease



Appendix

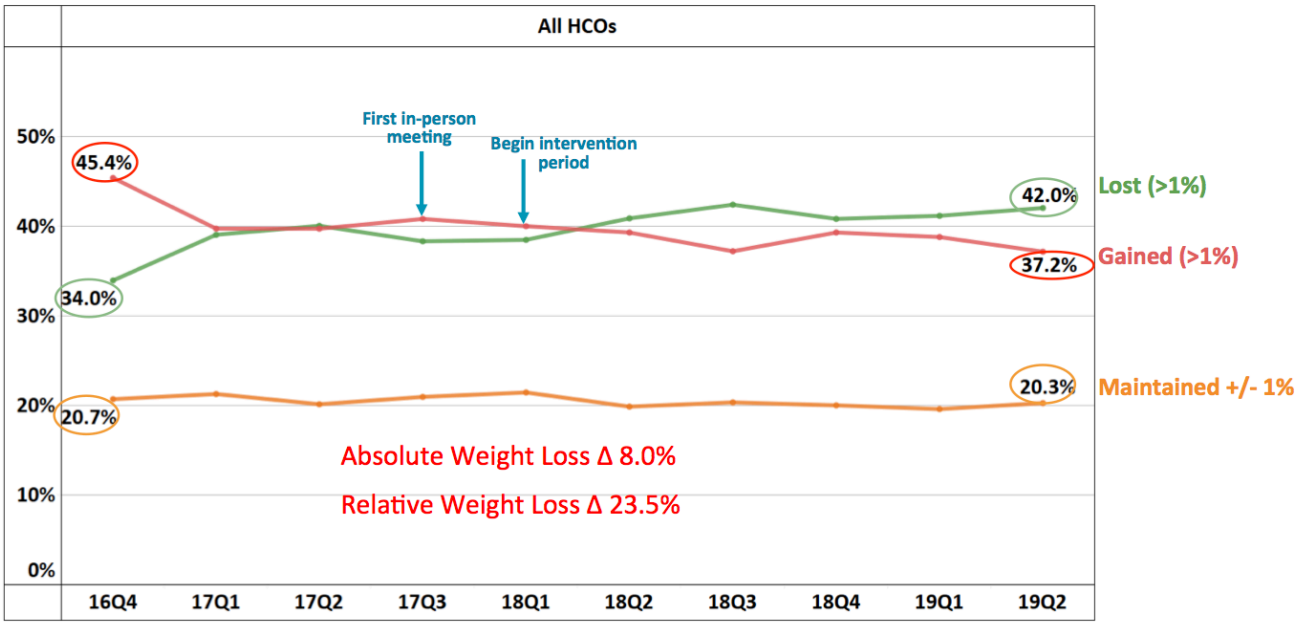
Obesity-Related Problem Scale

HCO	Pre-Surveys	Post-Surveys	Response Rate	Met Goal Pre	Calculated Δ
9	81	43	64%	Y	Y
5	19	19	24%	N	Y
3	44	7	54%	N	N
8	53	8	60%	Y	N
4	155	NA	73%	Y	N
10	96	NA	98%	Y	N
2	53	NA	100%	Y	N

Obesity and Weight Loss Quality of Life Instrument

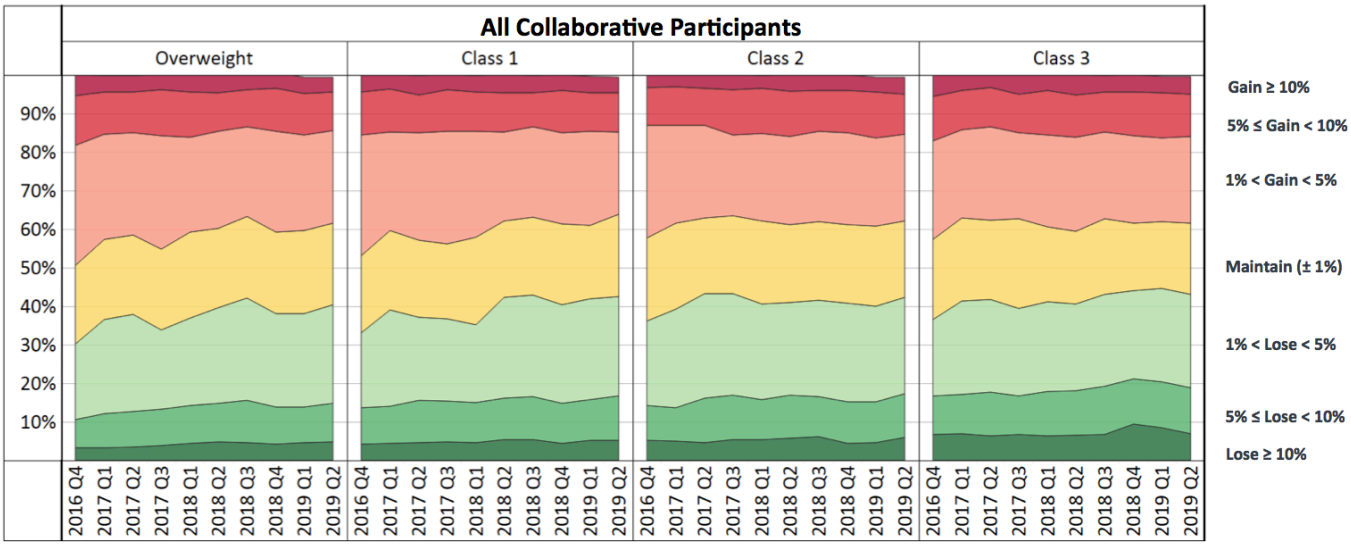
HCO	Pre-Surveys	Post-Surveys	Response Rate	Met Goal Pre	Calculated Δ
9	86	44	68%	Y	Y
5	19	19	24%	N	Y
3	44	7	54%	N	N
4	155	NA	73%	Y	N
10	96	NA	98%	Y	N
2	53	NA	100%	Y	N

Proportion of patients (BMI ≥ 25) by weight change category and reporting period



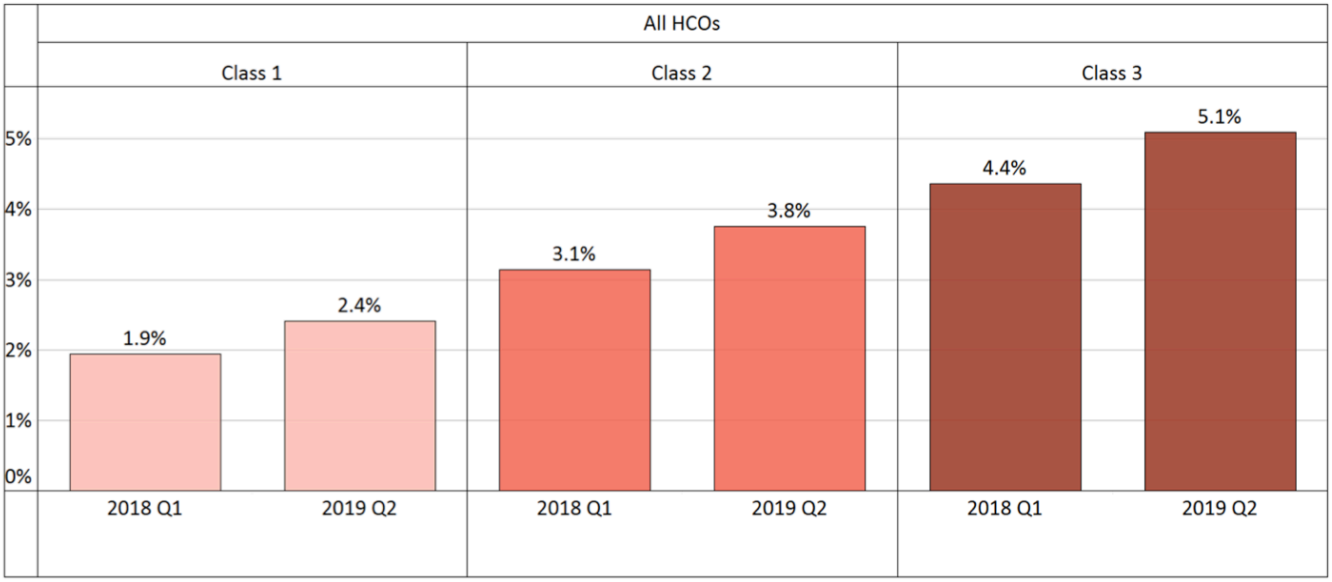
Measure 6: Proportion of Patients by Percent Weight Change

- By reporting period, weight class and 7 weight categories



Prescribing Anti-Obesity Medications

- Proportion of patients seen during the time period who have an active Rx for an anti-obesity medication
- Patient-weighted average across all organizations



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