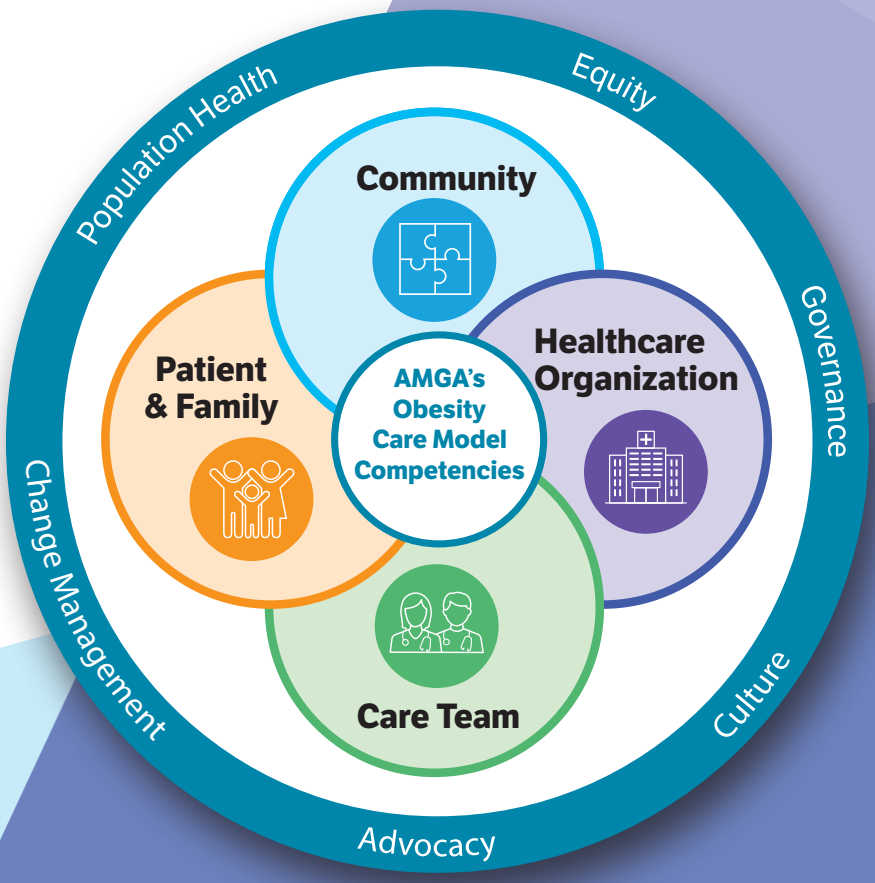
AMGA™

Advancing High Performance Health

Obesity Care Model Playbook



The information in this playbook represents evidence based best practices from 10 AMGA member organizations who participated in the Obesity Care Model Collaborative.

AMGA
Advancing High Performance Health

Obesity Care Model Playbook

The information in this playbook represents evidence-based best practices from AMGA member organizations who participated in the Obesity Care Model Collaborative.

AMGA would like to thank the 10 participating organizations for their dedication and commitment to improving the care of their patients with obesity. Without their contributions and efforts, none of this would be possible.

www.amga.org

Welcome to the Obesity Care Model Playbook!

AMGA's Obesity Care Model Playbook is a population health-based instructional guide for medical groups, multispecialty medical groups, academic health systems, and integrated delivery systems treating adult patients with obesity in primary care.

The playbook highlights *essential* interventions that 10 pilot organizations participating in the Obesity Care Model Collaborative successfully implemented and also found to be critical to building their obesity care management programs. Whether you are just beginning your journey in creating an obesity care management program or have an existing program, this is the guide for you.

What's Included

The playbook is organized in three main sections: Warm-Up, Pre-Game, and Plays.

- **Warm-Up:** This section will provide you with an introduction to obesity, the obesity care model collaborative, and key definitions and terms, which will assist you as you navigate the playbook.
- **Pre-Game:** This section provides the necessary but simple steps any organization must consider when implementing an obesity care management program. A Getting Started Checklist offers practical steps to help medical groups and health systems organize their approach. Quick wins are listed in a one-pager to help organizations that want to jump start their programs with easy, adoptable interventions.
- **Plays – Implementing the Obesity Care Model Domain Interventions:** The four Care Model Domains—*Community, Healthcare Organization, Care Team,* and *Patient & Family*—interventions were tested and implemented by the 10 pilot organizations. For each Domain, you will find specific examples on how some of the nation's leading healthcare organizations were able to implement the interventions. There is a wide range of practical, actionable, and easily modifiable interventions, which will provide guidance on implementation, on how to approach your leadership for support provided through the Obesity Care Model Resource Guide. In addition, a host of tools and resources are to help you operationalize these best practices.

This is Playbook is a living document and will be updated periodically. We hope that you find this Playbook useful as you care for your patients with obesity.

Contents

Warm-Up

I. Introduction to OCMC Playbook

a. State of Obesity – What We Already Know

Rates of obesity have increased over the years. In 2017-2018, the age-adjusted prevalence of obesity in adults was 42.4%[1]. Obesity related conditions such as hypertension, diabetes, heart disease, stroke and some cancer has contributed to the rising cost of obesity. An annual estimated medical cost of obesity in 2008 was $147 billion[2].

AMGA conducted a survey to its membership to identify gaps in knowledge surrounding obesity care management within healthcare organizations (HCOs) and to gauge interest in participating in a pilot Obesity Care Model Collaborative. The survey identified that 68% of respondents were not following any guidelines for obesity care management. Because of the survey results, lack of available primary care models for obesity care management, and the rise of obesity rates across the country, AMGA sought to develop a holistic model of care within a proposed framework.

b. Obesity Care Model Collaborative Overview

The Obesity Care Model Collaborative (OCMC) was a 35-month collaborative to define, pilot, and evaluate a framework and necessary components to address obesity in multispecialty medical groups, academic health systems, or integrated delivery systems treating adult patients in primary care. A National Advisory committee of expert advisors drafted the initial framework and metrics and developed

(1) Craig M. Hales, M.D., Margaret D. Carroll, M.S.P.H., Cheryl D. Fryar, M.S.P.H., and Cynthia L. Ogden, Ph.D. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018; NCHS Data Brief No. 360, February 2020

(2) Eric A. Finkelstein, Justin G. Trogdon, Joel W. Cohen, and William Dietz, Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates, HEALTH AFFAIRS VOL. 28, NO. SUPPLEMENT 1: WEB EXCLUSIVES, Published 2009

the inclusion criteria for selection of the ten AMGA member organizations to participate in the Collaborative. Two committees (framework and measurement), which included the National Advisory Committee as well a representative from each participating HCO, contributed towards the further development of the framework and determine the feasibility of the measures.

Participating organizations were selected based on their ability to contribute to the further development of the framework, test measures, and commit to implement an obesity program, which includes a minimum range of services, either within the health care organization or practice or through referral. Participating organizations met in-person four times, plus via a series of webinars, to share insights and challenges and to refine the model and measures based on the data and their experiences.

Measures

- **Operational Tracking**

  Measure 1a: Prevalence of overweight and obesity in primary care across the organization

  Measure 1b: Prevalence of overweight and obesity in clinics targeted for the collaborative

  Measure 2: Obesity-related complications per patient

- **Quality Performance**

  Measure 3: Documentation of obesity diagnoses

  Measure 4: Assessment for obesity-related complications

  Measure 6: Percent weight change in a 15-month period

  Measure 7: Prescribing of anti-obesity medications

- **Patient-Centered Care (Patient-Reported Outcomes)**

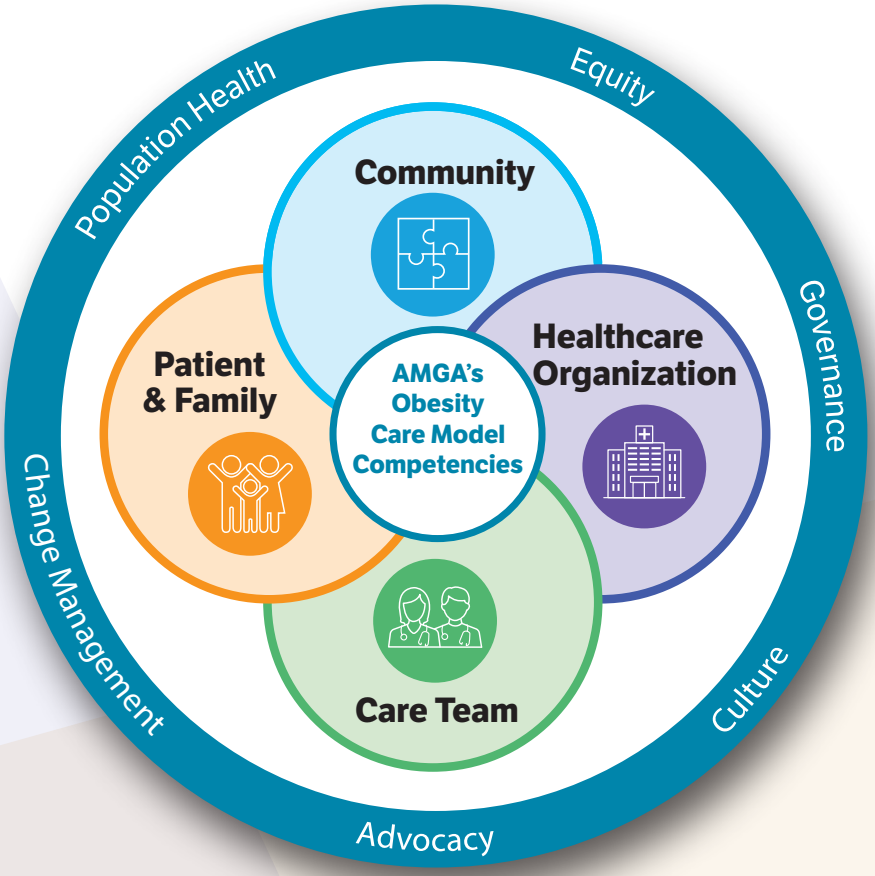
  Measure 5a: Number of patient-reported outcome measure surveys completed

  Measure 5b: Change in patient-reported outcome measure

After the initial development period, participating organizations had six months for program design and implementation. During this six-month implementation period, groups tested measures in their systems. AMGA refined the framework and measures based on group feedback.

After the implementation, period groups had 12 months for program operation, during which interventions were tracked and measures were reported quarterly. The participating groups hosted AMGA staff members for its second round of site visits to assist groups with adapting and implementing the model and to assist with translating emergent best practices across groups. As a result, the Obesity Care Model Competencies and Playbook was developed for use as a resource and to provide a summary of the successful insights and strategies identified by the ten participating organizations for implementing obesity models of care in their health systems.

AMGA's Obesity Care Model



c. Key – Definition of Terms

The below definitions describe the ways in which the interventions are categorized.

- **Essential:** Multiple pilot participating organizations considered these interventions necessary to the success of building the obesity program.
- **Additional Interventions:** Multiple pilot participating organizations successfully implemented these interventions.
- **Advanced:** These interventions require that essential interventions be already in place. Advanced interventions require more resources than essential or additional interventions. Multiple pilot participating organizations successfully implemented these interventions. (A)

Legend

(A) = Advanced – highlights an intervention that is considered advanced

(S) = Services; (R/E) = Roles & Education; (T/W) = Tools & Workflow; (M/E) = Measurement & Evaluation; (R) = Reimbursement

Intervention Categories

- **Services:** The management and delivery of high-quality and safe health services. S
- **Tools & Workflow:** Use of tools and workflow to achieve efficiency, quality, adaptability, auditability and measurability. T/W
- **Roles & Education:** Develop and manage functions of each team member. Train and continuously educate team on obesity related matters. R/E
- **Measurement & Evaluation:** Measuring, reporting, and comparing healthcare outcomes will help achieve the Quadruple Aim of healthcare: M/E
    - Improve the patient experience of care
    - Improve the health of populations
    - Reduce the per capita cost of health care
    - Reduce clinician and staff burnout
- **Reimbursement:** Reimbursement for professional services R

Obesity Care Model Domains – Definitions describe the four general areas of focus, under which all obesity program activities transpire.

- **Community:** This domain focuses on building relationships with and engaging the community (local, external businesses, and organizations) to provide services to patients with obesity. We have provided examples of our members proactively engaging with their communities. These organizations are the catalysts in their communities.
- **Organization:** This domain focuses on the medical group/health system's administrative, financial, and clinical initiatives to develop and provide support for care delivery to patients with obesity.
- **Care Team:** This domain focuses on the medical group/health system's care teams implementing initiatives that directly affect patient care.
- **Patient & Family:** This domain focuses on patient- and family-centered interventions that develop relationships, and create partnerships among practitioners, patients, and their families.

Care Model Organizing Principles – Definitions describe overarching guidelines that should be considered when developing and implementing any intervention.

- **Equity:** Health equity means providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Advocacy:** Health advocacy encompasses direct service to the individual or family as well as activities that promote health and access to health care in communities and the larger public.
- **Culture:** Culture in health care is defined as integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- **Governance:** Governance in health systems is a systematic approach to maintaining and improving the quality of patient care, and holding the system accountable.
- **Population Health:** Population health aims to improve the health of an entire human population, including access to care. A priority considered important in achieving the aim of Population Health is to reduce health inequities or disparities among different population groups due to, among other factors, the social determinants of health.
- **Change Management:** Change management is about evaluating, planning, and implementing operations, tactics, and strategies and making sure that the change is worthwhile and relevant.

Pre-Game

II. Getting Started

a. Checklist

The Obesity Care Model Getting Started Checklist will assist in preparing for your quality improvement journey. This concise tool will ensure you and your team are organized and equipped with the right knowledge to begin developing a comprehensive, population-based, obesity care management program.

Step 1: Secure buy-in from key leaders and stakeholders.

Ensure the obesity care management program is seen as a top priority at your organization by fostering support and commitment from key leaders and stakeholders. This buy-in will be important as your team works to secure the resources and attention needed for the project (e.g., data, staff time, budget). To do so, meet with the most prominent supporter at your organization (e.g., Chief Executive Officer, Medical Director, Board of Directors). Talk with key Division Chiefs, Department Chairs, and administrative leaders in person to share information and address any concerns they may have (e.g., staffing, resources).

Step 2. Assemble your team.

Including the right people on the team is critical to your success. Ensure that there is a combination of clinical leadership, technical expertise and day-to-day leadership to include frontline leadership.

Required project team members include:

- **Project Lead:** Guides the team through the process to achieve the goals and objectives.

- **Clinical Champion:** Employed or clinically integrated affiliated physician and/or clinical champion as an *identified* team lead/champion, dedicated to this project, with demonstrated interest and expertise in obesity care.
- **Administrative Champion:** Administrator with operational responsibilities in obesity or related area
- **Patient Champion:** This can include organization employees who have been diagnosed with obesity. Throughout the project, this team member will provide a firsthand perspective of living with and being treated for obesity.
- **Data/IT Analyst:** Dedicated to this project, will create, retrieve, and submit project data

Additional team members for consideration:

	Implementation Team Member Categories				
	Clinical	**Lifestyle**	**Community**	**Data/IT**	**Operations/ Finance**
Responsibilities	Identify and treat medical aspects of patients with obesity	Treats the behavioral, physiological, nutrition and physical activity aspects of patients with obesity	Relationship with external facilities for patient referral	Implement, test, and refine success metrics Leverage patient portal (if one exists) for enhanced communication with patients Develop a patient registry for obesity or use existing registry to identify and track patient progress	Billing, coding compliance, insurance, business development, marketing, staffing, operations, physical space requirements
Team Members for Consideration	Primary care physician Specialist Advance practice clinician Nurse, Care manager Quality improvement specialist Bariatric surgeon (or access through referral)	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	Quality improvement specialist Billings and coding manager Project manager Process improvement

Conduct internal team kick-off meeting. Consider using the initial meeting to:

- Orient team members to program goals, timeline, measures, and reports.
- Define specific roles and responsibilities for each team member.
- Schedule regular team meetings for the duration of the program to develop and monitor your plan.

Step 3. Ensure commitment that dedicated IT resources will be available

a. Identify sources of data collection (claims, EHR, population health tools, HIE, payers)

b. Run a report on baseline performance. If available, segment the results by care site and providers.

c. Use baseline data to identify high-performing providers and sites of care. Meet with the physicians, care teams, and leaders to discover their best practices and create a plan to disseminate these across the organization.

Step 4. Define your population health strategy

a. Review the Obesity Care Model Domains

b. Assess your current environment (e.g., physical and education) and practices within your organization

   i. Create a flowchart or fishbone diagram of current processes to better understand how chronic obesity is managed and treated in your system. The resulting diagram will allow the team to visualize patient flow, as well as discover and address opportunities of improvement such as redundancies, bottlenecks, and/or gaps in care to achieve greater efficiency.

   ii. Document the step-by-step actions experienced by a typical patient and by a typical care team. This should include activities before the visit (e.g., scheduling, lab tests, reminders), during the visit (e.g., arrival, rooming, decision-making, after-visit summary), and after the visit (e.g., education, follow-up calls, home monitoring).

   iii. Include information about who is responsible, time constraints, and necessary resources.

c. Develop an AIM statement for your program and interventions for implementation. Review recommended quality improvement documentation with your team (e.g., Gap Analysis, PDSA Cycle, and Action Plan tools)

d. Use the gap analysis tool to determine the gaps between current practices and selected objectives that you want to implement.

e. Create an action plan to implement the interventions. The plan should address:
   - Key areas for improvement
   - Plan for accomplishing the improvement in each area, including measureable goals and the activities needed to achieve these goals
   - Project leader and team (be sure to include individuals that directly work in the area that is under assignments)
   - Quantitative and qualitative measurements to monitor progress
   - Timelines and deadlines

f. Modify your baseline flowchart to incorporate the changes you will make to adopt the interventions. Be specific, note on your chart who is responsible and timelines.

g. Implement the interventions using your action plan as a guide. Consider introducing the changes at a single site of care as a pilot using the PDSA cycle tool before system-wide implementation.

h. Monitor the revised process to ensure the change is implemented and sustained over time. Documenting the changes in policies and procedures can assist in assuring standardization, sustaining the activities, and training new staff.

Step 5. Develop a Communication Plan

a. With the right messaging and delivery, efforts can be visible across your organization and community.

b. Prepare an "elevator speech"—a quick way to communicate objectives in a clear, compelling manner—about the program. Consider including why the obesity program is important, how your organization will achieve the goal, and what specific changes each physician or staff member will need to make in order for the project to be successful.

c. Schedule a meeting with your communications, marketing, and/or public relations team and/or agency. In this meeting, begin to discuss:
   - Target audiences (internal and external) who should be made aware of your organization's obesity program efforts
   - Goals and objectives of this communication
   - Messages that align with the goals and objectives
   - Strategies and tactics for reaching these audiences (e.g., email newsletters, media outreach, social media, paid advertisements)

d. Develop the communications plan using information gathered in the initial meeting. Ensure the plan includes responsibilities, timelines, and evaluation mechanisms to determine if the communications activities are reaching your target audiences with the right messaging through the identified channels and achieving the selected goals.

b. Quick Wins

Consider these "quick wins" for each domain as some easy accomplishable steps.

To see examples and resources for each quick win, go to the specific domain section.

COMMUNITY

- Identify and create Community Partnerships for identified gaps and identify "community champions" to facilitate partnerships. S
- Determine organization's approach to the Community domain. If needed, gain leadership support for creation of community outreach services. S
- Compile existing community resources lists for care team and patients and include how to access resources. S

HEALTHCARE ORGANIZATION

- Assess and develop a business case. S
- Provide staff and provider education. R/E
- Develop and integrate EHR. T/W
- Designate a physician champion. R/E
- Conduct educational meetings; use train-the-trainer strategies. R/E

CARE TEAM

- Determine types of care delivery services offered and associated needs. S
- Provide staff and provider education. R/E
- Develop a patient support group or refer to an existing support group. S
- Support, create and integrate a multidisciplinary team into the workflow. R/E
- Create a provider template to manage productivity. S
- Create an obesity registry or dashboard to manage productivity. S

PATIENT & FAMILY

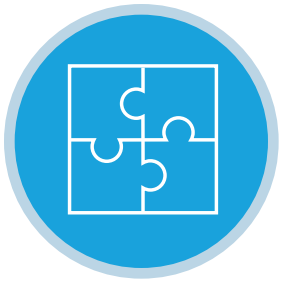
- Include a patient/family champion or patient advisory group during planning to represent the patient perspective. S
- Provide education for patients. R/E

Legend

A = Advanced – highlights an intervention that is considered advanced

S = Services; R/E = Roles & Education; T/W = Tools & Workflow; M/E = Measurement & Evaluation; R = Reimbursement

Plays



Community

This domain focuses on building relationships with and engaging the community (local, external businesses, local government and organizations) to provide services to patients with obesity.

Essential

- Identify and create Community Partnerships for identified gaps and identify "community champions" to facilitate partnerships. S
  Examples: *Annual Food and Farm Family Festival; Local trainers and gyms (Exercise Prescriptions)*
  Confluence Health
  The Guthrie Clinic
  Creating and Maintaining Partnerships
- Determine organization approach to community domain. If needed, gain leadership support for creation of community outreach services. S
  The Guthrie Clinic
  Building and sustaining community-institutional partnerships for prevention research
- Compile existing community resources lists for care team and patients and include how to access resources. S
  Examples: *Fit and Strong Together (FAST)*
  The Guthrie Clinic
  Mercy Clinic East Communities
- Pilot community outreach by placing employees on community boards/organizations. R/E
  Examples: *Community Obesity and Diabetes Summit*
  The Guthrie Clinic
  Blue Zones Project Overview
  Blue Zones Project Website

Additional Interventions for Consideration

- Educate care team and patients on existing resources in the community and how to access resources. R/E
  Advocate Aurora Health
  Cleveland Clinic
- Identify roles and provide education for health provider responsible for community partnerships.
  Examples: *Community navigator, case manager, interns and students, volunteers.* R/E
- Build and train a portable team to provide community services. A R/E
- Integrate community referrals into EHR. M/E
  Utica Park Clinic
- Measure patient experience, effectiveness, and utilization of community resources. M/E
  Example: *Develop and implement an algorithm.*

Legend

A = Advanced – highlights an intervention that is considered advanced
S = Services; R/E = Roles & Education; T/W = Tools & Workflow; M/E = Measurement & Evaluation; R = Reimbursement

Essential (cont.)

- Use patient experience, effectiveness, and utilization patterns to adjust care and services. A ME
  Utica Park Clinic
- Determine payment model. A R
  Example: *Free, self-pay, and reimbursable.*
- Determine costs community resources and provide to patients and the system. R
  Example: *Handouts, tools at check-in and during patient visit.*

Additional Interventions for Consideration (cont.)

- Research hidden insurance benefits. Work with the identified community or population to outline costs, benefits and burdens of participation. A R
  Health Reform and Health Mandates for Obesity
- Develop community specific risk stratification templates and integrate measures. TW
  Example: *Mercy submitted PROM surveys to be integrated into their EHR (Epic). They are currently doing pre-/post-surveys of patients who visit their Weight and Wellness Clinic.*

Winning Plays

The Iowa Clinic

The Iowa Clinic, in partnership with the Iowa Department of Public Health worked on a public 5-2-1-0 Education Campaign across the state. They started by targeting four communities: West Union, Mt. Pleasant, Dubuque, and Malvern. Their multi-sector approach includes early childhood, schools, communities, workplace, after school, and healthcare and follows three core principles: environmental and policy change influences behavior change; interconnectivity across sectors is essential; and strategies are evidence based and continuously evaluated.

Tips

- ✓ Communicate with your community resources/services and incorporate them into your program and workflow. R/E
- ✓ Incorporate questions into your patient satisfaction surveys. M/E
  Example: *CGCAHPS has health education and promotion questions on the survey–"In last 3 months have you or anyone on your healthcare team talked about healthy diet, exercise/physical activity?"*

Healthcare Organization

This domain focuses on the medical group/health system's administrative and financial initiatives to develop and provide support for care delivery to patients with obesity.

Essential

- Assess and develop a business case. (S)
  Example: *Long-term commitment for investment, resources, space*
  Cost of Obesity
- Provide staff and provider education. (R/E)
  Advocate Aurora Health
  CME Websites
- Assess the culture of the organization for weight bias and stigma and support the development of training. (A) (R/E)
  Example: *Offer cultural competency training*
  Novant Health
  Initiating Obesity Discussions
  Keys to Successful Conversations
  Talking to Patients about Weight Issues
  Multicultural Communications
  Ensuring a Welcome Environment for Patients with Obesity
- Designate a physician champion. (R/E)
  The Iowa Clinic
- Conduct educational meetings; use train-the-trainer strategies. (R/E)
  Example: *Evening physician forums*
  Novant Health
  The Iowa Clinic
- Develop patient reported outcome measures. (M/E)
- Establish an insurance verification team to determine insurance and patient reimbursement. (R)
  Working with Your Insurance Provider

Additional Interventions for Consideration

- Integrate obesity-related programs and activities within your quality department services. (S)
  Example: *Alignment of Obesity Program and Quality Department*
  Utica Park Clinic
- Evaluate your employee wellness program for services for weight management. (S)
  Utica Park Clinic
  Tulane University Medical Group
- Provide ongoing services for weight management for employees. (S)
  Advocate Aurora Health
  Tulane University Medical Group
- Obtain leadership buy-in. (A) (R/E)
  Healthcare Partners
- Define your governance's roles and responsibilities for the care delivery model. (A) (R/E)
- Obtain marketing support to help with organization awareness of AMGA's Obesity Care Model implementation (for employees and patients).
  Example: *Develop educational materials.* (A) (R/E)
  Advocate Aurora Health
- Leverage fundraising to target obesity. (R/E)
- Procure appropriate equipment. (R/E)
  Medical Office Equipment Designed for Patients with Obesity

Legend

(A) = Advanced – highlights an intervention that is considered advanced

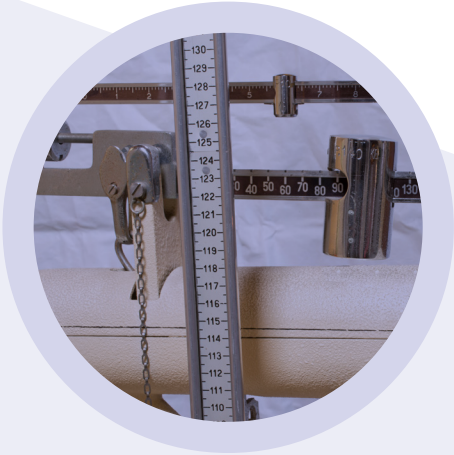
(S) = Services; (R/E) = Roles & Education; (T/W) = Tools & Workflow; (M/E) = Measurement & Evaluation; (R) = Reimbursement

Essential (cont.)

- Ensure appropriate coding for diagnosis and level of service. R
  ICD-10 Website
  Billing Codes and Strategies
  Weight Management Coding Tip Sheet
- Work with payers on negotiating coverage for anti-obesity medications. R
- Support a multidisciplinary team (RD, PCP, BH, RN, Quality, Specialist, etc.). R/E
  Advocate Aurora Health
  Cleveland Clinic
- Develop patient/family champion program.
  Example: *Create a patient advisory board.* R/E
  Mercy Clinic East Communities
  Cleveland Clinic
- Train staff on use of appropriate equipment. R/E
  Advocate Aurora Health
  Medical Office Equipment Designed for Patients with Obesity
- Develop and integrate tools in the EHR. T/W
  Examples: *integrate referrals in EHR; develop risk stratification; develop templates; embed resource tools in the EHR, use of registries, BPAs to alert that patient should be considered for an obesity diagnosis per BMI.*
  Mercy Clinic East Communities
  The Iowa Clinic
  Advocate Aurora Health
- Develop referral process for providers for new or existing obesity/weight management programs. R/E
  Guthrie Clinic

Additional Interventions for Consideration (cont.)

- Develop standing orders. R/E
- Approve and integrate framework and treatment algorithm.
  Example: *Add Obesity as a diagnosis and include on the problem list; development of a simplified algorithm to help guide coordination with the multidisciplinary team.* R/E
  Confluence Health
- Educate providers on referral process for existing obesity programs. R/E
- Provide resources for ongoing measurement of programs. M/E
- Ensure frequent audits while early in development. A R
- Contract with insurers.
  Example: *Utilize verification forms.* R
  Nutrition Solutions Insurance Verification Form
  Bariatric Solutions Insurance Verification Form
- Evaluate your Employee Wellness Program for expenses and potential savings with programs for weight management. R
- Coordinate care and schedule with ancillary services to ensure highest reimbursement. A R



Winning Plays

Advocate Aurora Health

As of 2019 a new BMI initiative, tied to the Centers for Medicare and Medicaid STAR rating, was rolled out for primary care. This includes two elements:

Patients with class 3 obesity require an obesity diagnosis.

Any adult with a BMI over 30 requires a documented plan of care at their annual physical. The treatment plan can include follow-up with the primary care provider or referral to treatment.

Tips

- ✓ Start steering committee of early adopters
- ✓ Create a MD support/mentor program to observe, develop workflow
- ✓ Champions visit pilot sites to motivate and train site physicians
- ✓ Physicians shadow champions
- ✓ Use obesity board certifications to identify champions
- ✓ Identify key individuals (at sites) to bring feedback to leadership team/managers to continually refine program
- ✓ Identify one or two physicians at each PC site who want to work on obesity
- ✓ Create a monthly luncheon to organize implementation teams
- ✓ Find a nurse champion at each site

Care Team

This domain focuses on the medical group/health system's care team implementing initiatives that directly affect patient care.

Essential

- Determine types of care delivery services offered and needs. S
  Example: *Behavioral Health, Registered Dietician, Exercise Program*
- Provide staff and provider education. R/E
  Examples: *ABOM certification; CME, CEU offerings; Invite national speakers to speak at organization; annual and new hire training; new resident training.*
  CME Websites
- Assess patient referral services to gauge clinic access. Set thresholds for referral to appointment timeframe and monitor. A S
  Examples: *Meal replacement may require a contract, body composition will require purchase of scale, etc.*
- Develop a patient support group or refer to an existing support group. S
  Utica Park Clinic
- Implement family based intervention training for Care team. A R/E
- Support, create, and integrate a multidisciplinary team into the workflow. R/E
  Advocate Aurora Health
- Create an obesity registry or dashboard to manage productivity. S
- Develop referral networks. T/W
  Advocate Aurora Health
  Mercy Clinic East Communities
- Use tools to understand the reimbursement landscape. R
  Example: *Provide a guide for providers on diagnosis codes and documentation, guides for insurance verification to navigate insurance company conversations*

Legend

A = Advanced – highlights an intervention that is considered advanced

S = Services; R/E = Roles & Education; T/W = Tools & Workflow; M/E = Measurement & Evaluation; R = Reimbursement

Winning Plays

Confluence Health

Confluence Health developed a comprehensive Weight Management Program handbook as an education tool for providers and staff caring for patients with obesity. For more information, visit their **case study**.

Additional Interventions for Consideration

- Develop and implement patient outreach tools. T/W
  Example: *Reminders via patient portal*
- Facilitate relay of clinical data/output to staff and providers. T/W
  Example: *Transparent reports at the clinic, provider, and patient level.*
- Monitor and provide feedback on treatment algorithm. M/E
- Develop tools for care team. R
  Example: *Preauthorization; system of appeals; coding and billing requirements*
  Weight History Intake Sheet
  Working with Your Insurance Provider
- Appoint team to facilitate communication with patients regarding financial responsibility versus benefit coverage, when applicable. A R

Patient & Family

This domain focuses on initiatives that patients and families are in direct contact with and enables partnerships among practitioners, patients and their families.

Essential

- Include a patient/family champion or patient advisory group during planning to represent the patient perspective. S
- Provide education for patients. R/E
  Example: *Tools to use in treatment plan; develop handouts, classes, social media*
  Understanding Obesity
  Causes of Obesity
  Your Weight Matters Campaign
  Approaches for Healthier Eating and Physical Activities

Additional Interventions for Consideration

- Develop and promote Patient Centered Services center. S
  Example: *Use of social media and technology; patient portal; care navigation; specific patient populations (maternal, geriatric, geographic areas); lifestyle interventions; include manufacturer programs.*
  Utica Park Clinic
  Advocate Aurora Health Care
- Offer support groups. A S
  Utica Park Clinic
- Offer shared medical appointments. S
  Cleveland Clinic
- Provide shared decision-making tools. A T/W
  Goal Setting for Weight Management
  Setting Compelling Goals Patient Handout
- Administer, collect and review patient reported outcome measures. M/E
  Utica Park Clinic
- Develop and provide patient friendly resources at no cost. A R
  Example: *Co-pays; cost of benefits, reimbursements, services, providers, local and free resources*
  Working with Your Insurance Provider

Legend

A = Advanced – highlights an intervention that is considered advanced
S = Services; R/E = Roles & Education; T/W = Tools & Workflow; M/E = Measurement & Evaluation; R = Reimbursement

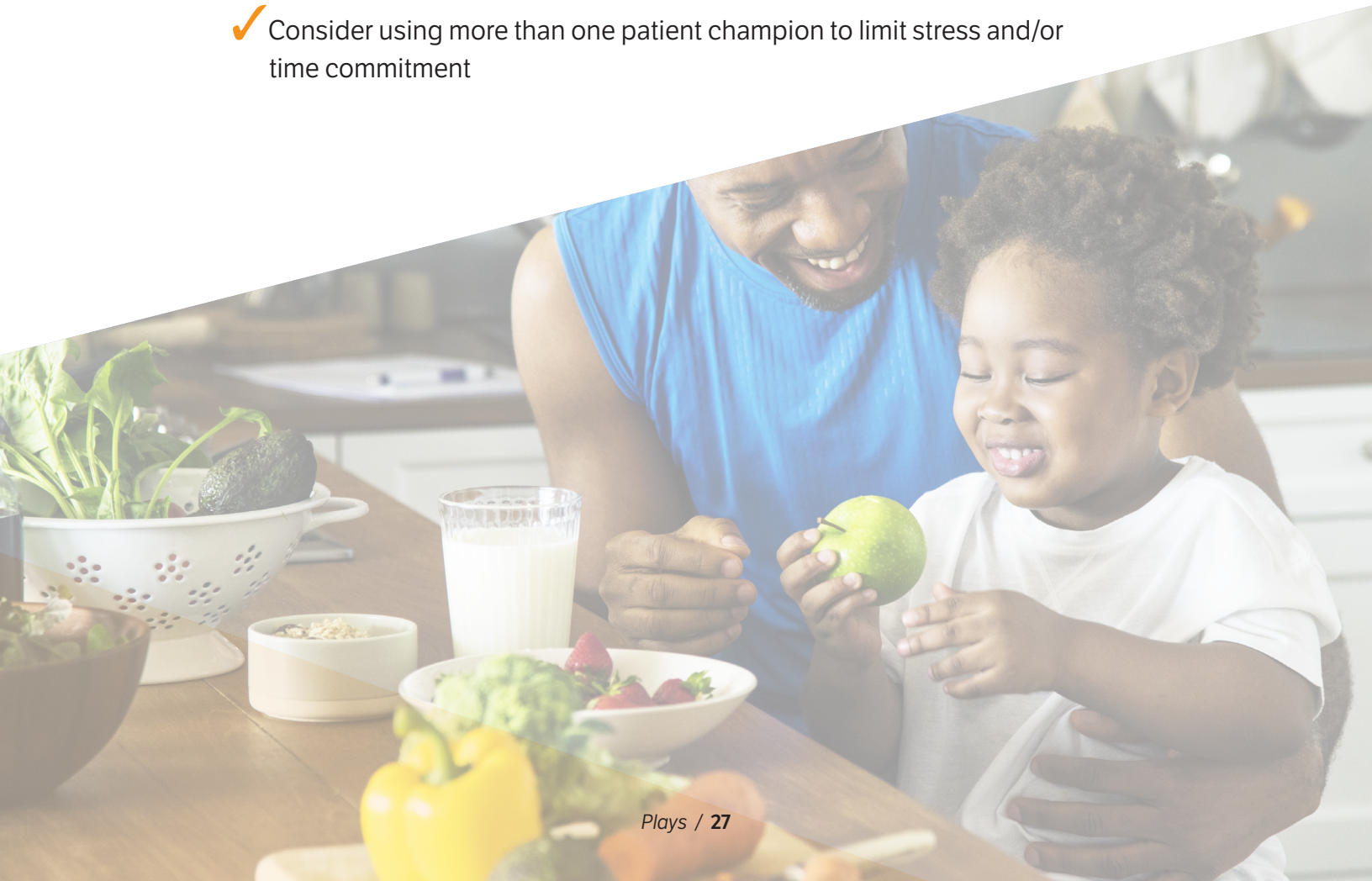
Winning Plays

Cleveland Clinic

Cleveland Clinic worked with its HealthCare partners' liaison to identify patients interested in partnering. In total, two HealthCare partner meetings were held and the HealthCare partners were invited to the AMGA group meeting. The HealthCare partners provided positive feedback of the current content and flow of the SMAs and several suggestions were identified by the HealthCare partner and are being considered. The HealthCare partners' feedback was very informative and Cleveland Clinic incorporated their suggestions into its SMAs.

Tips

- ✓ Consider using an employee that is a patient
- ✓ Consider using more than one patient champion to limit stress and/or time commitment



Obesity Care Model Collaborative Resource Guide

The **Obesity Care Model Collaborative (OCMC) Resource Guide** contains resources on all aspects of treating patients with obesity. It is intended to supplement the framework and provide resources on all aspects of obesity care management. The resources contained here are meant to support a variety of staff and clinicians or providers that interact with and assist the care of patients with obesity. The goal of the OCMC Resources Guide is to provide the best resources available for organizations to better facilitate success in managing care for patients with obesity.

For more information on AMGA's initiatives to address population health, visit amga.org.

One Prince Street
Alexandria, VA 22314-3318

amga.org