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Advancing High Performance Health

Obesity Care Model Collaborative: Case Study

Utica Park Clinic

Organizational Profile

Utica Park Clinic (UPC) is part of Ardent Health Services and Hillcrest HealthCare System's physician group. UPC is one of the most established and recognized healthcare providers in its area and has a loyal patient base that consistently reports high satisfaction scores. As an expansive network of healthcare facilities, UPC takes great pride in a collective and individual commitment to quality. Their high standards for patient care direct every action. Very often, quality care draws the attention of peer review and UPC is proud to be consistently recognized as a leader in the field.

UPC's mission is to be a premier provider of healthcare services delivered with compassion for patients and their families, with respect for employees, physicians, and other health professionals. UPC is also committed to fiscal and ethical accountability and responsibility to the communities they serve.

UPC's population includes over 220,000 patients logging more than 550,000 outpatient visits annually. More than 70 local and rural clinic locations exist throughout the northeast Oklahoma region. UPC employs 234 physicians and advanced practice providers, and over 20 specialty groups including Bailey Bariatric Center and urgent care. Primary care accounts for approximately 60% of UPC's patient visits.

UPC's Quality Improvement department was responsible for the project management and implementation of the Obesity Care Model Collaborative. When choosing the sites for this collaborative, there were many areas of focus considered, including patient population and which clinics demonstrated the highest rate of obesity. UPC chose four clinics separated by two rural and two metro locations with over 68,510 patients (or 78% of the population). Within those clinics, there were more than 60 staff members, with many having experience in weight loss management:

- 29 providers
- 12 weight management specialists
- 6 Quality Team members
- 5 Population Health specialists
- 6 administrative directors
- 4 marketing personnel

Acronym Legend

BPA: Best Practice Alert
BMI: Body Mass Index
EMR: Electronic Medical Record
PROM: Patient-Reported Outcome Measure
UPC: Utica Park Clinic

UPC's Quality Improvement department collaborated with the Bailey Bariatric Center, advising for services provided in weight management, measurement, and reporting.

Executive Summary

UPC piloted multiple levels of intervention that were data-driven and shared across the organization to show the impact of obesity financially and in relation to specific quality measures. The focus was to become transparent by providing accurate data to the pilot clinics and following up with resources, including a weight management guide and algorithm for physicians and providers to reference during a patient visit.

The team initiated five interventions that coincided with the collaborative. These were data-driven and provided best practice for physicians and healthcare providers:

- Data reporting was initially a struggle due to a new electronic medical record (EMR) implementation. UPC quickly rebounded with extensive and accurate data that provided a snapshot of the areas that needed the most attention.
- An algorithm was created that included a pathway for each class of obesity. The algorithm led to the production of an obesity resource guide which was used as a tool when discussing obesity with patients. The resource guide provides references for best practices, communication guidelines, and patient education

The team also developed several new programs that included staff and patients. Both interacted in different ways to benefit individual needs:

- Behavioral Health classes piloted in Cushing, Oklahoma, provided an in-person weekly group meeting to discuss social determinants, patient needs or concerns, and

resources. These meetings gave patients a support system within the community while also providing medical resources when necessary

- Facebook Live cooking demonstrations were broadcasted once a month during the lunch hour in order to increase convenience. Utica Park clinic collaborated with the Tulsa Health Department to create an interactive and virtual avenue to learn new and healthy recipes. These were recorded demonstrations and were watched, shared, and enjoyed by many across the country.
- Employee wellness programs were established due to the large number of claims related to obesity and comorbidities. These programs were implemented to raise awareness, lower costs related to insurance premiums, and provide overall better health. Staff participated in quarterly weight loss challenges and gained access to online educational materials including weekly encouragement emails as well as exercise specialists if requested.

UPC's initial data was "a tough pill to swallow"; however, this was not at all shocking considering Oklahoma's high obesity rates. Raising awareness for obesity may continually be a challenge. Nonetheless, UPC has taken great strides to provide resources that initiate change in provider and patient communication. The expansion of employee wellness programs has brought engagement and participation throughout the health system, leading to better patient communication and awareness.

Program Goals and Measures of Success

The goals set for the Obesity Care Model Collaborative were based on obese patients in three body mass index (BMI) classification categories. UPC's overarching goal was to implement a tested model that manages patients with obesity by providing appropriate screening, intervention, and support for health improvement by educating staff and providers as well as developing tools to be used within the primary care setting. UPC's goals helped to improve overall obesity rates and increase communication across the health system.

Data Documentation and Standardization

UPC used data from 70+ locations that suggested which clinics would have the highest obesity rates. Based on this data, four pilot sites where chosen. Although these locations were the primary focus, most of the standardization across the health system was due to data within the EMR. Best practice alerts (BPAs) and flag indicators created to alert the provider of an obesity diagnosis were important communication tools implemented to raise awareness. Tip sheets regarding proper documentation, coding, and referral processes streamlined the providers' workflow for optimal quality improvement. All internal data processes calculated using the EMR and data warehouse sources were precise.

Population Identification

UPC identified patients through the EMR using BPAs and flag alerts. The system identified obese patients though BMI calculations, prompting the provider to address the diagnosis during an office visit. The provider assesses the obese classification as overweight in classes II, III, or I or class II with additional diagnosis of comorbidities. They are then prompted to diagnose and code appropriately.

Additionally, within the pilot sites patients participated by taking a patient-reported outcome measure (PROM) survey that identified any interest in weight loss programs. The patients that participated in the survey scheduled a follow-up appointment to address obesity, questions or concerns, and receive a referral to a bariatric center if identified as a need during the visit.

Interventions

Before the collaborative began, UPC had numerous methods to capture obesity rates and improve outcomes for patients. Included below are examples:

- Auto-populated BMI results within the EMR
- Educational materials for patients located in the EMR
- Healthy programs for patients and employees

UPC implemented a new system-wide EMR shortly after the collaborative began. This seemed to slow down some progress due to reporting resources. The situation was resolved in a timely manner and new interventions were created and implemented. These included:

- Accurately reported data
- BPAs
- Internal use of flags to alert providers to diagnose
- Improved referral process

One of the most fundamental lessons UPC learned from the collaborative is that when providers have accurate data and information regarding obesity, more engagement follows. In addition, communication and collaboration among facility staff, providers, and patients are key to a successful implementation of any program.

Background

There were many strategies considered when deciding where the primary focus should be during the collaborative. Knowing there would be a large population within the chosen pilot clinics and UPC employees, the question remained as to whom would receive the most benefit—employees or the public. The team decided that both initiatives would better serve the entire population and lead to the best impact related to obesity in the community.

Community

Facebook Live cooking demonstrations, led by registered dieticians, stood to serve a broader range of the community and reach those that may not have had the available resources to take in-person classes. These demonstrations proposed healthier cooking habits and provided education covering the overall better nutritional value of food. Overall, this initiative was a huge success and UPC will continue to develop this program for increased potential and benefit.

Organization

The team, which included weight management staff, revised an already existing employee program that could better serve those in rural areas through increased engagement and stronger outcomes. Champions appointed in outlying clinics and accurate data shared with central staff to calculate weight loss totals helped to determine which teams received awards for having the highest weight loss percentages. Weekly challenges sent to the members of the weight loss teams included 10,000 steps per day, increasing water intake, eating healthy foods and no junk food, along with many others to contribute to a healthier lifestyle. UPC will expand services in the future to provide more opportunities that will instill goals for employees and maintain levels of weight lost throughout these initiatives.

Care Team

One major challenge that UPC faced was patient communication and provider knowledge regarding where to find resources related to obesity. A weight management guidebook created by a team of physicians and providers closed the gap relevant to communication by answering questions regarding obesity and where to find helpful resources. The guidebook included communication guidance for providers with helpful tips for using motivational interviewing and governing difficult conversations. The guidebook also displays an algorithm that is useful to physicians and providers since it includes the different classes of obesity and how to engage patients successfully.

Patient/Family

UPC strategized with a team of physicians, dieticians, and social workers to combine and initiate an in-person behavioral health and nutrition class piloted at one of the rural clinics. This class brought patients who were classified with obesity into a designated safe area to discuss their struggles associated with weight loss, celebrate success stories, and gain access to an on-site nutritionist for strategies related to nutrition and exercise. This pilot program was such a success that UTC decided to continue and pilot in other communities that may have similar challenges.

Outcomes and Results

UPC had difficulty with securing results during the initial request for baseline data. After collaborating with several analysts and building reports to reflect the pilot clinics, the data was attained and accurate. Baseline data presented included notable expectations, which incorporated a large amount of the population within the overweight and obese categories. Throughout the collaborative, improvement with increased BMI documentation and improved lab requisitions were evident (see Appendix).

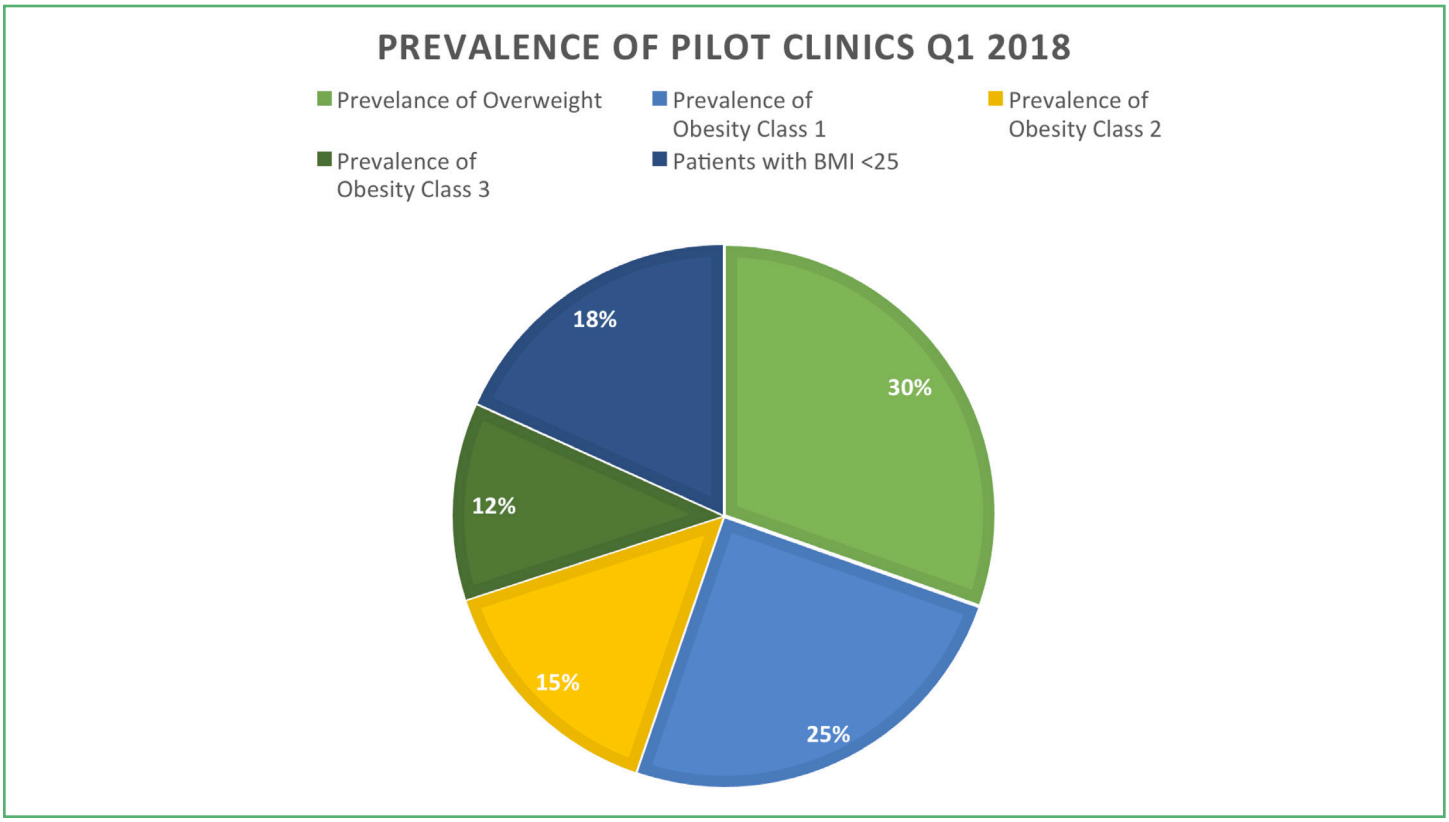
Lessons Learned and Ongoing Activities

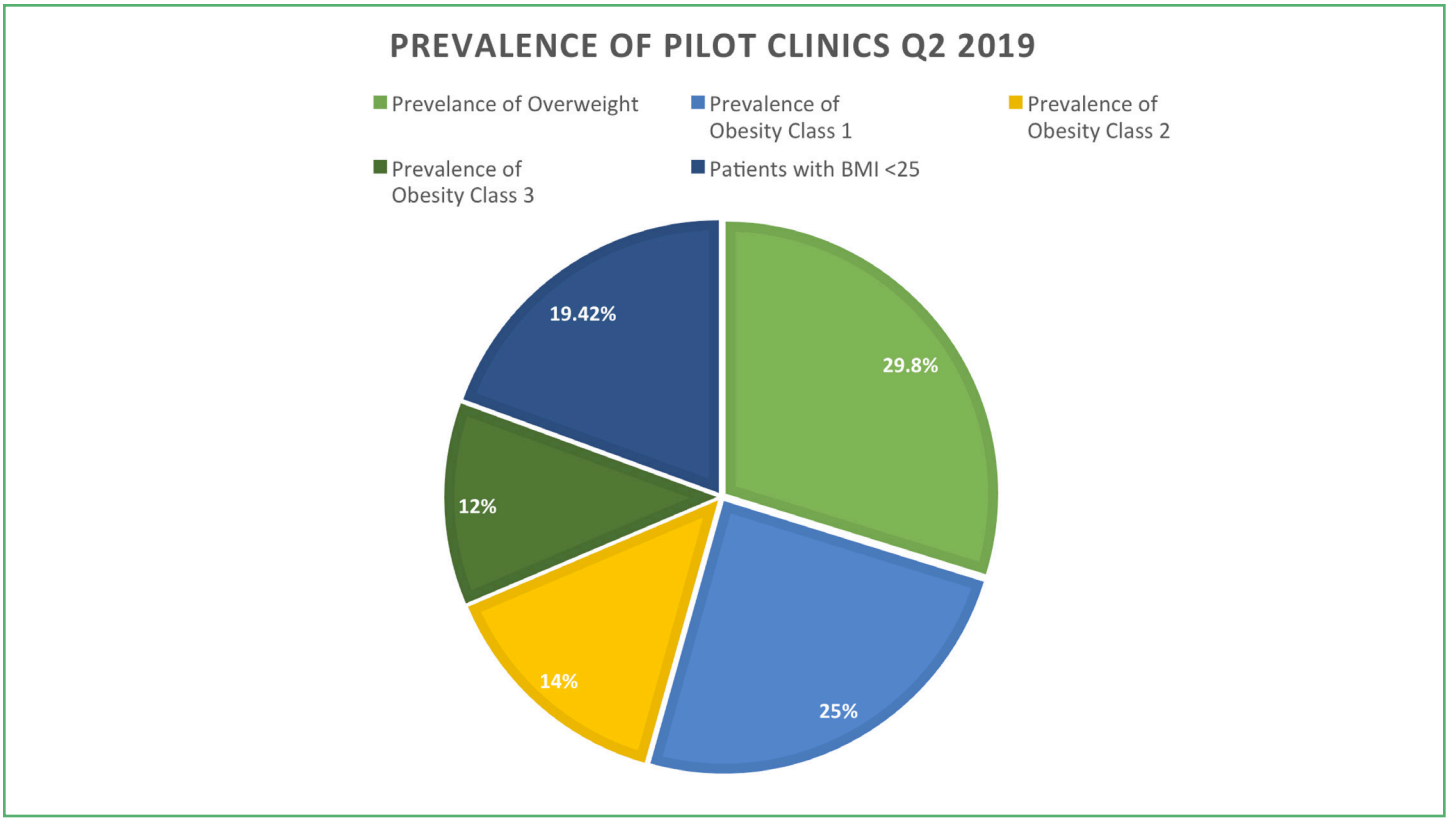
UPC definitely had its fair share of challenges during the collaborative. However, nothing seemed to diminish the diligence and dedication given to succeed and learn from the experience. Overall, UPC learned a considerable amount with reference to the time and consideration it takes to implement change.

The leading goal for UPC was to implement change with regard to communication and referral processes. Creating and distributing the provider guide that included an algorithm as a resource added a valued approach and reflected communication through best practice and tip sheets for reference.

One key factor learned though the collaborative is that provider engagement remains a key component to a successful approach to change. If given an opportunity to improve any aspect, UPC would have elected to appoint more than one provider champion. Providers have different interpretations regarding communication techniques and best practices. Having more than one opinion or level of expertise would be a strong advantage that would allow for more avenues of insight when considering engagement.

Appendix

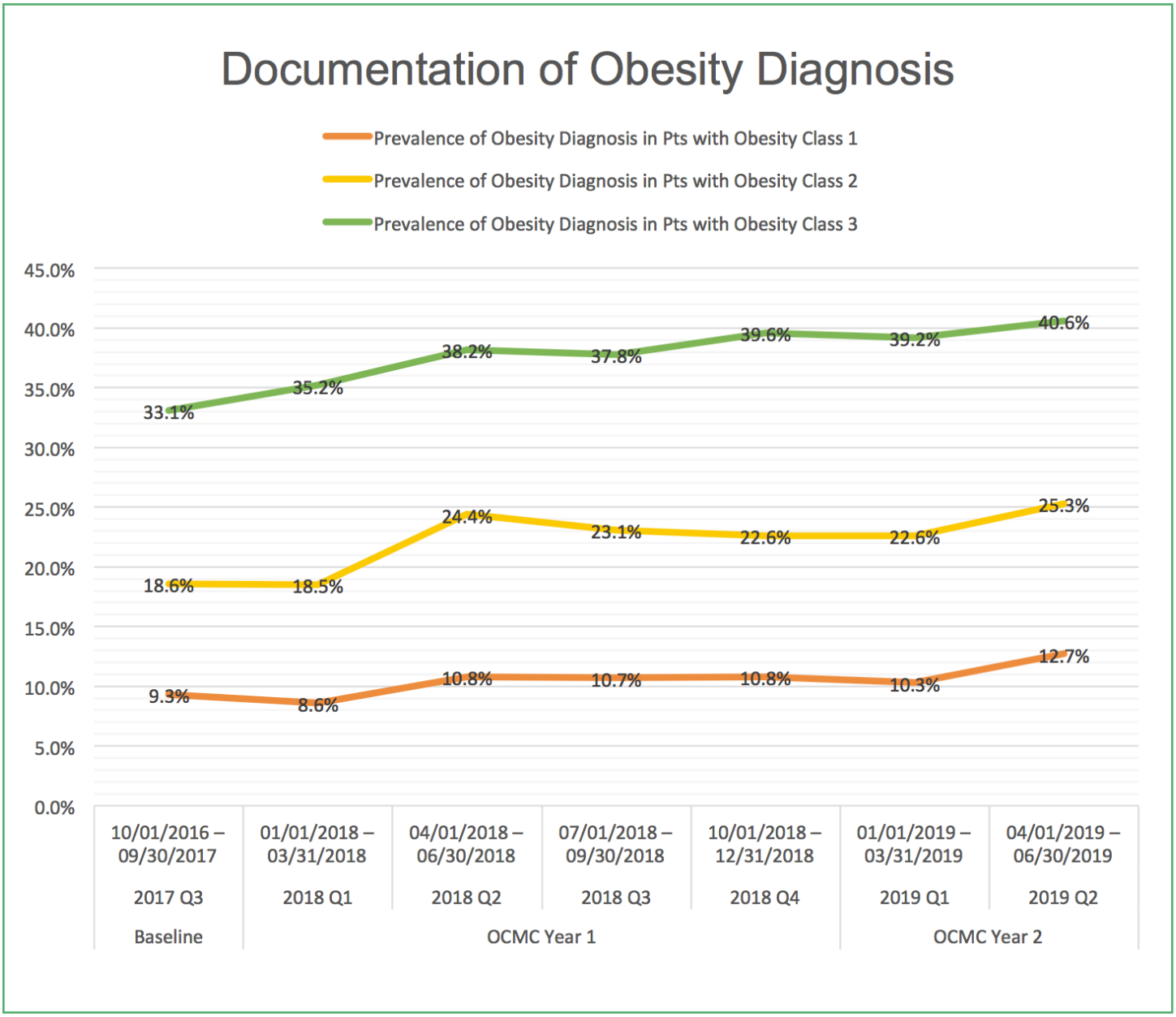

PREVALENCE OF PILOT CLINICS Q1 2018
Prevelance of Overweight
Prevalence of Obesity Class 1
Prevalence of Obesity Class 2
Prevalence of Obesity Class 3
Patients with BMI <25
18%
30%
12%
15%
25%


PREVALENCE OF PILOT CLINICS Q2 2019
Prevelance of Overweight
Prevalence of Obesity Class 1
Prevalence of Obesity Class 2
Prevalence of Obesity Class 3
Patients with BMI <25
19.42%
29.8%
12%
14%
25%

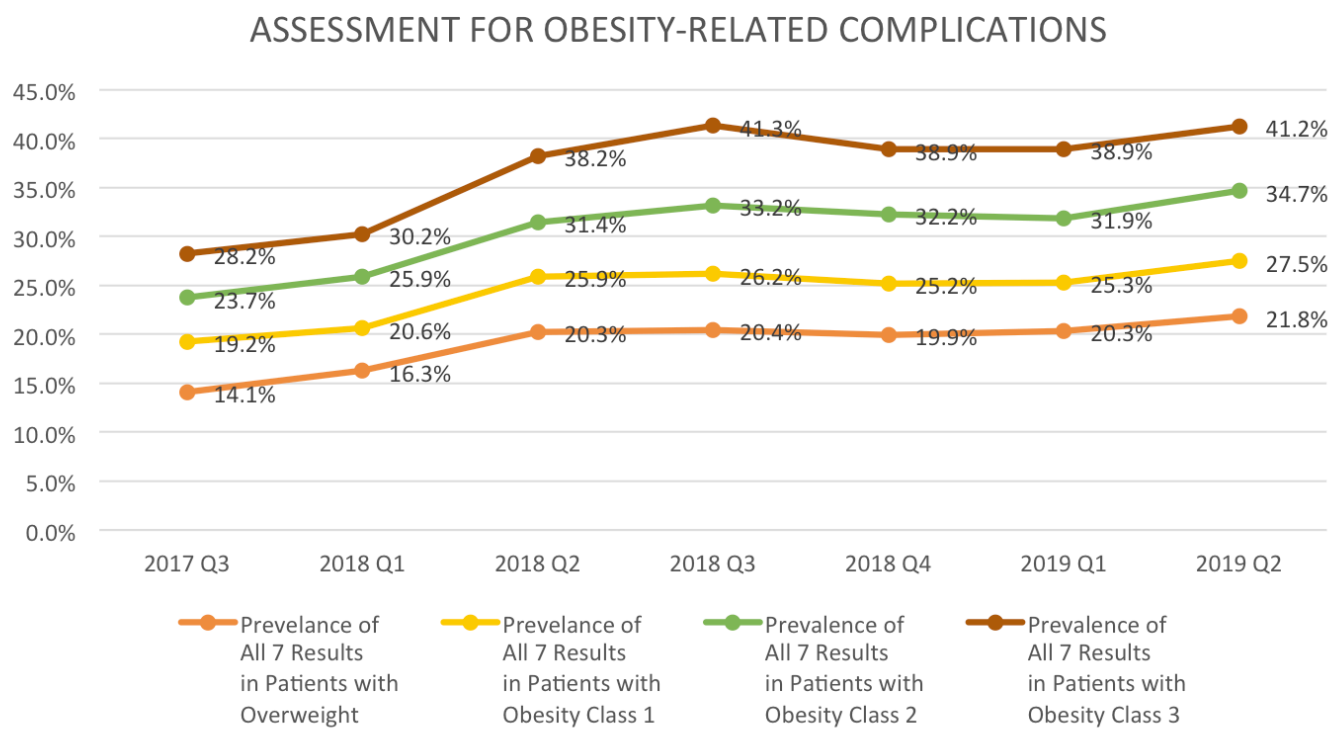
Appendix


AVERAGE NUMBER OF OBESITY-RELATED COMPLICATIONS PER PT.
Average Number of Complications per Patient in Pts with Obesity Class 3 (40 ≤ BMI)
1.86
2.00
1.93
1.99
1.99
1.88
1.97
Average Number of Complications per Patient in Pts with Obesity Class 2 (35 ≤ BMI < 40)
1.68
1.84
1.76
1.80
1.75
1.71
1.80
Average Number of Complications per Patient in Pts with Obesity Class 1 (30 ≤ BMI < 35)
1.47
1.61
1.53
1.54
1.53
1.47
1.56
Average Number of Complications per Patient in Pts with Overweight (25 ≤ BMI <30)
1.19
1.41
1.25
1.24
1.27
1.23
1.30
Baseline
OCMC Year 1
OCMC Year 1
OCMC Year 1
OCMC Year 1
OCMC Year 2
OCMC Year 2

Appendix

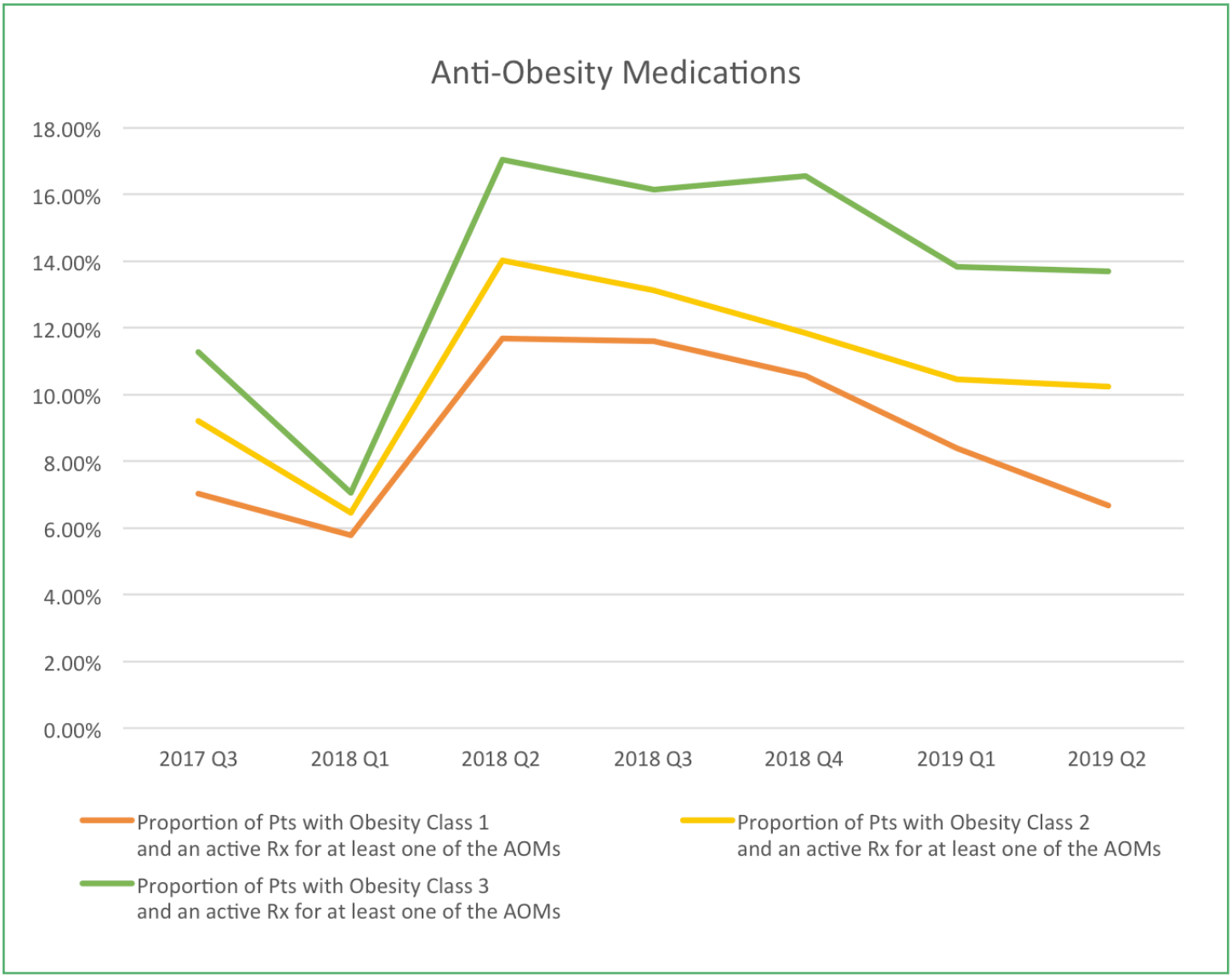

Documentation of Obesity Diagnosis
Prevalence of Obesity Diagnosis in Pts with Obesity Class 1
Prevalence of Obesity Diagnosis in Pts with Obesity Class 2
Prevalence of Obesity Diagnosis in Pts with Obesity Class 3
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
33.1%
35.2%
38.2%
37.8%
39.6%
39.2%
40.6%
18.6%
18.5%
24.4%
23.1%
22.6%
22.6%
25.3%
9.3%
8.6%
10.8%
10.7%
10.8%
10.3%
12.7%
10/01/2016 – 09/30/2017
01/01/2018 – 03/31/2018
04/01/2018 – 06/30/2018
07/01/2018 – 09/30/2018
10/01/2018 – 12/31/2018
01/01/2019 – 03/31/2019
04/01/2019 – 06/30/2019
2017 Q3
2018 Q1
2018 Q2
2018 Q3
2018 Q4
2019 Q1
2019 Q2
Baseline
OCMC Year 1
OCMC Year 2

Appendix

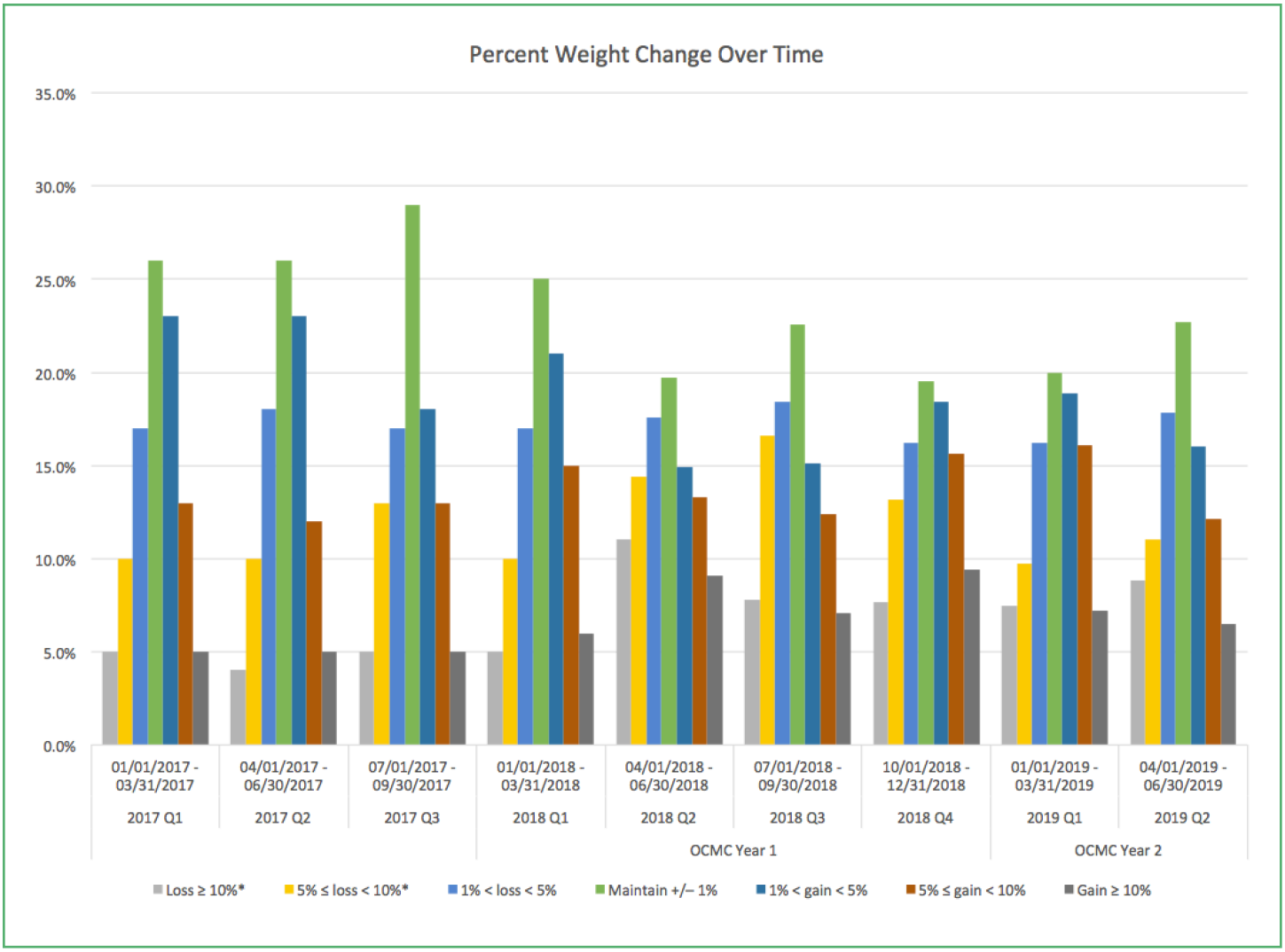


1. Blood pressure
2. HbA1c or FPG
3. HDL Cholesterol
4. Triglycerides
5. Thyroid Stimulating Hormones (TSH)
6. Serum Creatinine
7. AST, ALT, or AST/ALT

Appendix


Anti-Obesity Medications
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
2017 Q3
2018 Q1
2018 Q2
2018 Q3
2018 Q4
2019 Q1
2019 Q2
Proportion of Pts with Obesity Class 1 and an active Rx for at least one of the AOMs
Proportion of Pts with Obesity Class 2 and an active Rx for at least one of the AOMs
Proportion of Pts with Obesity Class 3 and an active Rx for at least one of the AOMs

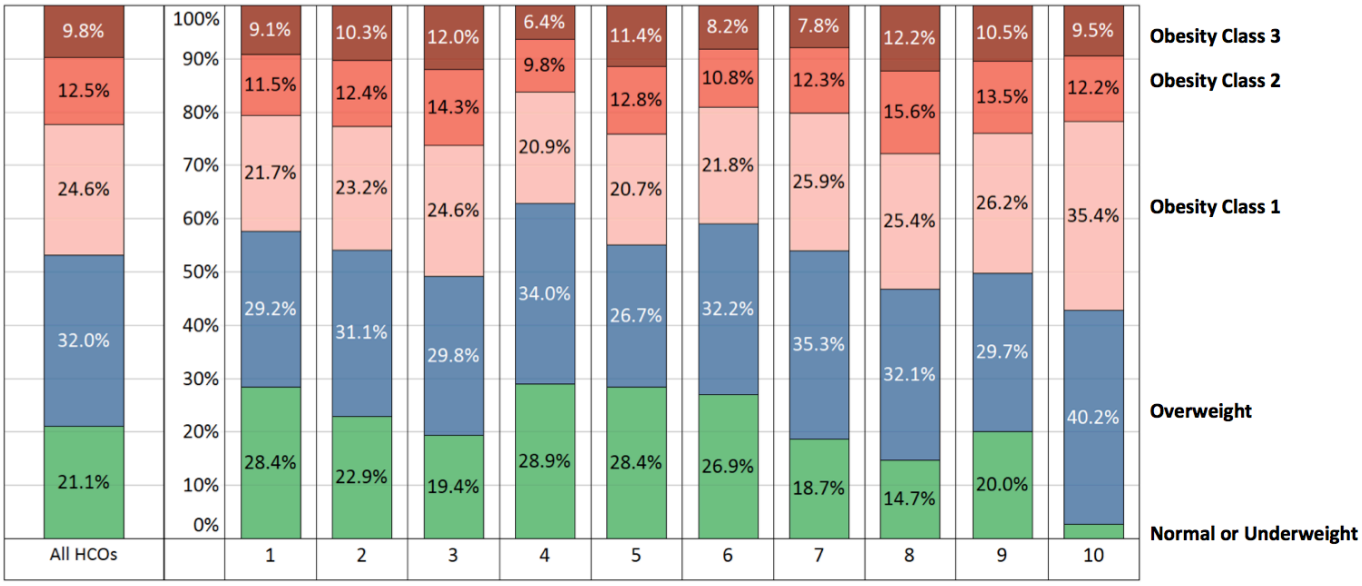
Appendix


Percent Weight Change Over Time
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
01/01/2017 - 03/31/2017
2017 Q1
04/01/2017 - 06/30/2017
2017 Q2
07/01/2017 - 09/30/2017
2017 Q3
01/01/2018 - 03/31/2018
2018 Q1
04/01/2018 - 06/30/2018
2018 Q2
07/01/2018 - 09/30/2018
2018 Q3
10/01/2018 - 12/31/2018
2018 Q4
01/01/2019 - 03/31/2019
2019 Q1
04/01/2019 - 06/30/2019
2019 Q2
OCMC Year 1
OCMC Year 2
Loss ≥ 10%*
5% ≤ loss < 10%*
1% < loss < 5%
Maintain +/– 1%
1% < gain < 5%
5% ≤ gain < 10%
Gain ≥ 10%

Final Data Report from AMGA Obesity Care Model Collaborative

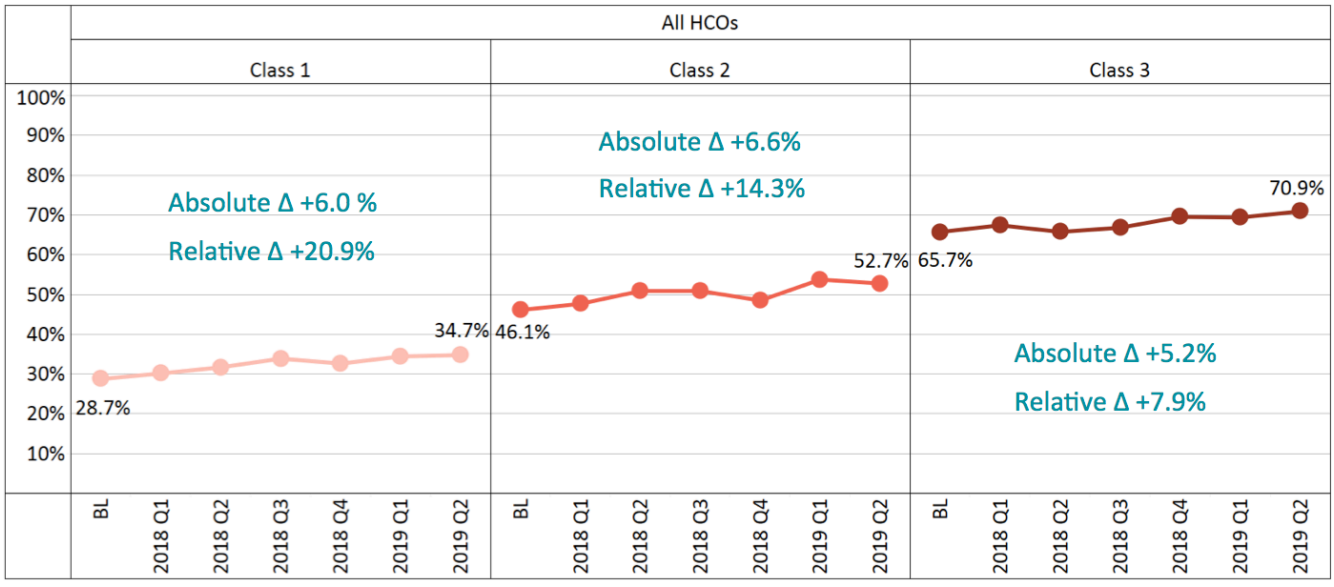
Prevalence of Overweight and Obesity: 2019 Q2

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



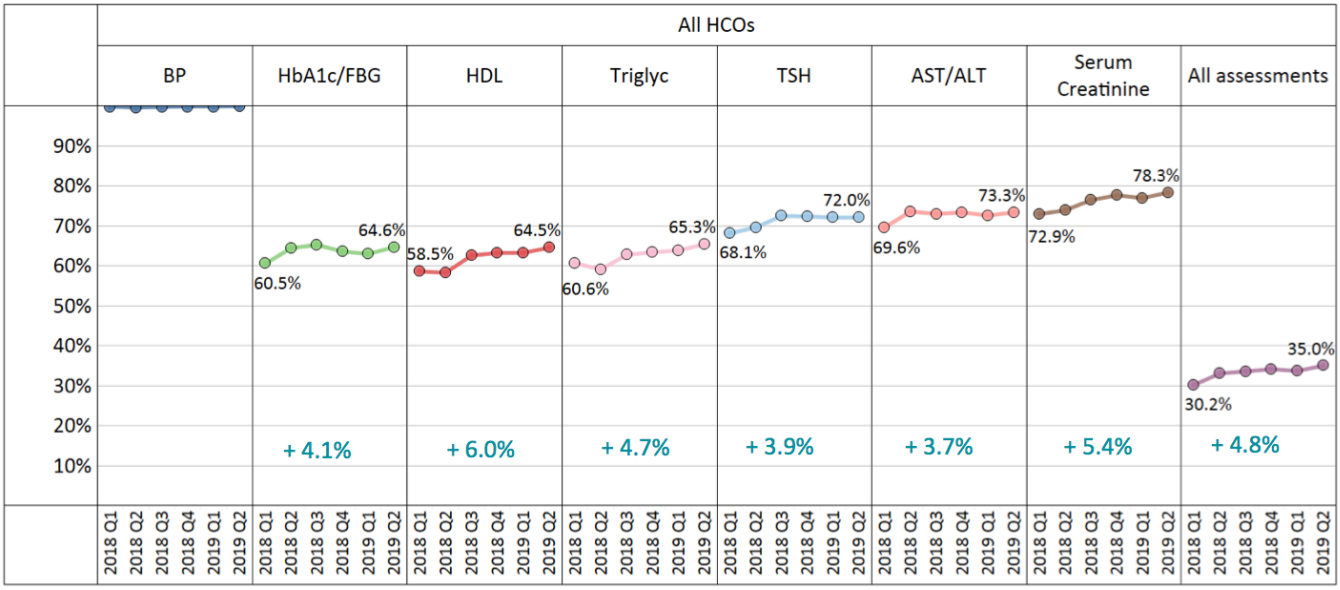
Collaborative Performance: Documentation of Obesity Diagnosis

- 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



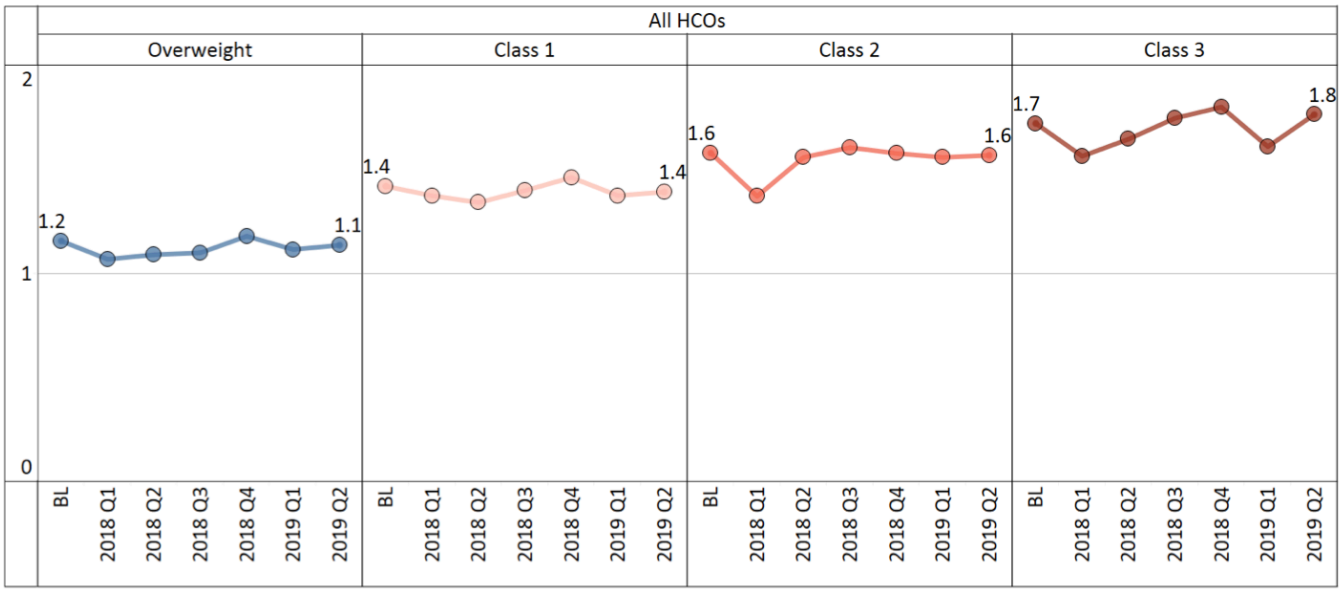
Assessment for Obesity-Related Complications

- 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



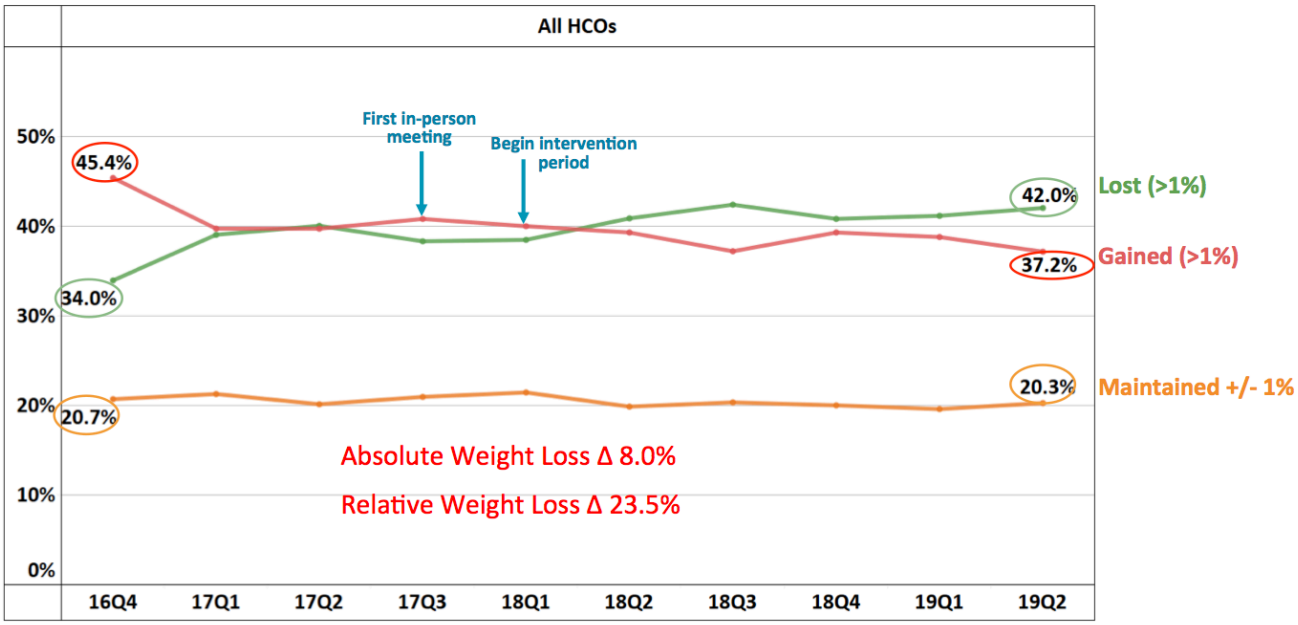
Obesity-Related Problem Scale

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

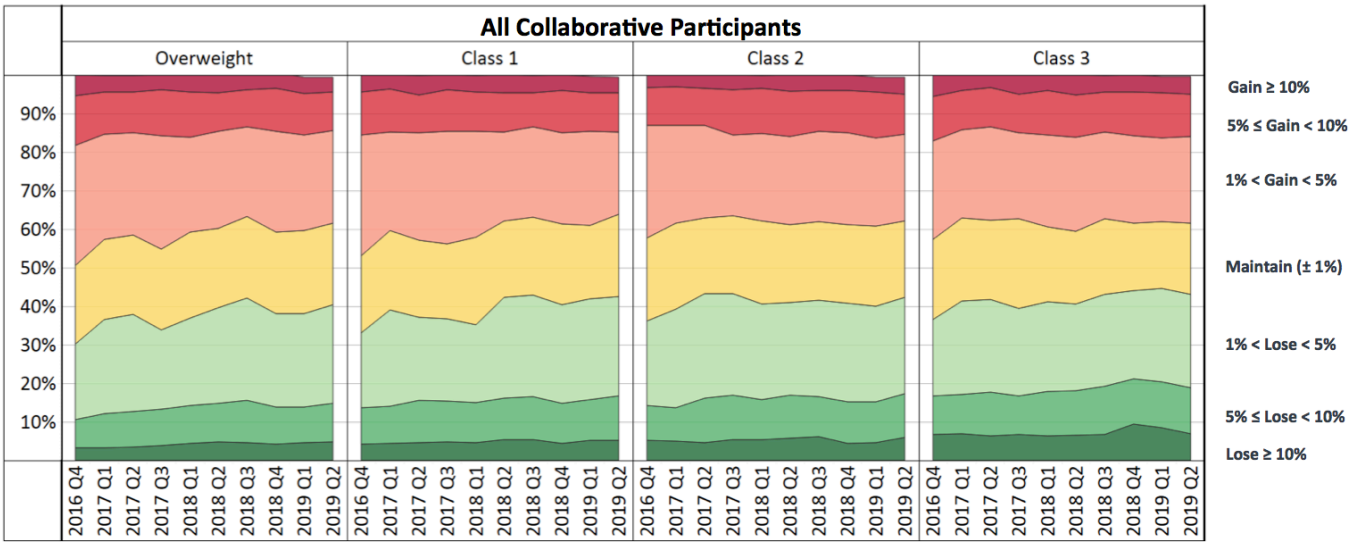
HCO	Pre-Surveys	Post-Surveys	Response Rate	Met Goal Pre	Calculated Δ
9	86	44	68%	Y	Y
5	19	19	24%	N	Y
3	44	7	54%	N	N
4	155	NA	73%	Y	N
10	96	NA	98%	Y	N
2	53	NA	100%	Y	N

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



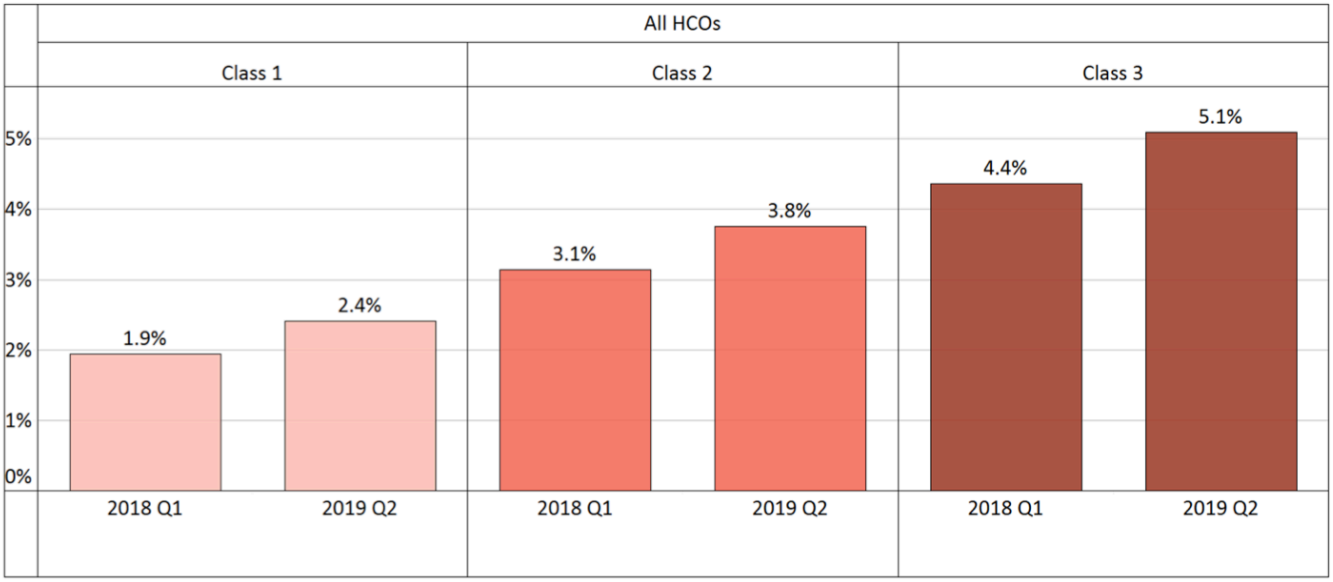
Measure 6: Proportion of Patients by Percent Weight Change

- 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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