CASCHEW Conference

March 2nd, 2024

Project Aims

Funded by the Patient Centered Outcomes Research Institute (PCORI)
Implementation Project
Funded intended to further implementation of evidence from PCORI-funded studies

Goal: Help patients get the help they need to successfully manage weight by supporting primary care practice teams to deliver evidence-based obesity care.

Aims:

1. Using the Exploration, Preparation, Implementation and Sustainment (EPIS) Framework, implement evidence-based approaches to obesity care through care delivery models and, using RE-AIM outcomes, evaluate the 1) adoption, implementation and maintenance (AIM) of the IBT for obesity models at the practice level and 2) reach and effectiveness (RE) of weight loss and maintenance at 6, 12 and 18 months at the patient level.
2. Using qualitative, quantitative and mixed methods, including qualitative comparative analysis, determine factors associated with RE-AIM outcomes including contextual factors (external environment as well as organizational, practice and patient characteristics), IBT for obesity models and their components, and implementation strategies.

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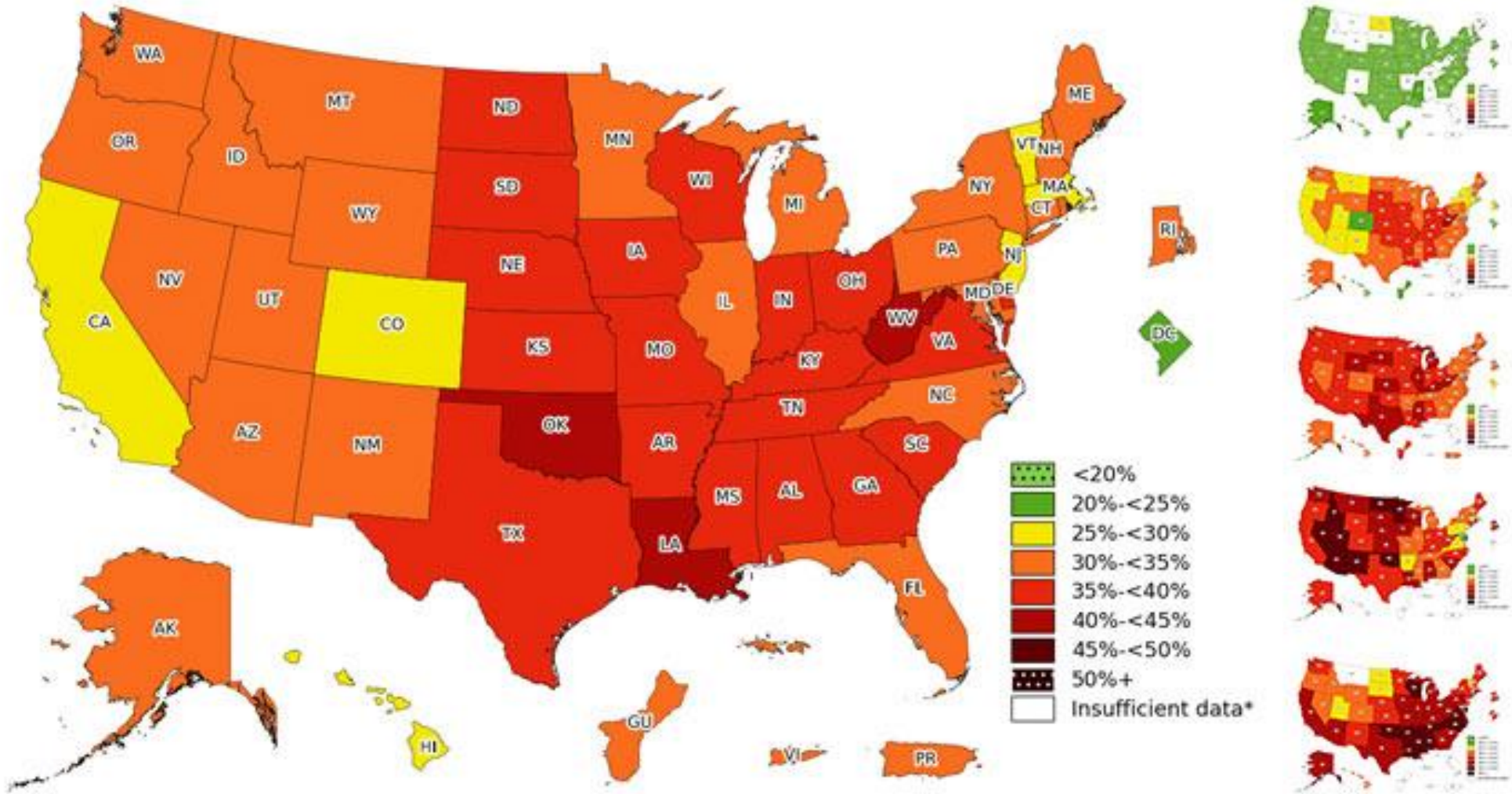
Obesity is a disease

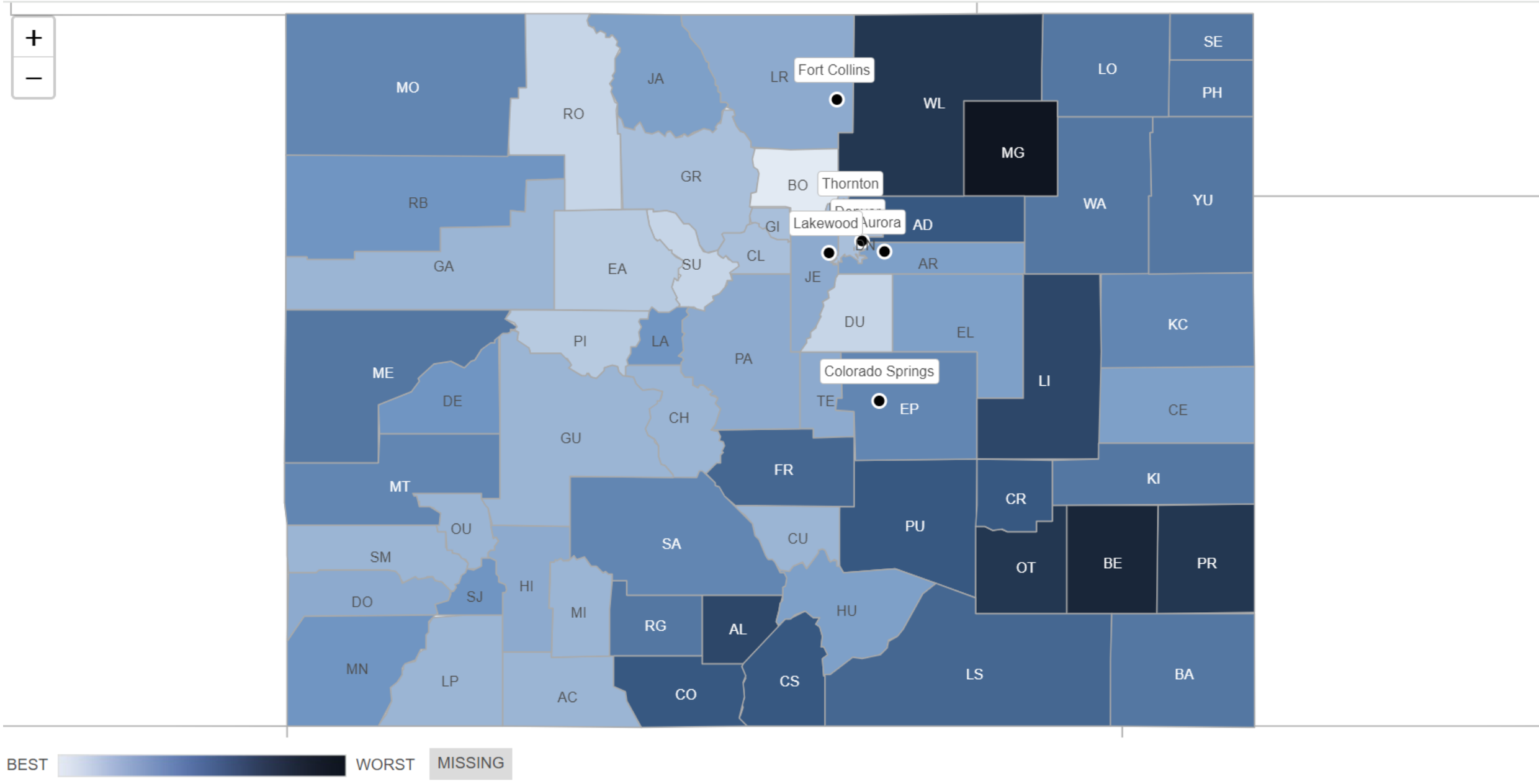
“A chronic, relapsing, multi-factorial, neurobehavioral disease, wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biochemical, and psychosocial health consequences”

2014-2015 American Society of Bariatric Physicians

Obesity is very common



https://www.cdc.gov/obesity/data/prevalence-maps.html#overall



https://www.countyhealthrankings.org/explore-health-rankings/colorado?year=2023&measure=Adult+Obesity

Also…

- Primary care is endorsed as a place where patients should get help to prevent and manage health problems, including obesity
- Evidence-based treatments for obesity are available
- Most primary care practices do not have the personnel, training and resources to help patients with obesity

Previous study results

- Befort, et al: (2021) compared three models (in clinic group visits with a practice clinician, telephone group visits with study staff, and in-clinic individual visits with a clinician) in rural practices. The in-clinic group visits were most effective for weight loss at 24 months, although all models achieved clinically meaningful weight loss
- Katzmarzyk, et al. (2021) found that IBT for obesity delivered by practice health coaches was effective in underserved populations

Structures (we are calling models)

Feature	Individual led by Billing Clinician	Individual led by Health Coach	Group led by Clinician
Intervention description Weight loss goal is 10%. Goals set and action plans for eating and physical activity. Patients encouraged to complete at least 175 minutes of physical activity per week.	Clinicians meet with patients individually to set goals and action plans and monitor progress.	Health coaches meet with patients individually to set goals and action plans for and monitor progress.	Practice-based interventionists leads group medical visits to set goals and action plans and monitor progress. Clinicians are provided feedback on progress.
Interventionist	Billing clinician (physician or APP)	Practice-embedded health coaches without a specific credential; receive training	Practice clinicians – usually a nurse or dietitian, but can be a physician, APP or behavioral health provider
Visit schedule and description Some options for telehealth may be available based on reimbursement potential and grant funding requirements	First 6 months: 16 in-person visits and 6 telephone visits Next 18 months: Alternating in-person and telephone visits 20–45 minutes per visit, conducted individually or in small (2–4 patient) groups depending on patient preference	First 6 months: 16 in-person visits and 6 telephone visits Next 18 months: Alternating in-person and telephone visits 20–45 minutes per visit, conducted individually or in small (2–4 patient) groups depending on patient preference	First 14 visits in person Option to switch to conference calls thereafter (most practices preferred continuing in-person visits) 60 minutes per visit, conducted as a group (8-14 patients per group)

What are the core components?

The approach is essentially lifestyle management support:

- Diet/calorie adjustment and tracking -- flexible, based on what fits best for the patient
- Exercise -- encourages at least 175 minutes of moderate physical activity/week
- Stress management and sleep improvement

Clinicians can also use:

- Medications
- Behavioral therapy/counselling
- Consideration of bariatric surgery referrals

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Intensive Behavioral Therapy (IBT)

- Type of lifestyle counseling
- Frequent visits over the course of one year, weekly for first 4 weeks, then biweekly through six months, then monthly
- Based on tracking diet/calories and increasing physical activity
- Medicare HCPCS codes allow for reimbursement for these visits (other codes can be used for non-Medicare patients)
- Has been shown to lead to meaningful weight loss

What about meds?

- Changing landscape!
- All med effectiveness studies done with an included lifestyle intervention
- No long term data yet
- Other health benefits related to diet and exercise

Participating Practices

- Group visits:
  - Primary care partners (GJ, CO)
  - Mountain Family (Basalt, CO)
  - Valley Wide (Canon City, Cesar Chavez, Sierra Blanca, all CO)
  - Winding Brook (DPC, NH)
  - Alere Family Medicine (DPC, PA)
- Health Coach
  - Hudson Clinic (CO)
- Both health coach and clinician
  - Internal Medicine at Valley View (Glenwood Springs, CO)
  - CU Family Health Services, Sheridan (Denver, CO)
  - CU Family Health Services, Belleview (Denver, CO)

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Participating Practices

- Individual visit with clinician
  - Arvada West
  - Castillo
  - Clinix
  - Denver Family Medicine
  - Himalaya
  - Honglan Lu Family Medicine
  - Midvalley
  - Rio Grande
  - St. Luke's
  - Telluride Regional Medical Center
  - Westminster
  - Integrity (DPC, KS)
  - Sparrow Family Medicine (DPC, PA)
- Summit primary care
- Inova (VA)

- Still deciding: 2 practices in FL

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HOPE Curriculum

- Based on National Diabetes Prevention Program Curriculum
  - Has been used in hundreds of sites across the country
  - Started in 90s, has been updated multiple times since then
  - Is the basis for most IBT curricula (including the studies the led to HOPE)
- Adjusted for obesity
  - Still focusing on diet/calorie tracking, increasing moderate physical activity, target percent weight loss
  - Not specific to preventing diabetes
  - Some content modified and additional resource options added
- Long-standing, significant evidence for effectiveness

Topics – First six months

Foundational:

- Introduction to the program
- Burn More Calories than you Take In
- Eat Well to Manage your Weight
- Track your Food
- Get Active to Manage your Weight
- Track your Activity
- Get More Active

Deeper dive:

- Shop and Cook to Manage your Weight
- Manage Stress
- Find Time for Fitness
- Cope with Triggers
- Keep your Heart Healthy
- Take Charge of your Thoughts
- Get Support
- Eat Well Away From Home
- Stay Motivated to Manage your Weight

Topics – second six months (or longer)

- When Weight Loss Stalls
- Take a Fitness Break
- Stay Active to Manage your Weight
- Stay Active Away from Home
- Learn About Obesity and Health
- More About Carbs
- Have Healthy Food You Enjoy
- Get Enough Sleep
- Get Back on Track
- Manage your Weight —for Life!

Data collection plans

- Baseline, midpoint and end of project mixed-methods analysis
- Practices submit:

Monthly

- HOPE Patient Enrollment (excel)
- Individual visits: HOPE Individual Patient Visits and Intervention Delivery (excel)
- Group visits: HOPE Group Patient Visits and Intervention Delivery (excel)

Ongoing in the medical record

- Height (once at enrollment)
- Weight
- Total minutes/week physical activity since last visit
- Goal for next visit
- Goal attainment from last visit
- PROMIS/QOL (at specific times)

Progress thus far

- Practices onboarded, training, curriculum developed
- Will complete baseline data collection soon
- Many have started offering to patients
- Meeting with practice facilitators

Project Organization

- Principal Investigators
  - Nederveld – practice implementation and support
  - Holtrop – evaluation and reporting
- Design and Advisory Team
  - Kwan – lead
  - Hightower, Koren - advisors
- Training and Content
  - Jortberg, Wearner – leads
  - Befort - expert
- Practice Facilitation Team
  - Halfacre, Wearner – leads
  - Bell, Brennan - facilitators
- Evaluation Team
  - Connelly – study manager
  - Glaros, Connelly – qualitative
  - Luo, graduate assistant - quantitative
- Scientific Team
  - Bessesen, Glasgow – advisors
  - Kwan, Holtrop, Befort, Luo, Nederveld

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