UNIVERSITY of GUELPH

CHANGING LIVES
IMPROVING LIFE

Obesity Management Planning Framework for Inter-professional Primary Care

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Science in Practice

CAHSPR
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Tools to Help Primary Care

- CON Key clinical tools – 5As, 4Ms
- Manuals, equipment, etc

- 60% adults
- 32% children
- Adults
  - Average loss 3 kg
  - 1 in 5 can lose 5%
- Chronic condition
- *“shift and squish”*

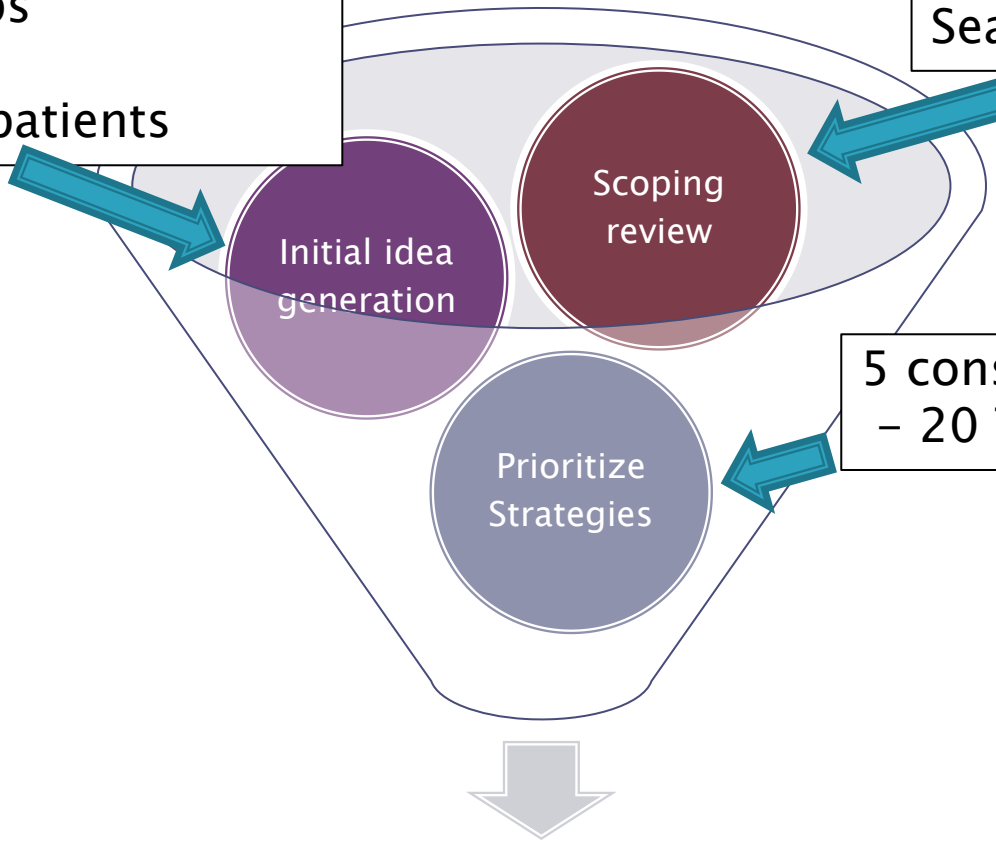
Tool to Guide Program Planning

- For teams and planners
- Obesity prevention and treatment
- Population-based
- Lifestyle or combination
- Evidence and provider perspectives!

Approach

11 focus groups
Hamilton FHT
Providers and patients

2003-2012
Search for PHC Studies



5 consensus workshops
- 20 Teams

Draft Planning Framework
½ day in-person, revise, review

Similar activities grouped
Reflect providers views
first, evidence to support

Considered feasible
Cost not considered

Defining target groups

- Many ways to categorize “populations”
- Aimed for least number of different groups for planning services
- Professions differed – prevention separate?
- Evidence mostly by disease
- Used common age groupings and general health

Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex

Overview

Classification	Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex
Raising Awareness					
Identification and Initial Management					
Follow-up Management					
Expanded Services					
Practice Initiatives					

	Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex
Raising Awareness					
Providing information and resources on weight-health	[A] Raising awareness about the weight-health connection			[B] Waiting room pamphlets etc.	[D] Waiting room resources - not mentioned by providers
Providing info on community services	[D] Community resource information - not mentioned by providers	[B] List of community resources / activities	[A] Providing information on community programs and resources		

Provider rankings

[A] = high priority (ranked 1-5)
[B]= moderate priority (ranked 6-10)
[C]= limited priority (ranked >10th)
[D] = not mentioned

Category *Strategies*	Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex
Identification and Initial management					
Wellness Care /Health Check	[A] Consideration of weight within a wellness visit rather than episodic care *[not explicit in evidence - in research would have an additional visit]*			**[A] Screening as part of a wellness or prevention visit - supported by evidence and high priority by providers**	
Episodic Care	[B] - Episodic visit to identify risk	[D] Episodic care to identify risk - not mentioned by providers		**[C] Episodic visits for screening - supported by evidence and limited priority by providers**	[C] Screening for depression *[already seeing providers regularly?]*
Drop-in clinics	[B] Drop-in clinics (baby weigh-ins, parental support)	[D] concept not mentioned by providers	[C]Drop-in clinics	[D] concept not mentioned by providers	

Bolded and underlined = strategies from clinically relevant studies and also endorsed by providers

Bolded only = strategies from clinically relevant studies, but not identified by providers

Category *Strategies*	Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex
Follow-up Management					
Group Program Specific	[A] Group education: pre & post natal classes, parent and baby groups	[A] Parental education / family education focused on raising awareness and healthy development	[A] Teen group education [B] Family support system / parent groups	**[A] Group education for weight issues highly supported by evidence and providers**	[A] Support programs *[no evidence for wt loss]*
Ongoing Support by Practice	[C] System navigation guide; ongoing support	[D] Concept was not mentioned		**[D] Ongoing support for treatment in evidence** [C] System navigation for marginalized [C] Improved access to exercise by practices	[A] Routine visits for chronic disease check-ups; [A] Case-management to navigate system *[no evidence]*
Social and Peer Support	[C] Some support through group programs		[C] Teenage peer support group with peer leaders	[D] Peer support groups with other opportunities for group – not a separate strategy	[B] Peer led self-management support groups

Category *Strategies*	Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex
Expanded Services					
Availability of Team Services in Practice	[A] Access to dietitian and physical activity specialist [C] Lactation specialist services	[D] Access to team not mentioned by providers *[may already have expertise in teams? may not be seeing many children]*	[C] Access to team services	**[D] Adding expertise in diet and physical activity to team - in evidence only** *[not a big issue for providers as they already have a team?]*	[B] Increased access to mental health expertise, diabetes specialists, chiropodist, social work and heart health *[expertise already available?]*
Access to External Specialist Services	[D] External specialist services not mentioned by providers *[assumption of connection to other services so did not emerge as a priority?]* *[conducting a research study would provide access to specialist services]*			[C] Integration with bariatric programs	[D] External specialist services not mentioned by providers

Category *Strategies*	Pregnancy to 2 years	3 -12 years	13-18 years	18+ Generally Healthy	18+ Medically Complex
Practice Initiatives					
Team Practice /Education	**[B-C] Age-specific provider education on differing roles; care maps for practice, common language, team function** ***[would be included in any* evidence]**			**[B] Provider education with algorithms and formal programs – in evidence and moderate priority by providers;** **[D] Practice facilitation;** **[D] RN expanded scope in evidence**	[C] Provider education *[have focused on chronic disease management over last several years*]
Patient Outcomes Review /Use EMR	[D] EMR tracking not mentioned	[B] Develop EMR for plotting child growth	[D] EMR tracking not mentioned	**[C] EMR long term tracking of changes;** **[D] External audit - evidence only**	[C] EMR tracking
Coordination Collaboration /Partnerships / Advocacy	[B] Establish partnerships (e.g. parent and baby groups, public health)	[A-B] Work with the community and schools		[B] Partnerships with workplaces; [C] Community partnership	[C] Partnerships with community agencies *[already partnered?)*

Overall

- Evidence and provider support for wellness care; episodic care for rest
- Group programs!
- Support for provider tools; training

- Provider priorities to direct patient care
- Evidence gaps!

Lessons Learned

- Target audience of organization level planners difficult to reach
- Providers most interested in direct care and work to routines
- Evidence may or may not link well to typical ways of practice
- Describing populations differs – mental health and SES – all groups
- Need more methods for melding evidence and provider perspectives
- Intermediate tool for developing scalable interventions

Pre-diabetes – example

	MD only	Expanded	Desirable
Build Awareness	Pamphlet on health risks and what to do	+ Community facilities	+ web screening
Initial Identification	Diagnose 10 min Advice	Diagnose <5 min Advice	+ Screening program
Follow-up Management	6 and 12 month visit – blood work	+ Group classes – overview	Coordinated team Program for 1 year
Expanded Services (team, specialist)		+ Some referred to RD (and for exercise advice)	
Practice Initiatives		+ Start to assess outcomes	+ YMCA partnership

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