

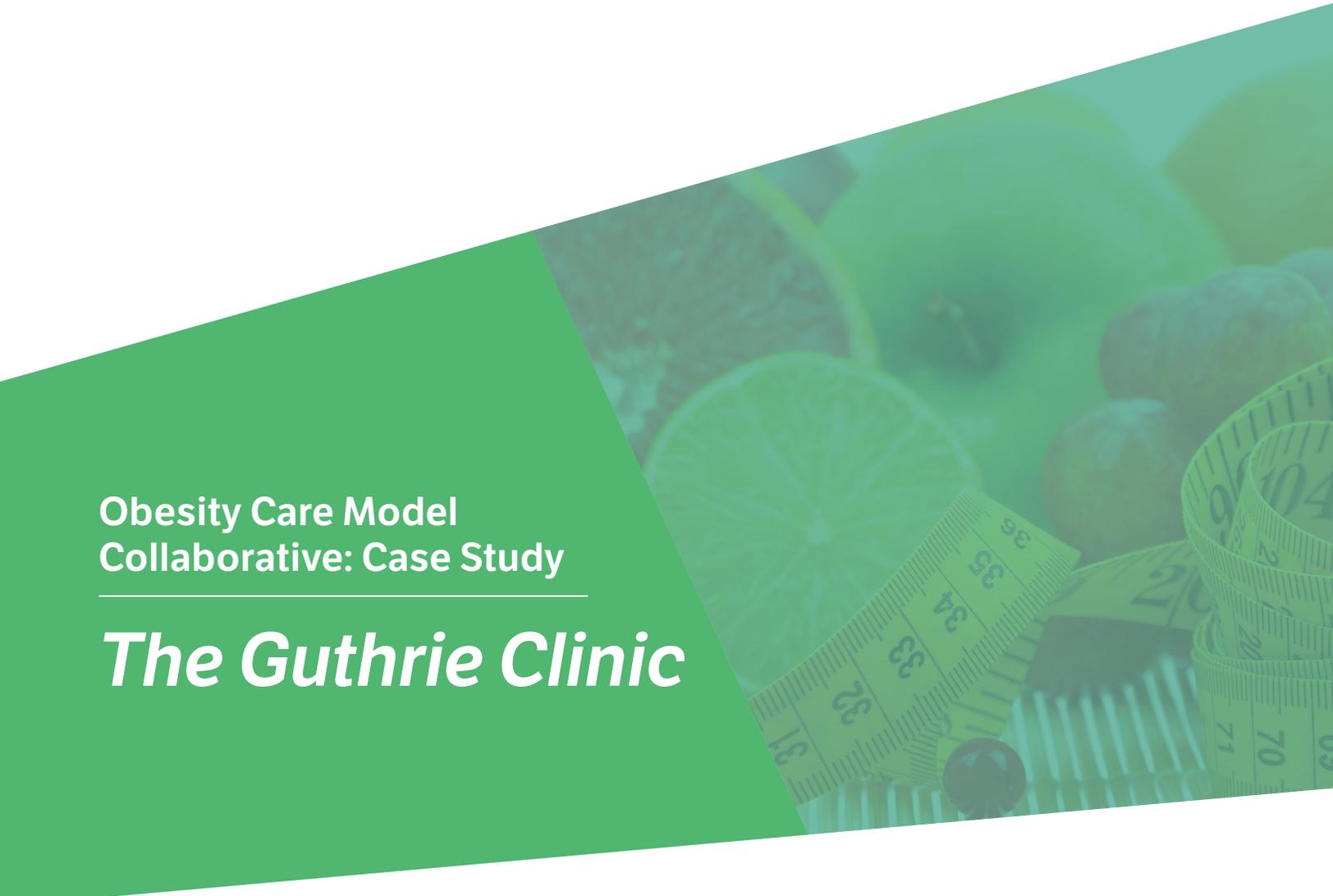


Advancing High Performance Health

Obesity Care Model  
Collaborative: Case Study

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*The Guthrie Clinic*



## Organizational Profile

The Guthrie Clinic is a non-profit integrated health system with headquarters located in Sayre, North Central Pennsylvania. Modeled after the Mayo Clinic, the Guthrie Clinic was founded by Dr. Donald Guthrie in 1910. Guthrie is located in 23 rural communities spanning 12 counties across north eastern Pennsylvania and the southern tier of upstate New York and provides primary and outreach specialty care and testing to patients in proximity to their neighborhoods.

Guthrie is comprised of hospitals in Sayre; Corning, New York; Towanda, Pennsylvania; Troy, Pennsylvania; and Cortland, New York, as well as a multispecialty group practice of more than 325 physicians and 210 advanced practice providers offering 47 specialties through a regional office network. The Guthrie Clinic manages more than one million patient visits a year. Guthrie also offers home health as well as hospice care. In addition, Guthrie offers home medical equipment and respiratory therapy products at seven convenient Med Supply Depot locations.

Committed to teaching, the school of nursing has long been established on the Sayre campus. Guthrie also has residencies in family medicine, internal medicine, general surgery, emergency medicine, pharmacy, and nursing. Fellowships available at Guthrie include cardiovascular, gastroenterology, and critical care. Guthrie is also a teaching site for Geisinger Medical College. Sixty-nine residents, fellows, and medical students were clinically trained at Guthrie in 2017-2018. The Guthrie Clinic also boasts a research institute.

Guthrie is a member of the Mayo Clinic Care Network and is the first health system based in Pennsylvania and New York to join this network. Guthrie received Stage 6 recognition by the Healthcare Information and Management Systems Society (HIMSS) Analytics for ambulatory services across the system, and Stage 6 recognition for Guthrie Robert Packer Hospital. Guthrie Robert Packer Hospital received Primary Stroke Center recertification from the Joint Commission based on a review of compliance with national standards, clinical guidelines, and outcomes of care. Guthrie has also been issued a shield by Fair Warning that represents its pledge to protect patient privacy and HIPAA standards across the system.

Other notable achievements include:

- Guthrie's new Virtual Care Division recently announced that the 101st virtual specialist visit had been scheduled.

## Acronym Legend

**BPA:** Best Practices Alert

**BMI:** Body Mass Index

**CHNA:** Community Health Needs Assessment

**EHR:** Electronic Health Record

**FAST:** Fit and Strong Together

**HIMSS:** Healthcare Information and Management Systems Society

**PDSA:** Plan, Do, Study, Act

**PROM:** Patient-Reported Outcome Measures

- Members of the Guthrie Cancer Committee were presented with pins in celebration of the Guthrie Cancer Center's 80 years of accreditation by the Commission on Cancer.
- Guthrie was highlighted by Healthy Me PA in a video highlighting telemedicine.
- Guthrie received bronze level recognition in the American Heart Association's Workplace Health Achievement Index for 2018.
- Guthrie Corning Hospital received the American Heart Association/American Stroke Association's Get with The Guidelines® Stroke Gold Plus Quality Achievement Award.
- Guthrie Corning Hospital has also been named one of America's Best Hospitals for Patient Safety, and Guthrie Towanda Memorial Hospital was named one of America's Best Hospitals for Emergency Care by the Women's Choice Award.

## Pilot Profile

Every three years, the Guthrie Clinic conducts a Community Health Needs Assessment (CHNA), a systematic process involving the community, to identify and analyze community health needs in order to plan and act upon priority community health needs. Obesity in both children and adults has been identified as the top health priority for the last seven years.

Three clinics in the Corning area were selected to participate in the Obesity Care Model Collaborative. Selection criteria included a large primary care network (three primary care offices) in close proximity to each other. These offices provide

primary care to about one third of the diabetics in the Guthrie Diabetes registry. Corning is a relatively developed area with access to more community resources than many of the other more rural and widespread communities. This allowed for establishment of the community portion of this collaborative as well as facilitated ease of provider training. In addition, this area has a long history of organization of community stakeholders, including Guthrie, uniting around the issue of childhood obesity. Therefore, an infrastructure existed in this community that was not necessarily available in other, more spread out portions of the Guthrie service area.

These three offices are staffed by a total of eight physicians and 13 advanced practice practitioners. Corning Internal Medicine is staffed by seven providers and sees 9,759 patients aged between 18 and 80 per year; Corning Family Medicine is staffed by ten providers and sees approximately 9,500 such patients per year; Erwin Family Medicine is staffed by four providers and sees 4,581 such patients per year.

Team members included a physician champion/group adviser, nurse/patient champion, bariatric medicine coordinator (master's level training in nutrition, certified exercise physiologist), and a senior practice administrator.

## Executive Summary

The main interventions consisted of didactic and one-on-one education with providers. Efforts were also made to provide support for providers to use in their clinical practices. This support included a small booklet with dietary and exercise information as well as local resources that patients could access to help in achieving and maintaining a healthy weight. Smart phrases were also embedded in Epic, which provided some guidance and efficiency in visits where obesity was addressed. Shared medical visits were also piloted in one of the smaller family medicine practices. This demonstrated techniques in educating providers how to quickly and efficiently counsel patients. This experience was well received by providers and patients alike.

## Obesity Program Goals and Measures of Success

### **Goals and Objectives**

The goal of this project was to create consistent, replicable, algorithmic care processes in obesity screening, diagnosis,

evaluation, and treatment in the primary care office setting. A secondary goal was to ensure that all primary care providers had basic competency skills as well as needed tools to address obesity. Patients with an increased body mass index (BMI) who were either overweight or with obesity were identified in Epic. This electronic health record (EHR) requires input of a height and weight and will automatically generate a BMI, which the clinician could use to direct the patient's obesity care.

## Data Documentation and Standardization

Based on a focus group meeting with most of the providers involved, and their sentiment of best practices alert (BPA) fatigue, the decision was made to forego incorporating any BPAs in Epic. Short smartsets were created for initial evaluation of obesity as well as follow-up visits. Instruction sets including quick breakfasts and tips for portions and food selection were incorporated in Epic. However, providers really wanted to have a document that they could physically review with patients and have them take home as opposed to instructions that were printed in the post-visit summary, which they reported were disposed of without much review. To accommodate this request, a small booklet was developed which contained the handful method of portion control, meal composition, and tips for food choices, as well as resources in the area that provide services that would help patients achieve a healthy weight.

## Population Identification

Any adult patient between the ages of 18 and 79 is eligible to be evaluated for obesity. Per the developed algorithm, patients with normal BMIs would be encouraged to engage in those activities that promote a healthy weight. Patients with elevated BMIs would be appropriately evaluated, treated, and/or referred for treatment (see Appendix).

## Interventions

### **Background**

The quality improvement process used to develop and implement interventions and the program was multi-dimensional, including PDSA (Plan, Do, Study, Act) cycles, action plans, and gap analysis. As the providers at Guthrie care for patients with ever-increasing BMIs, it was recognized that

all clinics were not adequately equipped to accommodate the patients of larger size. A bariatric needs assessment was done which included the physical facilities and available equipment and seating at the three pilot practices. The gap analysis provided information about services and infrastructure needed for primary care providers at these pilot sites to adequately care for patients with obesity. While there were some limitations of the physical space, opportunity for redesign exists, as two of the three practices will be sharing a combined space shortly and renovations are necessary. This included having at least one room with a hydraulic exam table with weight capacity of at least 1,000 lbs. Each office would have at least one scale with a weight capacity of 500 lbs.

## **Community**

A listing of community resources was developed. The initial thought was to incorporate this in Epic in a smart phrase, which could be embedded into the post-visit summary. However, primary care providers were adamantly opposed to this, preferring a booklet that they could give to the patients. Such a booklet was developed and delivered to each provider at the individual offices for distribution to patients.

A significant hurdle existed in that a lot of time and effort was spent trying to incorporate this material into Epic in terms of navigating institutional committees and securing the appropriate approvals to do so. This hurdle was overcome by essentially figuring out the process. Having an administrator on the team was very helpful in this regard.

A community obesity/diabetes summit was organized by one of the physician champions in the Corning area. This was hosted at a local community college and engaged several sports and fitness groups as well as supermarkets such as Wegmans, which conducted cooking demonstrations of both omnivorous and vegetarian meals. A hurdle here was that the event was poorly attended. It was thought that the timing—late July around middle day—was at least in part responsible for the poor showing. However, the event was well organized and community participants were open to engaging patients and further events. A second event was not planned for this summer. Marketing may have also played a role. The marketing department is located in Sayre and so the designated advertising outlets in Corning may not have been appropriate.

The Guthrie Clinic continues to be involved in two other longstanding obesity-related ventures in the community. Fit

and Strong Together (FAST) is a committee comprised of multiple stakeholders in the Corning area with an interest in addressing childhood obesity. Although primarily targeting childhood obesity, there is some cross connection with adult obesity programming, such as the Diabetes Prevention program at the local YMCA. The second initiative is in its fourth year and is a longitudinal nutrition curriculum for all third graders at one of the local elementary schools. Parents, teachers, and school administrators have been quite involved in this attempt to promote healthy eating and activity in these students. Evaluation via food frequency questionnaires have, since its inception, showed a consistent shift in the direction of healthier eating patterns.

The Guthrie Clinic established an annual Food and Farm Family Festival, a free community event that promotes healthy living in a family-friendly environment. The festival features free family fun, food samples, farmers' market items on sale, community organizations, and much more. Over 35 local vendors/farmers participate. Held in August each year, the Food and Farm Family Festival attracts 500 residents and 50-60 vendors, most of them farmers. In the summer of 2018, Guthrie also obtained grant funding to provide \$10 vouchers for families participating in the Food and Farm Family Festival, which were provided to families upon entrance to the festival. Vendors collected the vouchers used for purchases and redeemed them for cash at the end of the event. The vouchers proved extremely successful, with 90 of the 100 vouchers that were distributed being redeemed.

In 2015, the Guthrie Clinic established a community garden on a portion of five acres of land owned by the Guthrie. From about 10 volunteers in 2015 to approximately 50 today, the community garden has successfully provided food for community members who cannot afford or do not have access to fresh, nutritious foods. The community garden is operated by the Guthrie Community Garden Committee and utilized only volunteer labor for planting, watering, weeding, and harvesting. The food grown at Guthrie's Community Garden is given to families with food insecurities who are identified by the Guthrie Weight Loss Center and distributed to those in need through a partnership with a local food pantry. Guthrie has also donated food to the local high school's backpack program.

The Guthrie Clinic is currently working on implementing a pilot food pharmacy program that will run out of the Guthrie Weight Loss Center. The focus is to provide patients with food

insecurity and dual diagnoses of obesity and diabetes access to good quality food in hopes to improve their comorbidities. The plan would then be to implement this on a larger scale.

## **Organization**

As an organization, the Guthrie Clinic is looking to expand what was done at its pilot sites to the entire Guthrie Primary Care Network. The system is currently working through the planning and proforma stage of this process and have a target of implementing it in all locations in the next 18-24 months. In order for this to occur, the clinic has had to consider adding an Obesity Nurse Coordinator. It is recognized that through the collaborative this role is necessary in order to better accommodate the needs of the primary care provider. At first, it was thought that Guthrie would be able to utilize existing nurses, but early on it was realized that more time was needed for patients to receive the care they need. This coordinator would help to bridge that gap and be able to focus on the care of the patient with obesity.

A hurdle to this is the fact that Guthrie covers a large geographic region, so the process will take significantly more time than at the pilot sites and more man power will be needed than currently exists.

## **Care Team**

Provider education was conducted via four lunch-and-learns. Topics included defining obesity as a disease, screening, evaluation, and treatment of obesity including referral, anti-obesity medications, as well as the weight effects of commonly used medications. Stigma relating to obesity was also addressed. Subsequent sessions were scheduled at monthly staff meetings to provide follow-up and receive feedback about how the intervention was being implemented as well as process evaluation. Providers were also apprised of collaborative data at these meetings and provided an opportunity to ask questions. In some cases, it was necessary to engage providers on a one-on-one basis.

Provider engagement/buy-in were hurdles here, as some providers were already feeling overwhelmed by the system requirements and were less than enthusiastic about the prospect of having yet another disease process being presented to them for monitoring. As well, only about half of the providers consistently showed up to the sessions. Media overload (inbox messages and emails) was also a challenge for providers as many did not check emails or

internal messaging systems consistently, which presented difficulty in confirming meeting times. Scheduling was also challenging—providers from two of the three offices drove to the third and larger facility for the training sessions, which resulted in many latecomers.

These hurdles were quite time and labor intensive to overcome. Having a physical presence at the Corning meeting went a long way to reassuring providers that support would be forthcoming. Providers who attended were more receptive when they realized that the clinic was trying to work on a standardized approach and offering suggestions as to how to minimize the impact of obesity care on office work flows.

To increase communication, a newsletter was initiated as a way to furnish ongoing education with providers on such subjects as weight loss medications. Additionally, shared medical appointments were developed to help providers have a model of how to hold shared medical visits within their departments. These function not only as the patients' medical visits but also to provide additional education to the patient and, in turn, the provider.

## **Patient/Family**

The patient champion was very helpful in making sure that interventions were focused on patients.

# **Outcomes and Results**

## **Measure 1a: Prevalence of overweight and obesity in primary care across Guthrie**

Baseline data reported for both the organization and pilot clinics were for the period between October 1, 2016, and September 30, 2017. Data for the intervention was reported quarterly from January 1, 2018, through June 30, 2019. Three primary care clinics in the Corning area were included in the collaborative. The patient population there accounted for 16.8% of patients seen at the Guthrie Medical Group. At baseline, 88,232 patients were evaluated. That number decreased to 86,877.

Looking at all participating healthcare organizations in the collaborative at baseline, 26.9% of patients were under or normal weight, while 73.1% were diagnosed with overweight or obesity. This remained fairly consistent, with 26.3% being under or normal weight and 73.7% having overweight or obesity at the last reporting quarter.

### **Measure 1b: Prevalence of overweight and obesity in primary care clinics targeted for the collaborative**

Organization-wide data at Guthrie revealed 23.5% of patients were normal or underweight at baseline and 22.9% were normal or underweight at the end of the reporting period. In addition, 30.2% of the patients were diagnosed as being overweight, and 23.3%, 12.7%, and 10.3% were diagnosed with class I, II, and III obesity, respectively, at baseline; 22.9%, 29.8, 23.3, 13.1%, and 10.9% were categorized as normal or underweight, overweight class I, II, and III obesity, respectively.

In the targeted clinics, 24.4% were normal or underweight, 31.8% were overweight, 23.1% were diagnosed as class I obesity, 11.8% as class II obesity, 9.0% as class III obesity. When compared to the collaborative participants overall, 27.2% of the targeted patients were normal or underweight, while 26.8% were overweight; 22.0%, 13.0%, and 10.9% had class I, II, and III obesity, respectively. At the end of the quarter 1 in 2019, 27.2% were normal or underweight, while 26.8% were classified as overweight, 22.0% had class I obesity, 13.0% had class II obesity, and 10.9% had class III obesity.

### **Measure 2: Obesity-related complications**

This measure looked at the following obesity-related complications: type 2 diabetes, dyslipidemia, hypertension, obstructive sleep apnea, osteoarthritis, and nonalcoholic fatty liver disease. Overall, the number of obesity-related complications per patient with a BMI > 25 increased with increasing degree of obesity from 1.2 in patients in the overweight category to 1.7 in patients with class III obesity. The trend at the Guthrie Clinic paralleled what was noted with the participant group as a whole. In patients diagnosed as overweight at baseline, the average number of obesity-related complications was 1.0. At the end of the first quarter of 2019, the average number of obesity-related complications was 1.2. The average number of obesity-related complications in patients who qualified for obesity class I was 1.4. This increased to 1.6 at the end of the last reporting period. In patients who qualified for class II obesity, the baseline number of obesity-related complications was 1.6. This increased to 1.8 at the end of the reporting period. In patients who qualified for class III obesity, the average number of obesity-related complications at baseline was 1.7, which increased to 2.0 at the end of the reporting period.

### **Measure 3: Documentation of obesity diagnosis**

This measure looked at the number of patients who were obese and who had the corresponding diagnosis documented. Documentation of the diagnosis of obesity tended to increase as the severity of the obesity progressed. Overall, for all participating healthcare organizations, the baseline for obesity classes I, II, and III were 28.7%, 46.1%, and 65.7%, respectively. At the end of the reporting period, the documentation had improved to 34.4%, 53.8%, and 69.3%, respectively. This was an area where Guthrie excelled, starting with a baseline of 83.4% and increasing to approximately 98% at the end of the reporting period in patients with class I obesity. In patients with class II obesity, the baseline was 92.9% and improved to 99.7%; in patients with class III obesity, the baseline was 94.8% and increased to 99.2% by the last reporting period.

The high rate of documentation of obesity diagnosis at the Guthrie Clinic was likely due to the fact that the institution was responsive to primary care's concerns about the level of obesity and related diseases. To this end, a bariatric medicine referral clinic was established six years ago. A central part of the obesity medicine specialist position was to provide teaching for primary care and administrative time was built in to accomplish this.

### **Measure 4: Assessment for quality-related complications BMI ≥25**

This measure looked at select laboratory assessments in target pilot clinics in patients with a BMI ≥25. At baseline, 25.6% had all of the targeted laboratory assessments. This increased to 32.7% by the end of the reporting period. Blood pressure was assessed in all patients with a BMI ≥25; assessment of creatinine was 65.6% at baseline with an increase to 74.4%; HgA1C/FBC went from 58.2% at baseline to an increase of 67.8% at the end of period January 1-December 31, 2018; aspartate aminotransferase/alanine aminotransferase was 57.9% at baseline and increased to 67.4% by the end of the last reporting period. Thyroid stimulating hormone was evaluated in 59.8% of the patients at baseline, which increased to 64.8% by end of reporting period. Triglycerides were checked in 50.7% of patients at baseline and increased to 56.4% of patients by the end of the reporting period. High-density lipoprotein was recorded in 50.5% at baseline and increased to 56.3%.

Overall, the Guthrie pilot clinics had 13.8% of patients having all assessments; this increased to 27.6% at the end of the first quarter of 2019.

In patients at the targeted Guthrie clinics with class I obesity, 1.4 had obesity-related complications at baseline. This increased to 1.6 through the reporting period.

For class II, at baseline 1.6 obesity-related complications were diagnosed. This increased to 1.8 by the end of the reporting period. In patients with class III obesity, 1.7 obesity-related complications were reported at baseline, and this increased to 2.0 by the end of the reporting period.

#### **Measure 5: Patient-reported outcome measures (PROM) surveys**

It is unclear how many patient-reported outcome measures (PROM) surveys were initially distributed at the primary care office. However, 79 surveys were returned to the collaborative team. Only 24.1 (n= 18) of these initial respondents completed the follow-up survey. On the obesity-related problem questionnaire, there was no change. On the obesity and quality of life questionnaire, there was a change in score by a decrease in two.

#### **Measure 6: Weight change over time**

Over the course of the collaborative, the proportion of patients with a BMI > 25 who lost at least 1% increased from 34.0% to 41.2% from baseline to the end of the first quarter of 2019. The proportion of patients who gained at least one percent of their initial body weight decreased from 45.4% to 38.8%, with the proportion of patients who maintained their weight going from 20.7% to 19.6%.

The proportion of overweight patients at Guthrie who lost 1%-5% decreased slightly between the first quarter of 2017 to the first quarter of 2019; the percentage of patients who lost 5%-10% of initial body weight increased over the course of the collaborative, and the proportion of patients with decrease in weight of greater than 10% initially increased, but ultimately decreased between the first quarter of 2018 and the first quarter of 2019.

The proportion of patients with class I obesity who lost one to 5%, 5%-10%, and greater than 10% increased slightly from baseline to the end of the reporting period. This was true for patients with class II and class III obesity.

#### **Measure 7: Use of anti-obesity medications**

This measure looked at the proportion of patients with a BMI > 30 who have an active prescription for at least one of the anti-obesity medications. Although medication usage was low overall in the participating healthcare organizations, use generally tended to trend upwards with increasing BMI class. At Guthrie, baseline use of anti-obesity medications in patients with class I obesity was 2.0%. This remained fairly steady over the course of the collaborative, but dropped to 1.1% in the first quarter of 2019. In patients with class II obesity, 3.4% of patients at baseline had been prescribed anti-obesity medications. This decreased to 2.8% in the first quarter of 2019. In patients with class III obesity, 4.0% of patients at baseline were taking anti-obesity medications. This increased to 5.3% over the course of the collaborative. Many providers were initially uncomfortable with prescribing these medications. There was some discussion about which patients would qualify for medication and providers became more willing to try. However, many insurances do not cover these medications, and the prior authorization process is time- and labor-intensive.

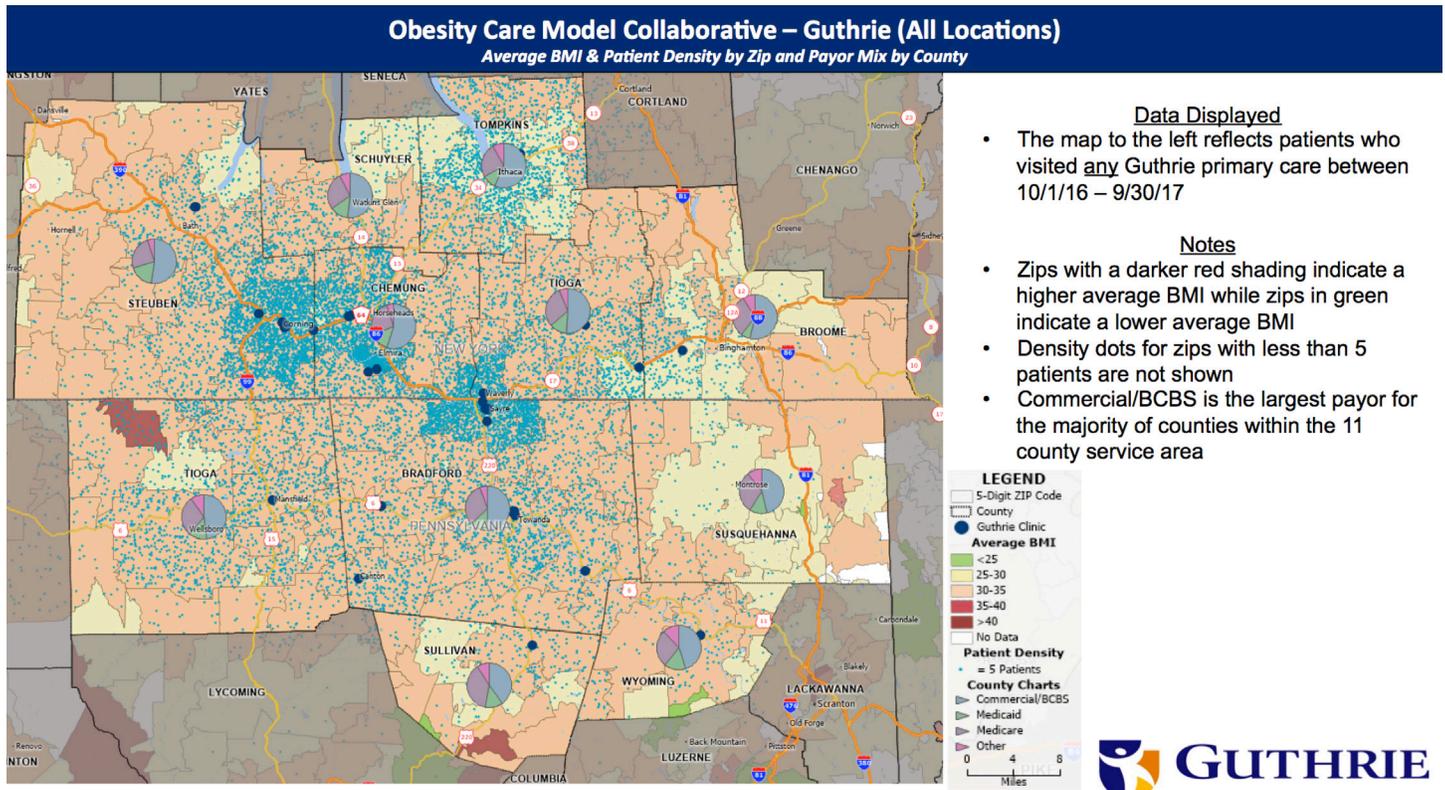
## **Lessons Learned and Ongoing Activities**

Throughout the development and implementation phase of the collaborative, there were a lot of lessons learned. The focus was how to get adequate buy-in from the chosen providers and how to help provide them with the tools they felt were necessary in their practices. Guthrie needed to be able to change its approach and initial thoughts based on what the providers reported worked better within their clinics. Providers became more engaged as the collaborative staff maintained a consistent presence and provided ongoing support.

Ongoing efforts include the continuation of piloted shared medical visits in the practice. In addition, many providers expressed a great need for Guthrie's weight management team to have a clinic in their location, so plans are being developed to regionalize Corning to better support the providers in the treatment and management of obesity.

Guthrie will also be implementing the work done in Corning to all of the primary care locations within the Guthrie Primary Care Network over the course of the next 18-24 months.

Health disparities are depicted below.



Source: EPIC - Guthrie patients who visited any primary care location from 10/1/16 – 9/30/17

The data table below reflects patients who visited any Guthrie primary care between 10/1/16 – 9/30/17

## Obesity Care Model Collaborative – Guthrie (All Locations) Average BMI & Patient Volume by County (11 County Service Area)

Patient Origin	Average BMI					Patient Volumes				
	18-24	25-34	35-54	55-64	65+	18-24	25-34	35-54	55-64	65+
<b>11 County Service Area</b>	<b>29.7</b>	<b>30.1</b>	<b>31.2</b>	<b>30.8</b>	<b>30.2</b>	<b>7,869</b>	<b>11,533</b>	<b>27,922</b>	<b>18,883</b>	<b>21,272</b>
BRADFORD, PA	30.6	30.8	32.1	31.2	30.3	1,805	2,494	5,826	4,138	5,203
BROOME, NY	26.8	29.7	30.6	30.1	29.8	177	292	717	652	732
CHEMUNG, NY	28.2	30.3	31.1	30.9	30.3	1,335	1,995	5,227	3,335	3,281
SCHUYLER, NY	27.7	30.1	31.3	30.9	30.3	181	276	732	508	511
STEUBEN, NY	30.2	30.1	30.8	30.9	30.2	1,696	2,546	6,058	3,588	3,668
SULLIVAN, PA	28.0	30.6	31.4	30.3	30.1	69	113	304	303	396
SUSQUEHANNA, PA	28.8	30.3	31.2	29.9	29.3	70	83	216	168	212
TIOGA, NY	27.7	30.3	32.0	31.2	30.4	752	990	2,824	2,228	2,521
TIOGA, PA	34.5	30.4	31.4	30.9	30.2	896	1,363	2,751	1,795	2,292
TOMPKINS, NY	26.9	28.4	30.0	29.8	29.3	722	1,204	2,920	1,919	2,141
WYOMING, PA	27.7	29.7	31.4	31.1	30.8	166	177	347	249	315

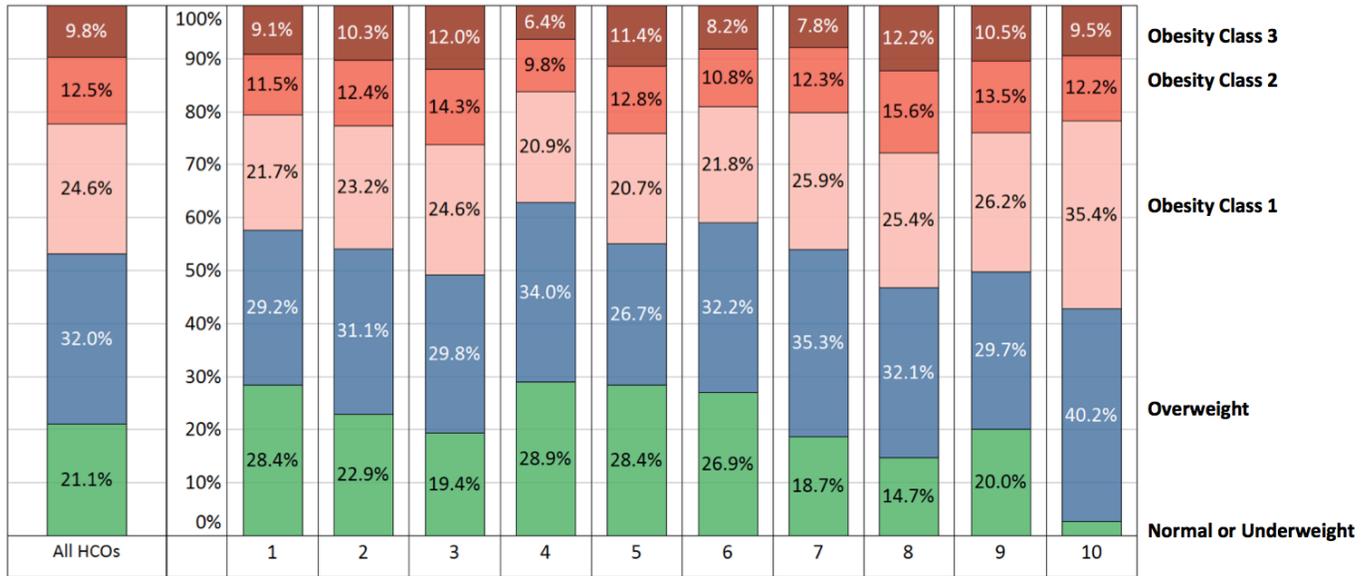
Source: EPIC - Guthrie patients who visited any primary care location from 10/1/16 – 9/30/17



## Final Data Report from AMGA Obesity Care Model Collaborative

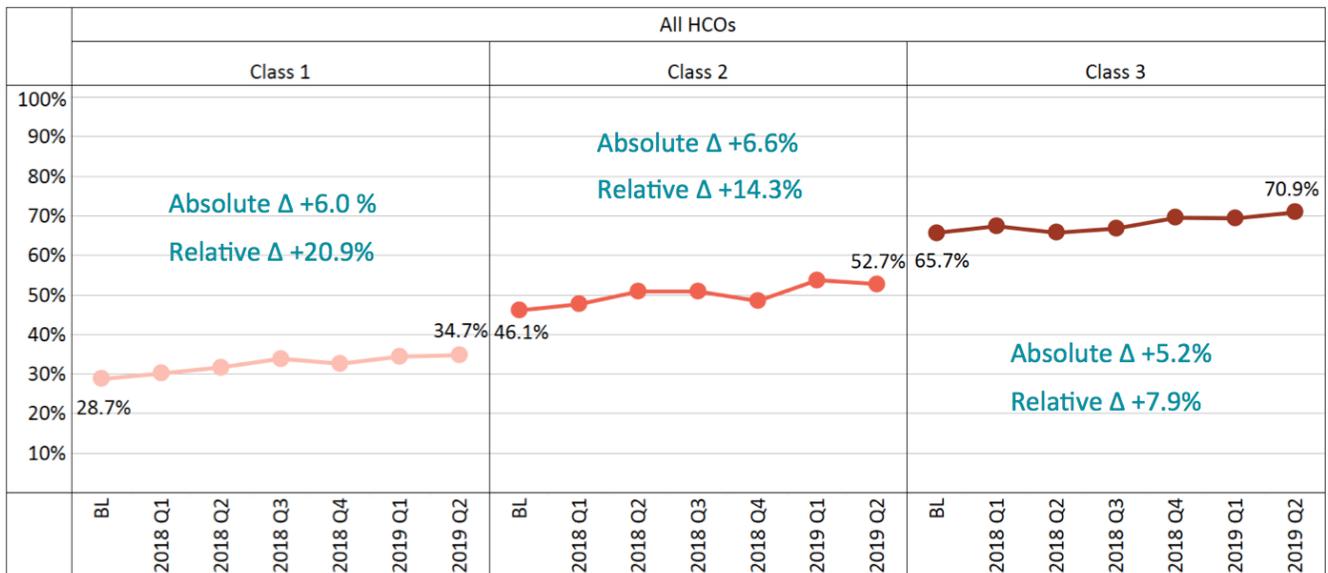
### Prevalence of Overweight and Obesity: 2019 Q2

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



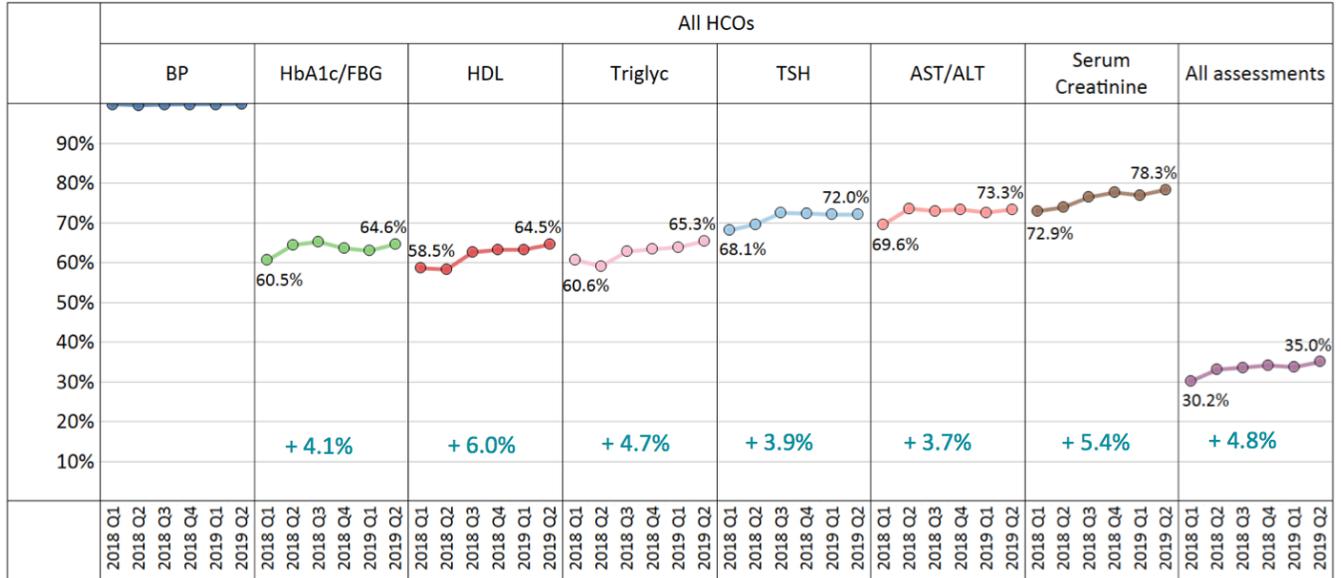
### Collaborative Performance: Documentation of Obesity Diagnosis

- 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



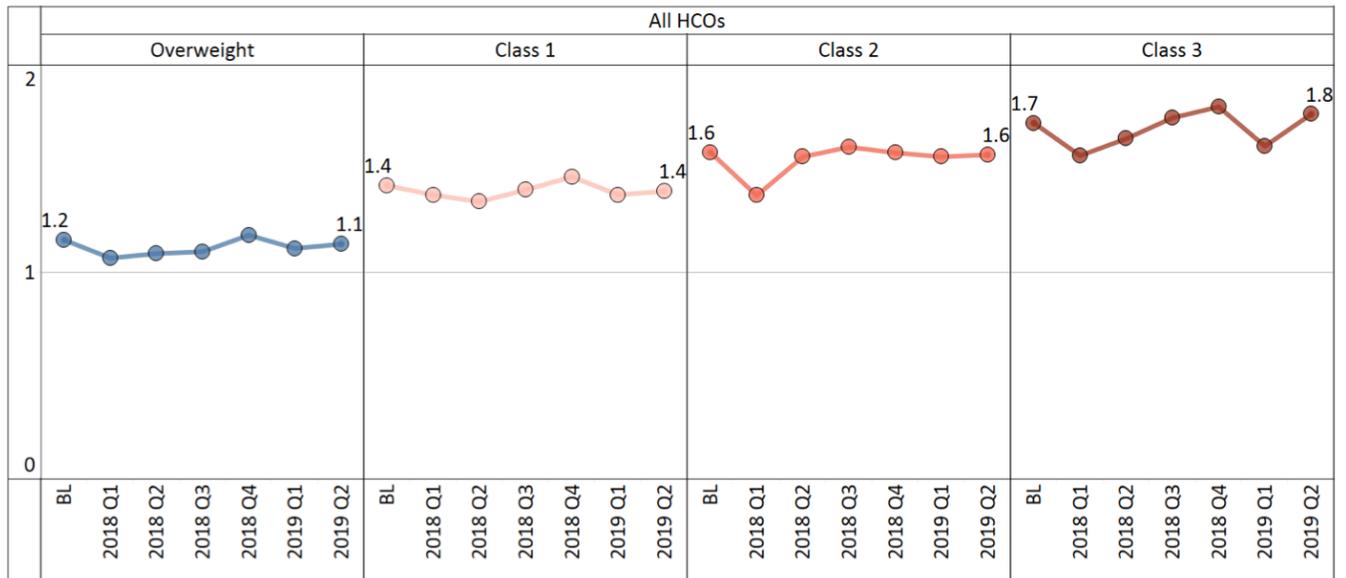
## Assessment for Obesity-Related Complications

- 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



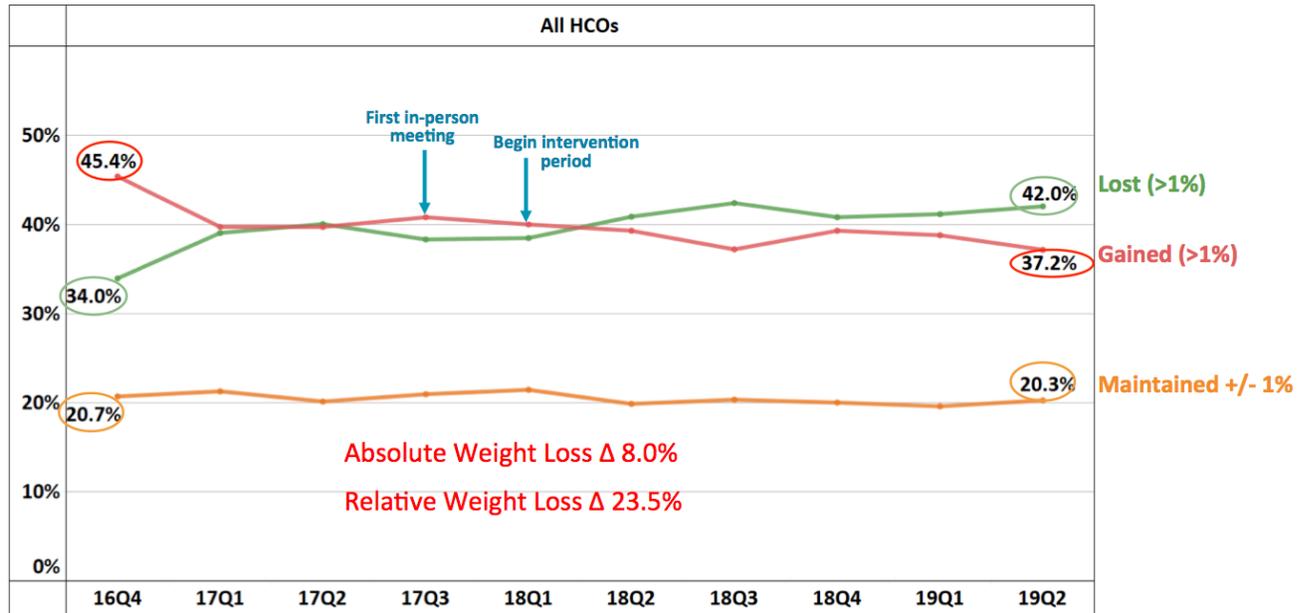
## Obesity-Related Problem Scale

HCO	Pre-Surveys	Post-Surveys	Response Rate	Met Goal Pre	Calculated $\Delta$
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

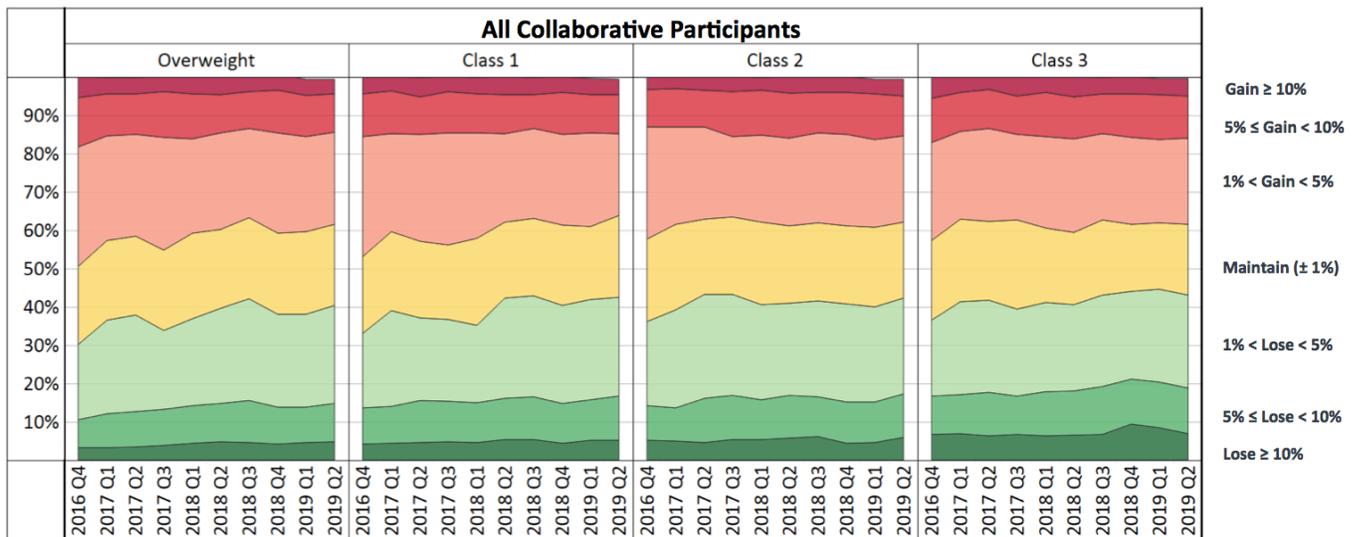
HCO	Pre-Surveys	Post-Surveys	Response Rate	Met Goal Pre	Calculated $\Delta$
9	86	44	68%	Y	Y
5	19	19	24%	N	Y
3	44	7	54%	N	N
4	155	NA	73%	Y	N
10	96	NA	98%	Y	N
2	53	NA	100%	Y	N

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



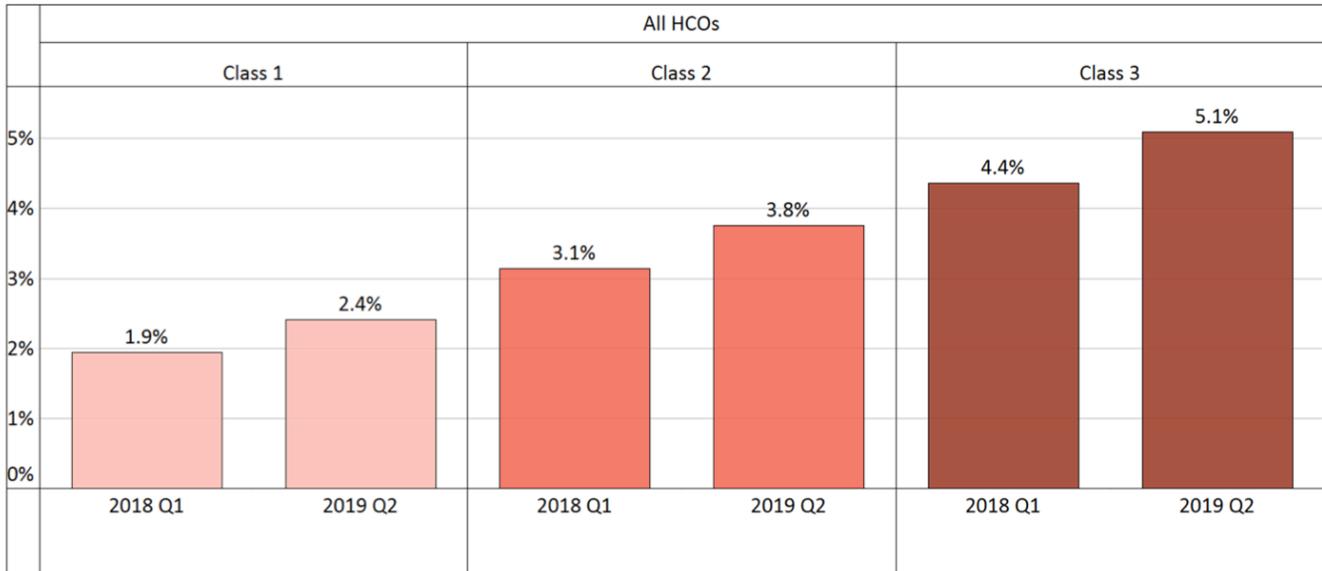
## Measure 6: Proportion of Patients by Percent Weight Change

- 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



## Project Team



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(year one)

*Back row (left to right) – Kathleen  
Dispenza and Jeffrey Dorman*

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