Department of Family Medicine

Development and Implementation of Intensive Behavioral Therapy for Obesity in the Primary Care Setting

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Introduction

Preventative healthcare measures often occur in the primary care setting where many patients have a strong therapeutic alliance with their primary care provider (PCP). Intensive Behavioral Therapy (IBT) for long-term weight loss is currently underused nationwide. Following the passage of the Affordable Care Act, Centers for Medicare & Medicaid Services (CMS) now cover IBT to facilitate long-term weight loss in patients who are both overweight/obese (Body Mass Index [BMI] > 25). Currently, CMS will cover up to 22 office visits per year for IBT in the primary care setting. This is a potentially more affordable way for patients to improve their health and wellness. Knowing this, Lehigh Valley Health Network (LVHN) assessed network data which showed that of the 186,754 adult BMIs documented per year in the primary care setting, 127,699 (68%) currently are >25. These are consistent with national data from 2010, which stated that two-thirds of adults in the US are overweight or obese (NIH).

In line with LVHN's Triple Aim – Better Health, Better Care, Better Cost – the LVHN Weight Management Center and the Department of Family Medicine wanted to make weight management more accessible for patients using a standardized IBT model. IBT incorporates Motivational Interviewing to facilitate self-directed behavioral modifications. This pathway includes 1) an evidenced-based IBT information packet, 2) EMR templates to facilitate documentation and billing, 3) patient education materials, and 4) periodic feedback surveys. Currently, two primary care practices of LVHN are pilot sites for IBT for long-term weight loss.

The goals of this quality improvement project were to:
- **Identify resources and barriers to implementing IBT in the primary care practices throughout LVHN.**
- **Create achievable countermeasures to overcome identified barriers to initial implementation of IBT at two LVHN pilot practices.**

Methodology

- *Organizing the team and identifying the problem*
  - Developed a problem statement, created a team charter (Figure 1) , and organized team responsibilities using a Gantt chart.
  - Shared individual goals, Myers-Briggs Type Indicator (MBTI), components of the Emotional and Social Competency Inventory (ESCI), and conflict management style among group members.
- *Analyzing the problem and identifying solutions*
  - Identified current conditions, targeted improvements and implementation barriers using an A3 (Figure 2).
  - Performed root cause analysis to identify barriers to IBT implementation using "The 5 Whys". This was documented in an Ishikawa (Fishbone) Diagram (Figure 3) with subsequent identification of multiple countermeasures (Figure 4).
- *Implementing the countermeasures*
  - Facilitated Motivational Interviewing Training Session for practitioners and administered pre- and post- MI workshop surveys (n = 4) (Figure 5).
  - Sent physician survey via email to all Family Medicine physicians of the Lehigh Valley Physician Group (n = 70/150) (Figure 6).
  - Developed supplemental educational materials including a MyFitnessPal tutorial and a pamphlet explaining IBT.
  - Designated medical student practice liaisons communicated for pilot sites to monitor implementation progress.
- *Ongoing from start to finish*
  - Conducted routine team meetings to check to evaluate goals, deadlines, and accomplishments and adjusted A3 and deliverables accordingly.

Results

Figure 1: Team Charter. A charter was developed to facilitate discussion on team organization and operational processes. **Team Norms** were based on individual **Myers-Briggs Type Indicator** (MBTI) and **Emotional and Social Competency Inventories** (ESCI). Individual **Conflict Management Styles** were integrated. By signing the **Team Charter** all were committed to achieving succes through shared accountability.

Figure 2: A3 Template. Developed in the Lean concept of Kaizen, or continuous process improvement, the A3 is a documentation tool used to facilitate assessment and analysis of the present state.

Figure 3: Ishikawa (Fishbone) Diagram. This **Lean Six Sigma tool** is a pictorial depiction of the root cause analysis using the "**The Five Whys**" to assess barriers to implementation of IBT. The countermeasures were determined based on root causes.

Figure 4: Countermeasures. The team determined next steps to mitigate the causes of the current condition.

Figure 5: Results from the Motivational Interviewing (MI) Survey. Overall, the MI workshop participants reported an average 1-point increase in Likert scores with a right-shift to all survey questions following the workshop.

Figure 6: Results from the Physician Survey. LVPG Family Medicine Physicians (n = 70/150) completed a 5-question online survey. Questions were answered on a Likert scale (1-5). Approximately 80% participants (Likert score >3) consider themselves A) confident in their ability address obesity in practice. B) As expected, about 80% of participants (Likert score < 2) were not aware that CMS reimburses for IBT for weight loss in the primary care setting. About 80% of participants (Likert >3) were C) willing to implement and D) likely to use a "ready-made" IBT program with support in their practices. In an open-response question (data not shown) participants indicated that patient education was their most needed resource.
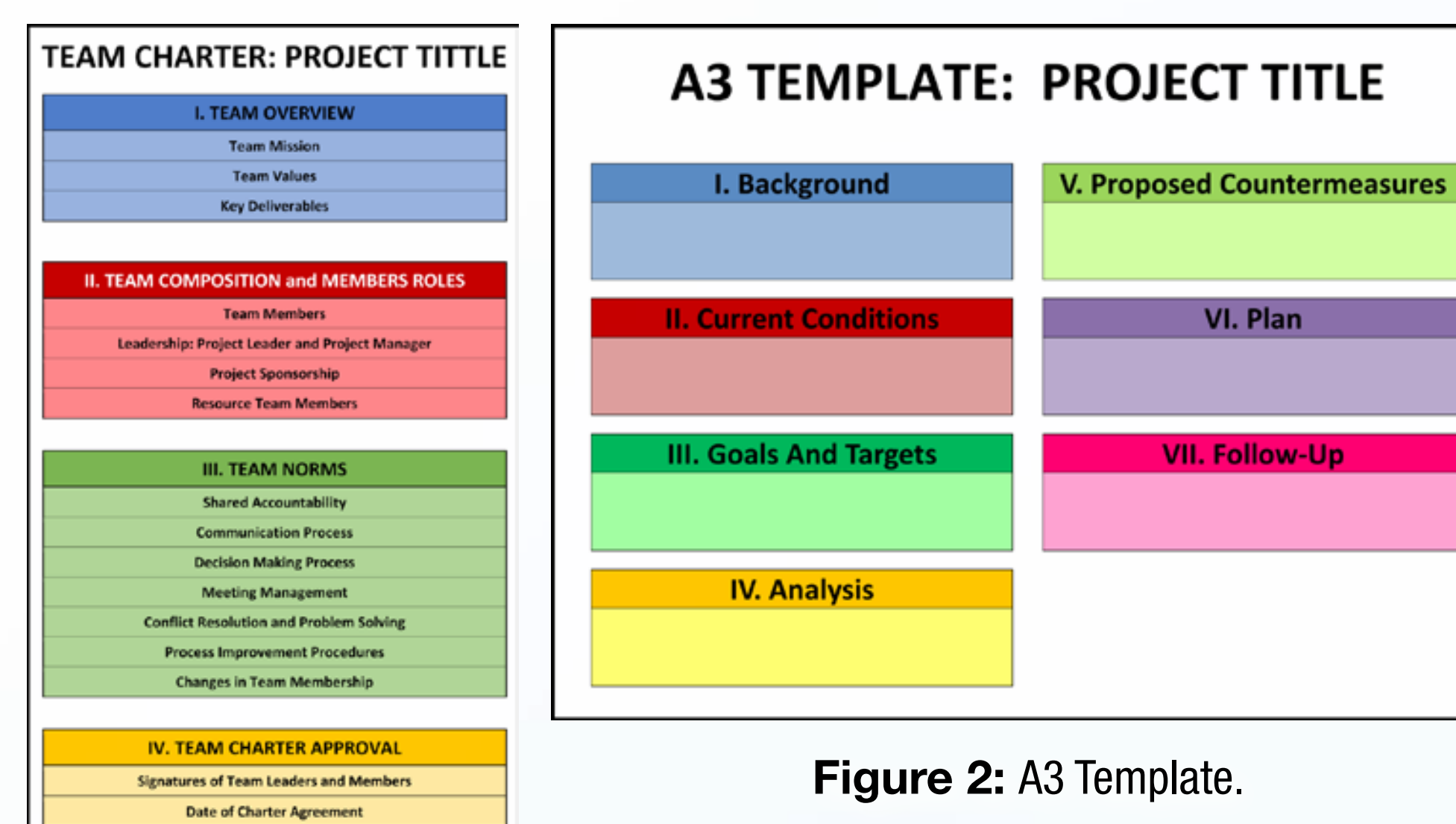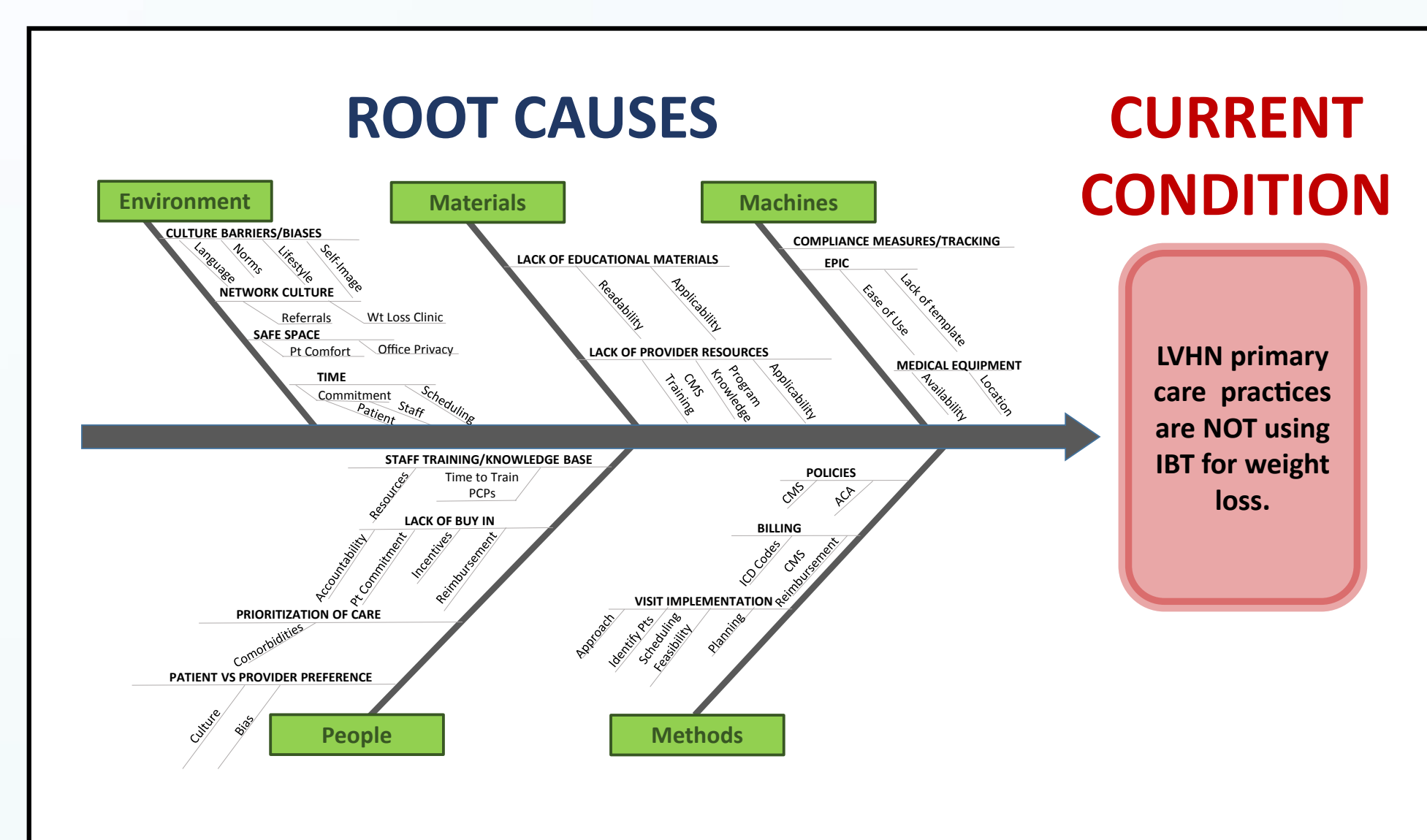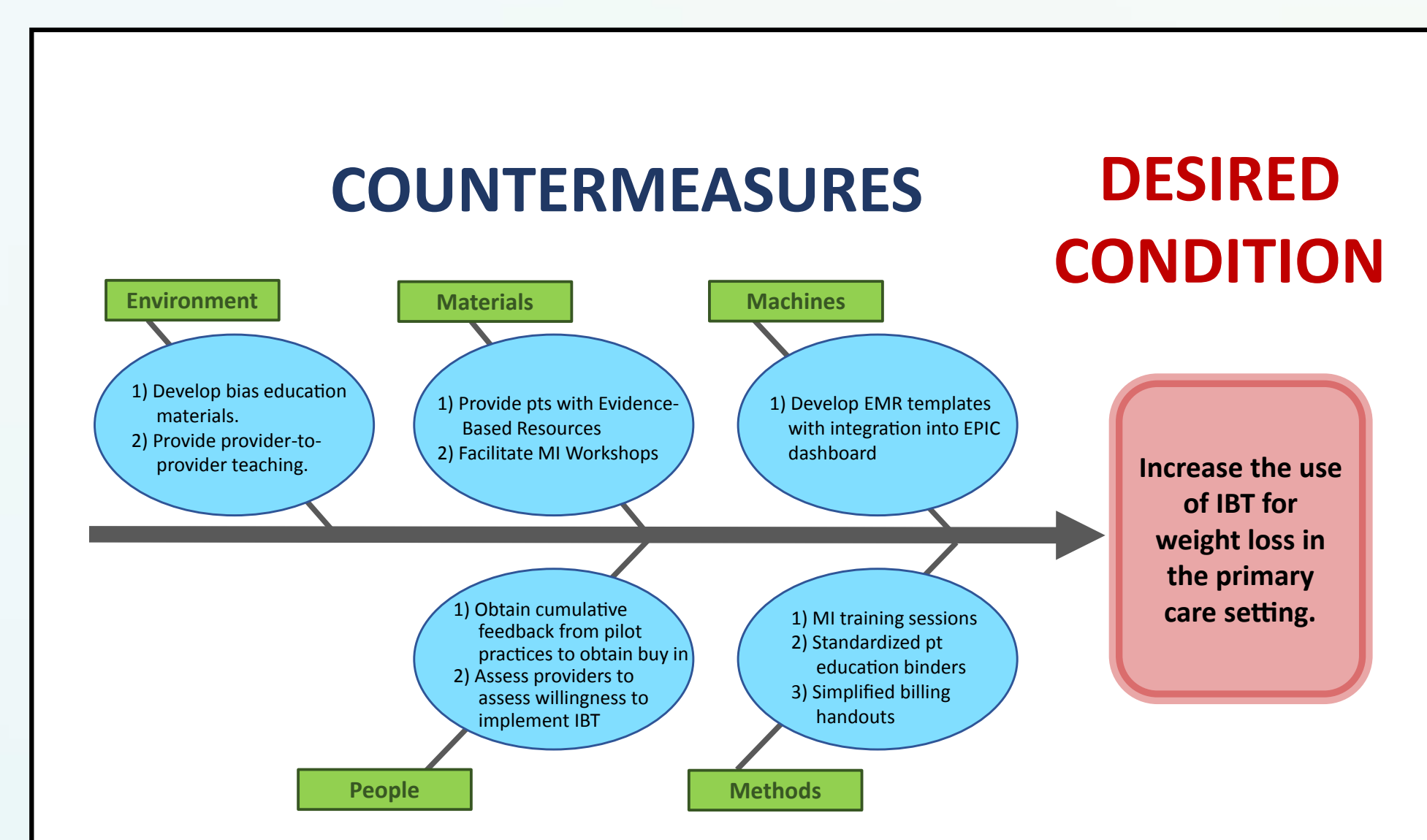

Figure 1: Team Charter.

Figure 2: A3 Template.

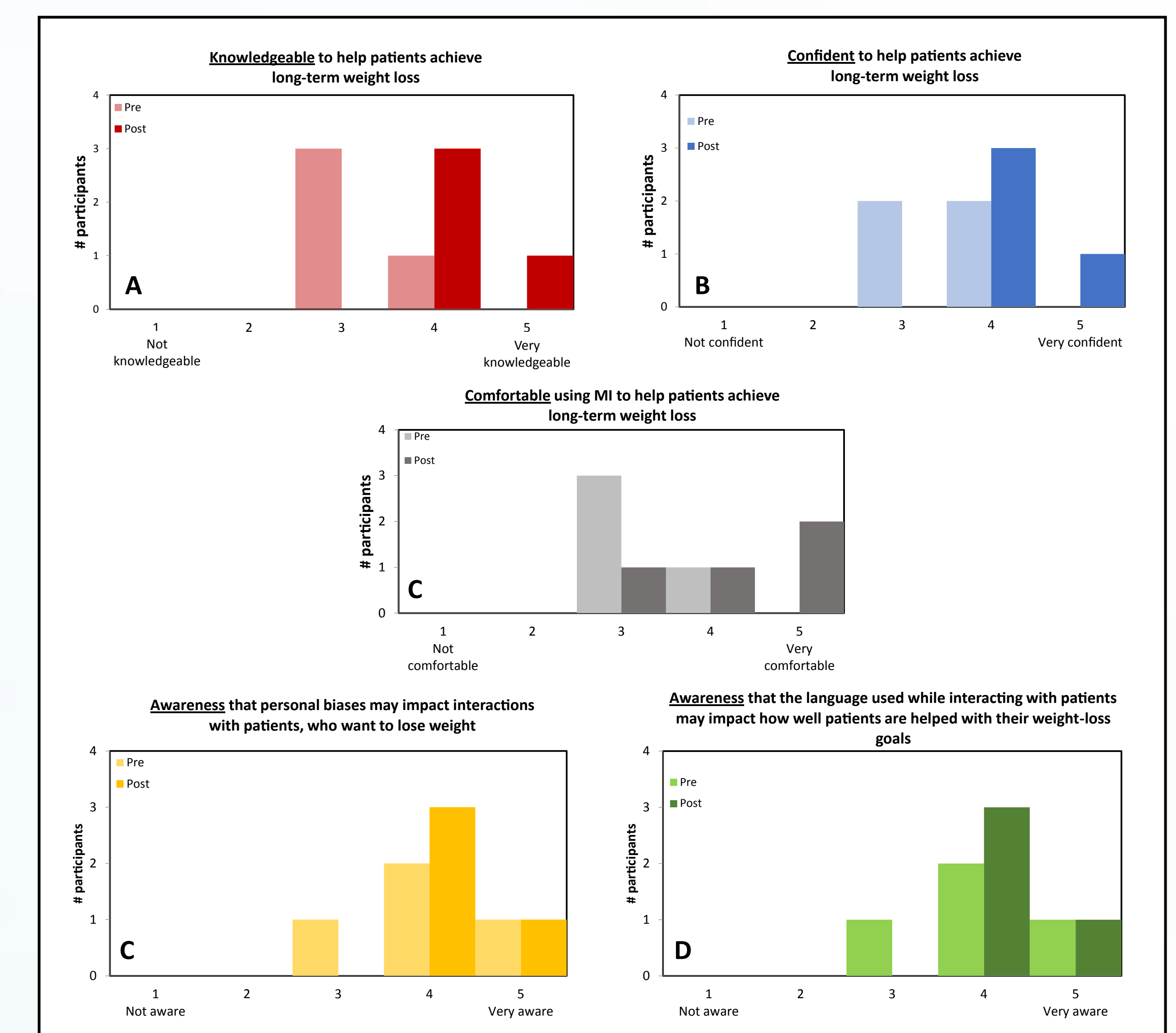**Figure 3:** Ishikawa Diagram.

Figure 4: Countermeasures.

Figure 5: Results from the Motivational Interviewing (MI) Survey. (Continued A-C)
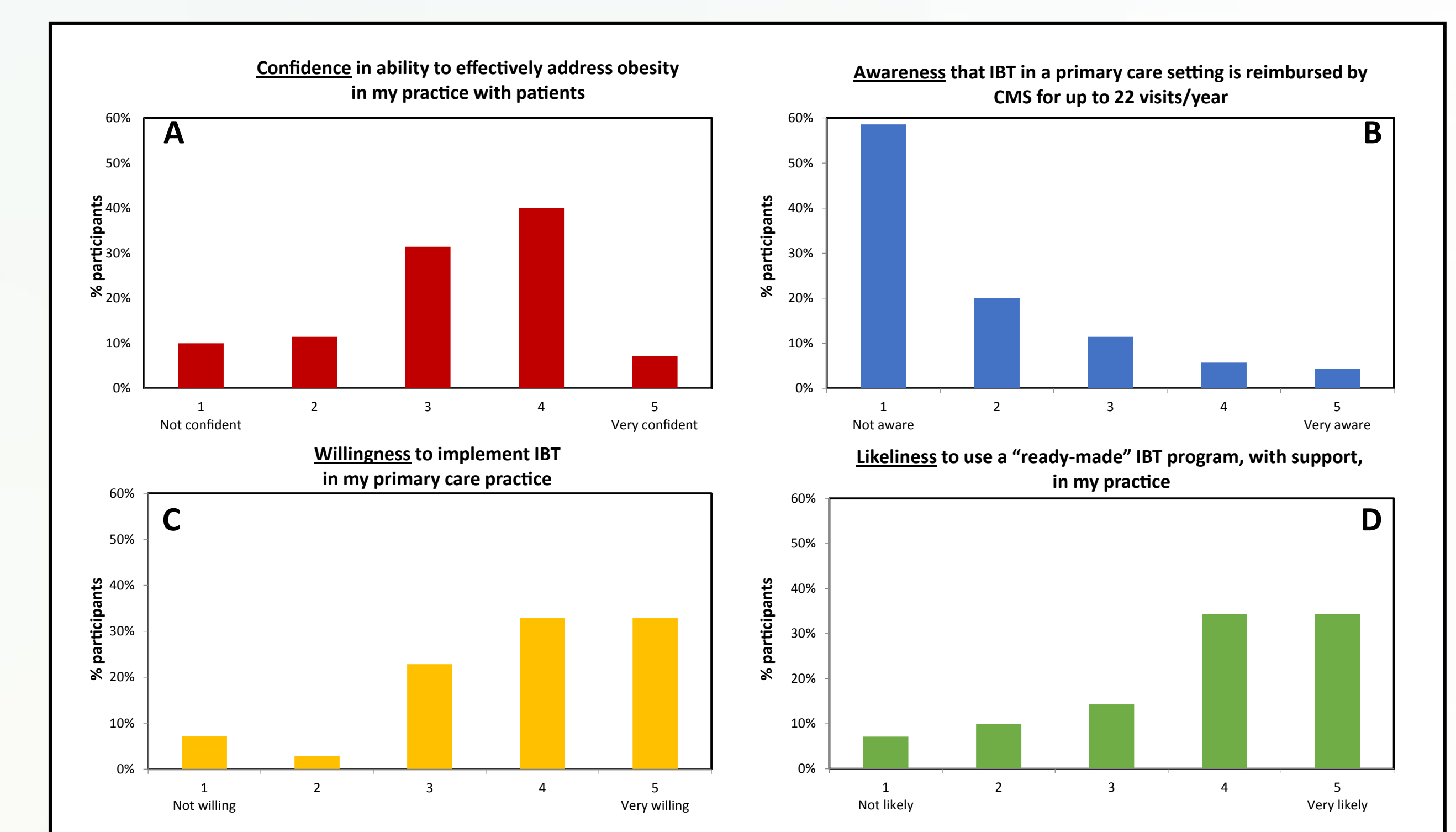**Figure 5:** Results from the Motivational Interviewing (MI) Survey. (Continued C-D)

Figure 6: Results from Physician Survey. (A-D)

Conclusions

- The Lean Six Sigma model used in this project is highly effective in identifying achievable goals based on thorough root cause analysis to make healthcare improvements.
- Incorporating MBTI, ESCI and conflict management styles into implementing the project was beneficial in organizing the team based on individual strengths.
- The perceived need for IBT was supported by outcomes from the physician survey. Despite having limited awareness of the CMS-coverage for IBT, providers were confident, willing, likely and confident to implement this for their patients.

Future Work

- Develop tools to measure efficacy throughout the implementation of IBT in the primary care office.
- IBT for weight loss, if proven successful with patients insured with Medicare, could also be transformative for non-CMS patients with obesity in any practice nationwide.
- Current plan for further roll-out within LVHN has been targeted for **September 2016**.

References:
1. Overweight and Obesity Statistics. National Health and Nutrition Examination Survey. National Institutes of Health, 2010. Accessed 20 May 2016.
2. http://www.niddk.nih.gov/health-information/health-statistics/Pages/overweight-obesity-statistics.aspx.

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