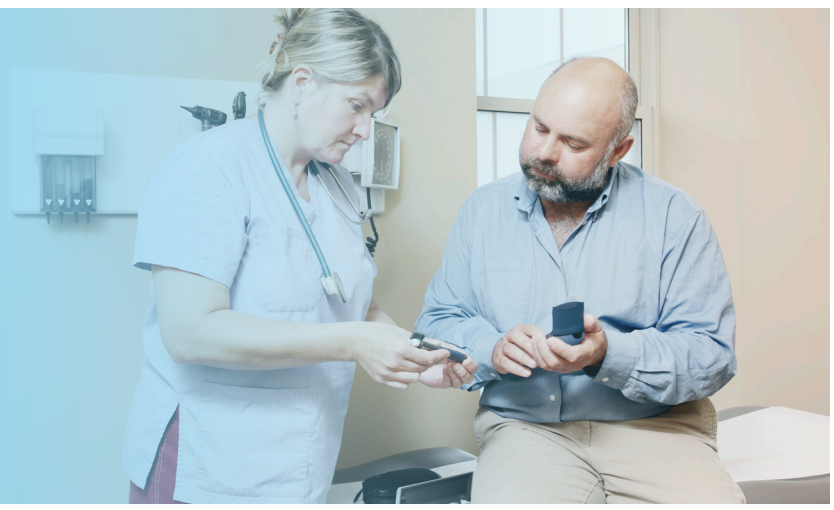
Weight management in general practice

A new model of care for managing patient obesity



What?

General practitioners (GPs) are often the first point of contact when someone is concerned about their health. GPs are therefore in a great position to coordinate care for patients who may be concerned about their weight. When allied health professionals like dietitians and exercise physiologists are included as part of the general practice care team, patients can access enhanced support to achieve a weight loss goal and improve their health.

Implementing a team-based approach which involves GPs working with practice nurses and allied health partners, strongly aligns with the principles of the Patient Centred Medical Home (PCMH) model of care. This approach aims to provide a comprehensive and integrated service for patients in a primary care setting, and is rapidly evolving to become the future of primary health care in Australia and internationally.

Why?

Obesity and other chronic conditions are the leading cause of illness and premature death in the South Eastern NSW region. Residents also have higher than average rates of lifestyle risk factors leading to such conditions. General practice can help to reduce the burden of obesity and other chronic conditions by facilitating weight management programs in the convenience of a patients primary care setting.

Weight management in general practice offers benefits across multiple levels, including:

- patients can achieve weight loss, with flow-on health benefits, such as lower blood pressure and improved glycaemic control
- GPs and nurses can enhance their skills and awareness through multidisciplinary support
- practices have increased client satisfaction and team involvement.

How?

Bulli Medical Practice's weight management program was one of 13 initiatives supported by COORDINARE. It was part of a project designed to build the capacity and capability of our region's general practices to move towards a PCMH model of care.

With funding from COORDINARE, the practice was able to run a 12-week weight management program, working with patients most in need of support.

A review of practice records identified that 50-70% of patients were overweight or obese, with several hundred of these patients also diagnosed with other chronic conditions including hypertension and diabetes.

In preparation for the program, staff training was provided in weight management and behaviour change. The 12-week program involved each patient having an initial GP consultation to set up a care plan. This was followed by weekly visits with the practice nurse to monitor progress and monthly visits with the GP for review. Referrals were made to relevant allied health professionals.

During the program, monthly multidisciplinary case conferences were attended by practice staff and allied health professionals, which provided further professional development opportunities. This project has proven sustainable, with the practice considering applying the model to other chronic illnesses.

"It's very good for our practice to have a weight-loss program to offer our patients – we're showing that we're confident to help them reach their goals." - *Dr Julie Blaze.*

Want to get involved?

At different times COORDINARE offers funding to support initiatives such as this. Practices which do not apply or are not selected for funding can still work with us and explore other opportunities. If we are outside of a funding round, we have resources to support practices on their change journey.

For further details on the steps involved to implement this model of care, visit http://bit.ly/MOCweightmanagement. For more information or support contact your Health Coordination Consultant, or phone 1300 069 002.

This initiative is supported by funding from COORDINARE – South Eastern NSW PHN through the Australian Government's PHN Program.

Outcomes

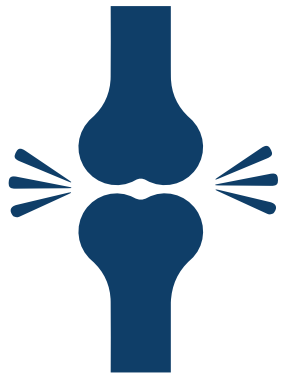
Patients:

weight loss (average 8.64 kg over 12 weeks)

reduction of body mass index (BMI) (average 3.47 over 12 weeks)

SF8 Health Survey improvements (average score improvement 7)

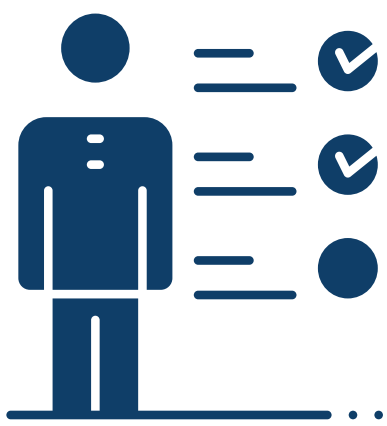
reduced need for blood pressure and lipid-lowering medications



reduced osteoarthritic pain

Clinicians:

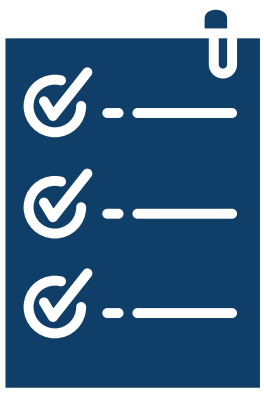
updated knowledge of medications and strategies for weight management



improved skills in managing patient overweight and obesity

Practice:

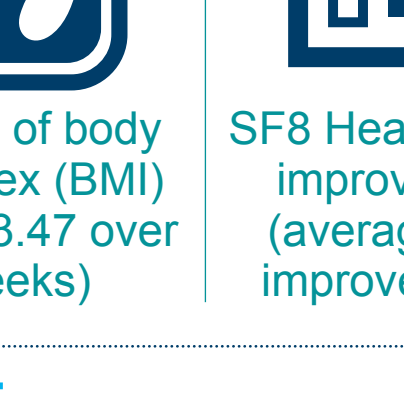
improved client satisfaction



capacity to roll out the program to address other prevalent chronic conditions

A patient's perspective

- Maria Ceroni



Maria Ceroni started on the weight loss program at Bulli Medical Practice when she found out her cholesterol levels were too high.

"My GP suggested I might need to go on lipid-lowering medication and I thought: No, I've really got to get serious and do something about my weight."

After developing a care plan with her GP, Maria began coming into the practice weekly to consult with the practice nurse and have her progress monitored.

"It became a bit of a competition between me and that scale," she jokes, adding that she found the accountability very helpful, as well as the ongoing support of the medical centre staff.

"Everyone involved – the whole team – really added to the success of my story," she says.

After completing the 12-week program, Maria not only lost significant weight, but also found her neck pain disappeared, as did her problems with indigestion.

"I feel really well… and I've had to buy a new wardrobe because nothing fits anymore!"

A GP's perspective

- Dr Julie Blaze

Dr Julie Blaze first developed a simple weight-loss program to offer to her patients several years ago. With a large proportion of patients overweight or obese, she felt there was a clear need for a structured program to help people achieve weight loss.

"I think it's very good for our practice to have a weight-loss program for our patients – we're showing that we're confident to help them reach their goals," she explained.

While the original version of the program only offered one option for patients – lifestyle management – the new, more comprehensive program developed with the support of COORDINARE offers an additional two options: low-calorie diet intervention and medical intervention.

"We realised we needed to offer more options, so we could cater to more than one group of patients," said Julie.

"It's a great model of care we have now. The new structure also lends itself to the management of other chronic conditions, such as diabetes."

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