HSRAANZ Webinar Series

Managing Obesity & General Practice

FUTURE EVENTS

Next webinar – 23 June 2016 Commissioning in primary care
10th Health Services & Policy Research Conference 2017

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COMPaRE-PHC

CENTRE FOR OBESITY MANAGEMENT & PREVENTION RESEARCH EXCELLENCE IN PRIMARY HEALTH CARE

Managing obesity in general practice

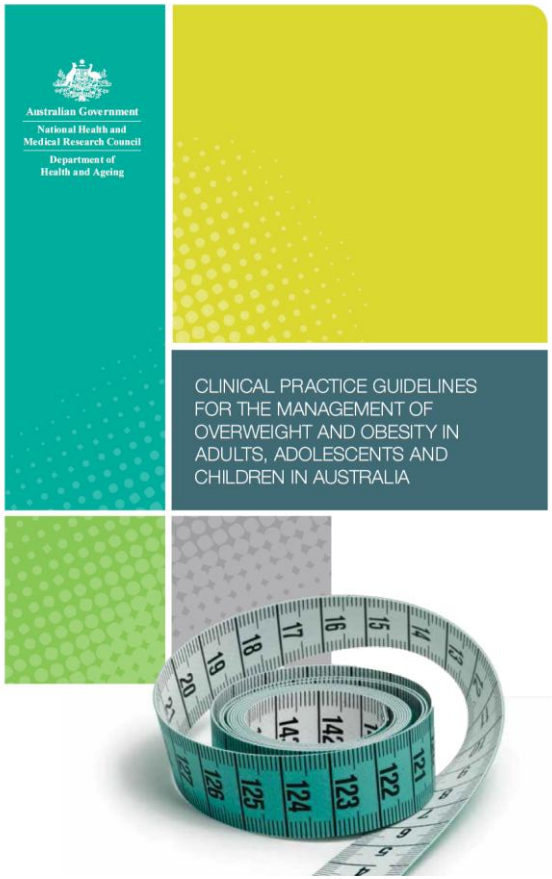
Professor Jon Karnon and Jodi Gray (University of Adelaide)
and Professor Mark Harris (University of New South Wales)

COMPaRE-PHC is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health

Outline

Mark Harris

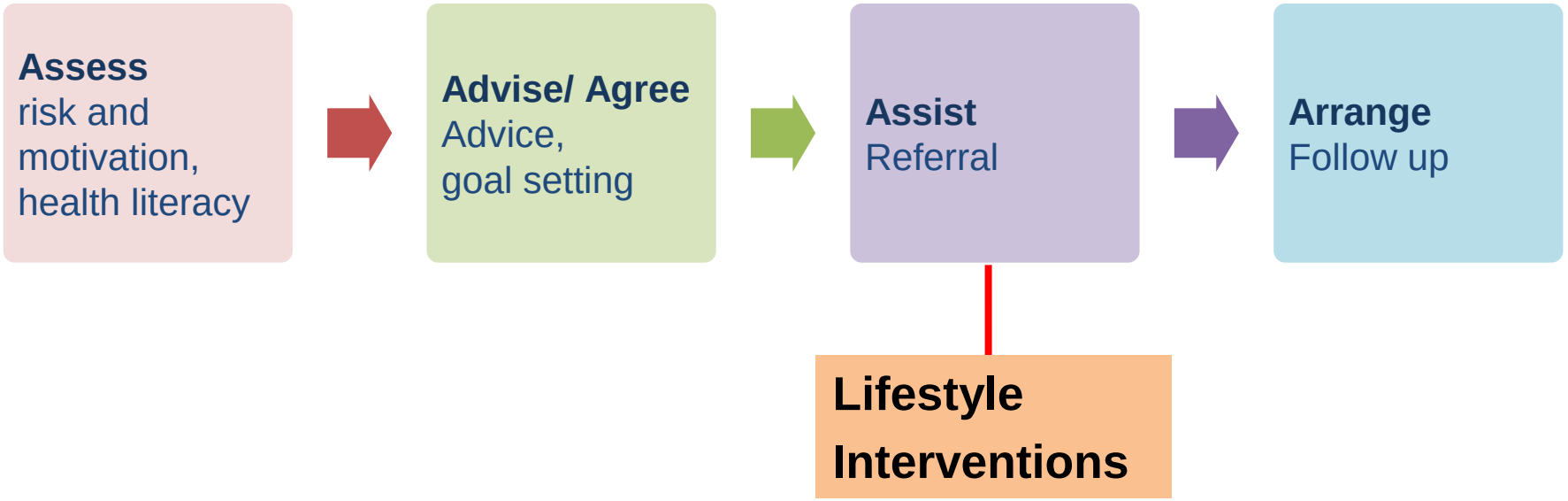
- Background
- 5As and guidelines
- Barriers to referral
- Options for referral



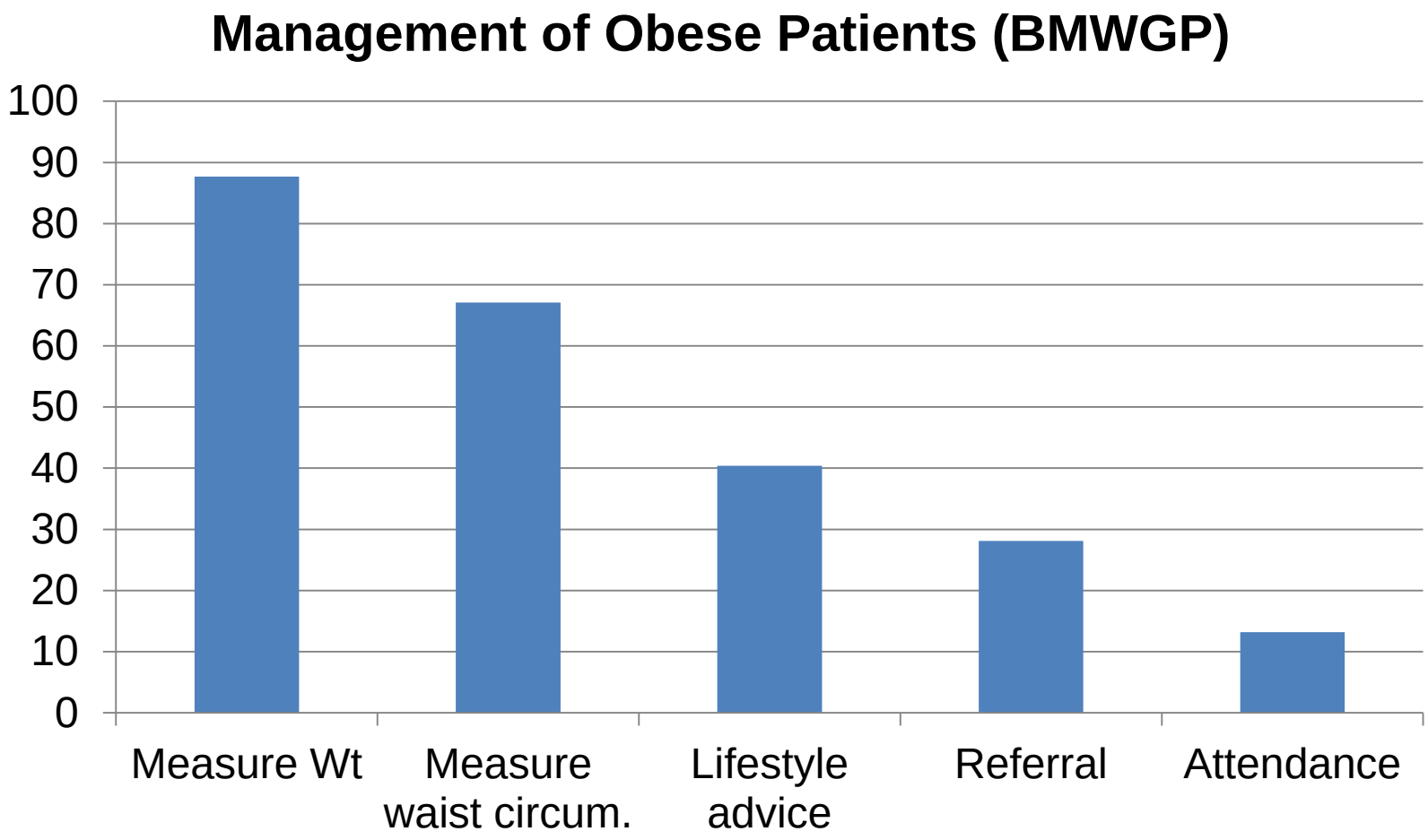
Background

- The proportion of obese adults attending GPs increased from 20.9% in 2002-03 to 26.1% in 2012-13 [BEACH].
- The NHMRC guidelines for the management of overweight and obesity recommend a multidisciplinary approach across the 5As (Ask, Assess, Advise/Agree, Assist and Arrange).

5As of preventive care



Provision of advice or referral



Barriers

GP Attitudes

Perceived Effectiveness

- *Most of them go and say, "I didn't really learn anything I didn't already know." [Rural GP #24]*

- *On the whole I'd say the success rate is quite low, in terms of major changes. [Urban GP #2]*

Patient attitudes

Motivation

- *I want lots of people with a BMI over 30 to go somewhere, but most are not really interested or motivated to change [Rural GP #1]*

- *I mean, seriously, they've usually done everything, all the Weight Watchers and their own attempts and whatever, and they've just rocketed back up again." [Urban GP #7]*

Barriers

System factors

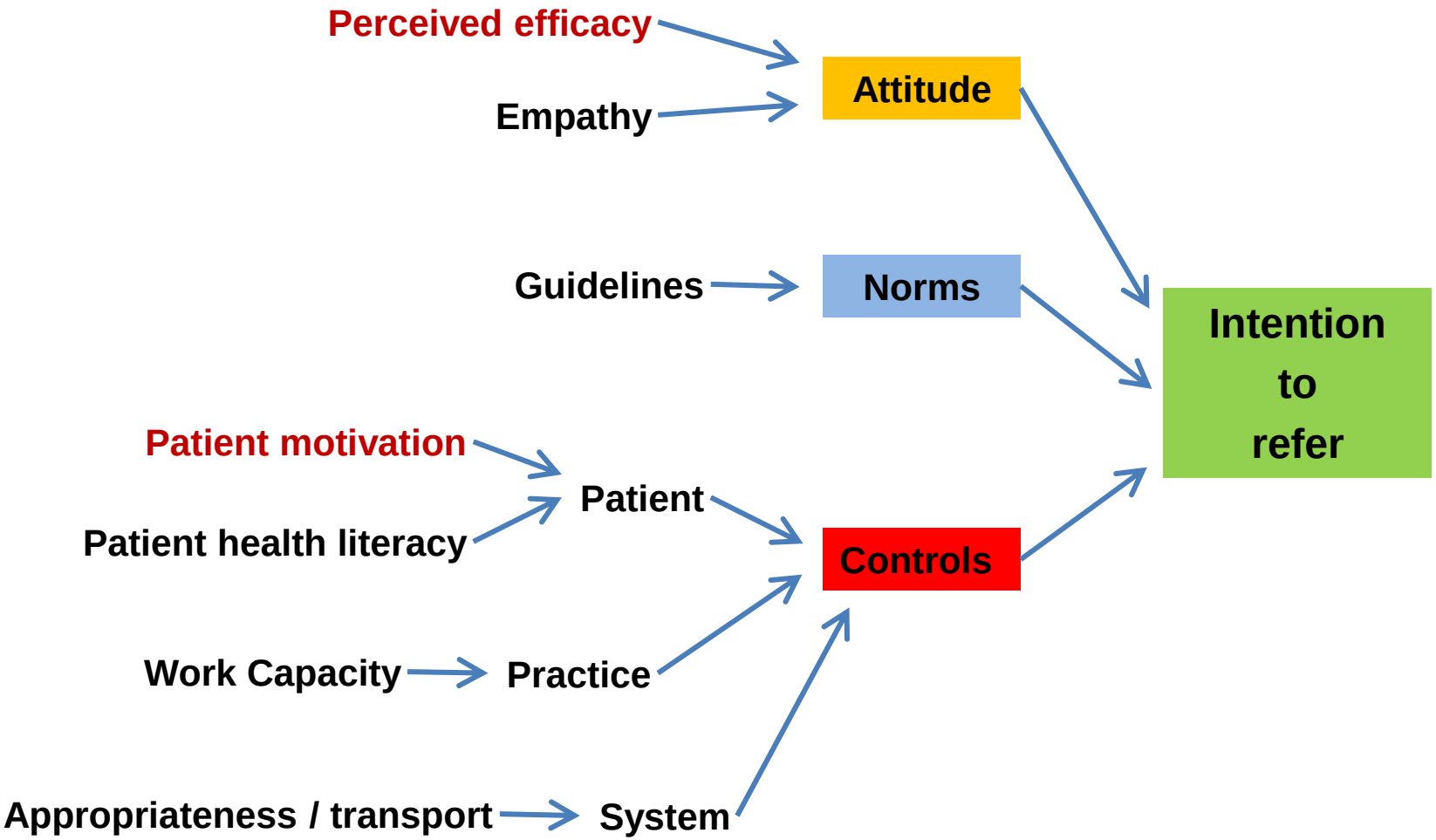
Access

- *The problem is in this area, 90% of patients Vietnamese and their English is of course not perfect so access to dietician who speaks Vietnamese. [Urban GP #4]*

Communication

- *If people go to the public system, it's a black hole. … They just disappear and we don't even know if they get there or what the outcomes are. [Rural GP #11]*

Factors influencing referral



Access to referral options

	Approachability	Acceptability	Availability and accommodation	Affordability	Appropriateness
Dietician/ EP/ psychologist	✓	✓	✓	-	✓
Group program	✓	-	-	✓	✓
Phone coaching	✓	✓	✓✓	✓✓✓	✓
Practice nurse	✓✓	✓✓	✓	✓	✓
Private programs	✓	✓✓	✓	-	✓

The Counterweight Program

Jodi Gray

- Delivered by practice nurses
- Developed by researchers, clinicians, dietitians

- Evidence based (consistent with NHMRC guidelines)
- Used in the UK for 15 years

- Aim: 5 to10% weight loss
- Positioned as an intermediate level intervention

Program structure and materials

Screen → 1 → 2 → 3 → 4 → 5 → 6 → 6m → 9m → 12m

Potential funding options

- Funding nurse training and patient materials?
  - PHN?
  - Patient co-payment?

- Funding delivery by practice nurses?
  - Using GPMP
    - Restricted eligible population
  - New MBS item numbers
    - Broader potential population
  - Patient co-payment?

Pilot of the Counterweight Program in SA

- Aims
  - Determine feasibility and acceptability
  - Identify necessary changes
  - Refine study methods

Pilot of the Counterweight Program in SA

- Recruited
  - 3 general practices
  - 2 nurses from each practice
  - 65 adult patients

- Focus on delivery of sessions 1 to 6
- Service payment for each session delivered
  - $25 per session 1 and 2 (~30min)
  - $20 per session 3 to 6 (~20min)

Baseline characteristics

	UK (2000-05)	Scotland (2006-10)	Australia (2014-15)
Number enrolled	1906	6715	65
% female	77.0	74.3	81.5
Mean age (years)*	49.4 (13.5)	53.0 (10.4)	54.3 (14.5)
Mean weight (kg)*	101.1		100.3 (22.7)
Mean BMI (kg/m^2)*	37.1 (6.0)	37.0 (6.2)	37.5 (7.6)
% with ≥2 comorbidities	48		55

*(SD)

British Journal of General Practice 2008, 58(553):548-54; Family Practice 2012, 29:i139-44

Weight change

	UK (2000-05)	Scotland (2006-10)	Australia (2014-15)
Number enrolled	1906	6715	65
% attending at 3mths	55	55	75
In attenders at 3m			
Mean weight loss*	3.3		4.6
% achieving any loss		67.4	93.5
% achieving ≥5% loss*	26.1	18.6	39.1
In all enrolled at 3m			
% achieving ≥5% loss*	14.2	10.2	27.7
In attenders at 12m			
Mean weight loss*	3.0	3.7	
% achieving ≥5% loss*	30.7	35.2	

British Journal of General Practice 2008, 58(553):548-54; Family Practice 2012, 29:i139-44

Value and acceptability

"I think there is a need for it, definitely. We have quite a few overweight patients and a lot of diabetic patients."

[Nurse D]

"...obviously the doctors saw the value to it because they would refer people and they obviously had good feedback because they kept referring people."

[Nurse F]

Value and acceptability

"The [patient] folder that you add leaflets to every visit is excellent. Some people use it as a bible, others just put it in the corner, but at least it's a building up a reference that they will always have."

[Nurse B]

Value and acceptability

"We encouraged people to go in the program and I think after a while we were hoping that it would become standard really. If we can continue it will be great – if it becomes standard management strategy."

[GP 4]

"But always, as you know with weight loss it's a long term thing. So certainly the results *initially* are quite encouraging."

[GP 4]

Value and acceptability

"That's more the, sort of - with getting into the program and having that support behind you, and being able to talk to people about it ... You know, they ask – they don't actually say, 'You shouldn't do this'. But they get you to question yourself and you give them the answer."

[Patient 9]

"Also knowing that there's someone that's going to be monitoring me. In the long term, it's like maybe I shouldn't get that. Maybe I should have something healthier."

[Patient 7]

But how do we fund the program?

"I would like to see it continue. Obviously we'll have to work out a viable financial model."

[Nurse A]

"Government, health buy-in, you know, MBS item numbers, that's what's really needed."

[Nurse F]

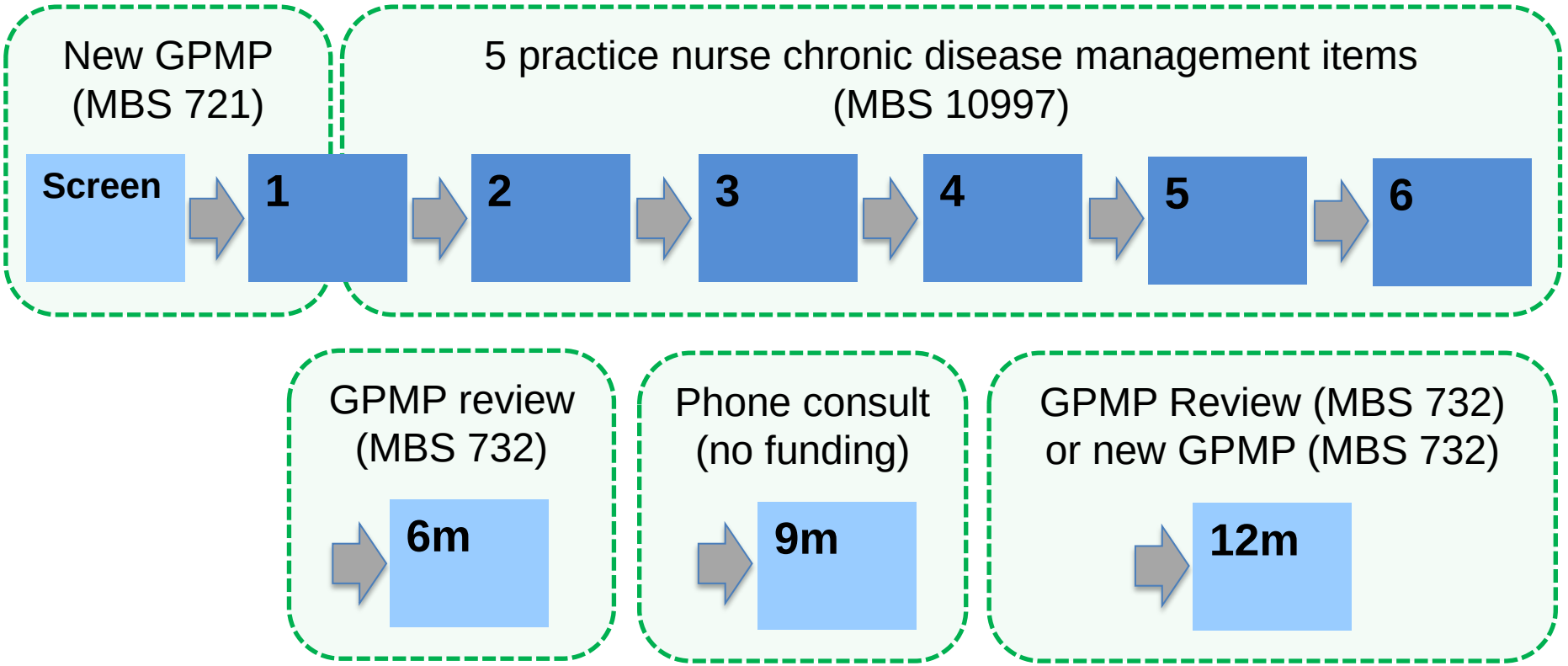
Evaluating Counterweight: a proposal

Jon Karnon

Funding options

- Using GPMP
  - Restricted eligible population
- New MBS item numbers
  - Broader potential population

Delivery under existing MBS items



NHMRC Partnership project

Partner-funded provision **+** NHMRC-funded evaluation
= Evaluation in practice

Evaluation options

Counterweight via GPMP vs. Usual Care

OR

Counterweight via proxy MBS item numbers vs. Usual Care

Plan

- University of Adelaide + University of NSW
  + 3 Partners
  + Counterweight Ltd
  + NHMRC

- 10 practices per partner
  - 5 intervention, 5 control
  - 20 patients per practice (600 in total)
- Control practices
  - post-trial Counterweight training & funding
- 60 + 60 patients in Counterweight per partner

Budget

- NHMRC contribution: $500k
- Counterweight contribution: $50k
  - No licensing and reduced training fees
- Partner cash contribution: $90k ($30k per year)
- Partner in-kind: $60k ($20k per year)
  - Assistance in practice recruitment and retention, office space for research nurse
- 1 research nurse per partner, Counterweight training, practice and session payments
- $750 per trial patient + up skilling of 20 practice nurses

Interested in being involved?

- Questions now?

- Or later…

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Charles Perkins Centre – Diabetes Prevention Study

- 12 month free comprehensive medical care. This includes:
  - Consults with dietitians and exercise physiologists for weight loss advice; bloods tests; body composition scans; cognitive function tests
- Required to attend Sydney University/ RPA Hospital (Charles Perkins Centre) in Camperdown 1 visit per month for first 6 months. Follow up visit at months 9 and 12
- Required to take natural medicine supplements for a 6 month period, before and after 3 meals per day
- An eligibility screening check is available at www.metabolictrial.com
- Main criteria:
  - Overweight
  - Elevated fasting sugar level ≥ 5.6 mmol/L
  - Not on cholesterol or glucose lowering medication