



A QI Initiative: Improving the Care of Patients With Obesity

Obesity Care Quality Improvement Tool Kit

<https://www.clinicaloptions.com/Obesity/ResourceHub>

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Introduction

This quality improvement (QI) tool kit is designed to serve as a guide for your practice as you work to improve obesity care. Many healthcare professionals (HCPs) may acknowledge that there is a need to improve obesity care but may not know where to begin and how to measure progress. This QI tool kit will help HCPs answer the following questions:

- How are we doing when it comes to providing obesity care?
- What proportion of my patients are achieving sustainable weight loss?
- What process and/or outcomes measure should we evaluate?
- What are some key opportunities for improvement?
- Who should be involved in our QI efforts?

Domains of Healthcare Quality

Consider each of these domains of healthcare quality as your team evaluates how obesity care is provided to your patients:

- **Safe:** Care is delivered safely. The risk of harm is minimized.
- **Timely:** Appropriate care is delivered without significant delays.
- **Effective:** Interventions are based on scientific evidence.
- **Efficient:** Reduce waste such as unnecessary tests, redundant processes, etc.
- **Equitable:** All patients are provided with the same type of care regardless of their personal characteristics (eg, gender, ethnicity, socioeconomic status).
- **Patient centered:** Care plans are developed through a shared decision-making process and reflect individual patient preferences, needs, and values.



FOCUS-PDSA

The FOCUS-PDSA model is a simple way to organize, develop, and implement a QI project. This team-based model includes the following steps:

F: Find a problem O: Organize a team C: Clarify the problem U: Understand the problem S: Select an intervention	P: Plan D: Do S: Study A: Act
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FOCUS

The initial steps in the FOCUS-PDSA model are designed to identify areas where a QI project can make a meaningful difference in patient care. Each step in FOCUS will help the team develop a clear problem statement so that they may implement effective interventions.

F: Find a Problem

Before starting a QI project, identify a meaningful clinical problem that needs improvement. Consider how you plan to quantify the problem and measure progress.



Performing an initial baseline assessment (see “Baseline Assessment” section below) will help your team identify potential opportunities for improvement by evaluating the following questions:

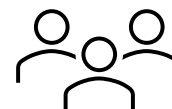
- How often do our HCPs include multimodal interventions when delivering obesity care?
- What proportion of our patients with obesity are engaged in their obesity care?
- When and how are antiobesity medications being used?
- What proportion of our patients with obesity are achieving sustained weight loss?

A problem statement should quantify the problem and describe its clinical importance.

- **Example:** After conducting a baseline assessment, our team has found that only 28% of patients with obesity are receiving an obesity care plan that includes multimodal interventions (eg, nutrition, exercise, pharmacotherapy, surgical evaluation). We feel that this low percentage is not acceptable and reflects suboptimal obesity care since multimodal interventions are often needed for patients to achieve sustainable weight loss.

O: Organize a Team

QI projects can be more effective and sustainable when a team-based approach is used. Identify a QI project leader and form a small multidisciplinary QI project team (usually 7 people or fewer).



Begin discussing the problem in a group setting and gather feedback from each member. Create a safe environment so that individuals may speak candidly about their thoughts, feelings, and observations regarding the problem that the team is evaluating. Remind the team that the QI project is aimed to focus on processes, not on individuals.

- **Example:** In a primary care office, the team may include physicians, nurse practitioners, physician associates, nurses, and medical assistants. One physician may serve as the QI project “lead” and work closely with a medical assistant to schedule meetings and coordinate communication about project updates.

C: Clarify the Problem

Clarify what is known about the problem. If the team is aiming to improve obesity care, discuss which aspects of obesity care the team plans to improve. For instance, your HCPs may feel that patients with obesity are having difficulty sustaining weight loss. Do they understand why this is happening?

Consider the types of data that will help the team study the problem and measure improvements on processes or outcomes. Work with data that are easy to collect and obtain (eg, data from electronic health records) rather than data that may be difficult to access (eg, insurance claims data).

- **Example:** The team may clarify that obesity care plans include different components such as clinical documentation, orders (referrals and prescriptions), and follow-up care. The team may agree that they need to review how HCPs are documenting the obesity care plan in the electronic health records and how providers are using referrals for nutrition or exercise interventions. They may also agree to review when and how antiobesity medications are being prescribed.

U: Understand the Problem

Throughout the QI project, the team may revisit the problem and perform root cause analyses (see “Root Cause Analysis” section below) to further understand the factors that are contributing to the problem. This will help the team identify what may be causing variations in care processes and implement effective interventions.

Teams may spend weeks or months to understand a problem, so establish timelines so that the team can also work on interventions. A suggested starting point is to spend 3-4 weeks identifying and studying the problem.

- **Example:** The team may find that they lack a standardized obesity care template. They may also find that HCPs have low levels of knowledge and familiarity with some of the newer antiobesity medications. These factors may lead to unwanted variations in how obesity care plans are developed and delivered.

S: Select an Intervention

As the team works through the QI process, the team may brainstorm and develop several potential interventions. Using a priority matrix (see “Priority Matrix” section below) can help the team identify a feasible intervention that has high clinical impact. For each potential intervention, place them in one of the quadrants based on its potential clinical impact vs the feasibility of developing and implementing the intervention.



Consider the entire proposed timeline for the QI project. If the team has spent 3-4 weeks identifying the problem, then plan to spend several months to develop and implement interventions.

- **Example:** The team may feel that creating a templated progress note in the electronic health record may be effective but will also require a significant amount of time from the IT department. An alternative short-term solution may be to use a combination of documentation shortcuts (eg, SmartPhrases) and paper forms to ensure that every obesity care plan includes several multimodal interventions and that patients are properly educated about their obesity care.

PDSA

Once the team has identified a problem statement, they are ready to use PDSA (Plan-Do-Study-Act) cycles to implement interventions and to track their progress.

PDSA may also be called PDCA (Plan-Do-Check-Act).



P: Plan

During the Plan step, the team drafts an aim statement and lists the steps they will take to implement a process change. Identify the people who will be responsible for the process, when the new process will begin, and how the team will evaluate the impact of the change.

An aim statement should be written as a SMART (specific, measurable, achievable, relevant, and time-bound) statement.

- **Example:** The primary care clinic aims to ensure that 85% of new patients with obesity have a completed obesity care plan in their charts. The templated care plan will include sections for nutrition interventions, physical activity interventions, mental health services, and surgical evaluation. The clinic aims to achieve this goal over the next 5 months.

D: Do

Describe what was done and what happened when the new process was implemented.

- **Example:** After launching the templated care plan, the QI team spends time at the next staff meeting informing everyone about the template. The team also sends weekly reminders to all staff members. The team asks several HCPs if they had any difficulty finding and using the template. They determine that the care plan is easy to use and takes approximately 10-15 minutes to complete.

S: Study

After several weeks, the team regroups during the Study step to review whether the planned change achieved the intended result. Depending on the type of change that is implemented, the team may reach this step after several weeks (small change) or a few months (medium or large change).

The team should also consider balancing measures. Did the intended change cause new unanticipated problems in other areas? For instance, an aggressive intervention that combines low-calorie meal replacement plus injectable antiobesity medications may cause some patients to lose weight too quickly and develop gallbladder problems.

- **Example:** After 4 weeks, the team may find that the templated care plan was completed by 67% of HCPs; 5% forgot to use the template; and 28% only used portions of the template. The team may revise the template and make it shorter or easier to use. They may also find ways to automate portions of the template by pulling information from other parts of the patient record.

A: Act

Now that the team has tested an intervention and evaluated its impact, the team must decide whether they will continue the intervention, modify the intervention, or develop a new intervention. Since the PDSA cycle is meant to be repeated, the Act step often leads back to the Plan step for a new intervention.

Depending on the scope of the QI project, the team may go through 2-5 PDSA cycles over 9-18 months before deciding that they are finished.

Continuous QI

The philosophy behind continuous QI emphasizes that there are always opportunities for improvement. However, the team must prioritize and determine their capacity for effective interventions. If the team tries to fix too many problems at once, they may be ineffective without the proper resources.

Continuing Education Activities

The following self-study continuing education modules can help HCPs learn how to develop effective obesity care plans and incorporate antiobesity medications safely and appropriately.

<https://www.clinicaloptions.com/Obesity/ResourceHub>

Module	Learning Objectives
Module 1: Treating Obesity as a Chronic Disease Faculty: Caroline Apovian, MD; Donna Ryan, MD; Susan Tiso, DNP, APRN, FNP-BC	• Incorporate processes to improve identification and prioritization of weight loss in patients with obesity • Evaluate patients based on the guideline-recommended criteria for diagnosis and treatment of obesity
Module 2: Updates on FDA-Approved Obesity Pharmacotherapies Faculty: Megan Adelman, PharmD, BCPS, BCGP, CDCES; W. Scott Butsch, MD, MSc; Susan Tiso, DNP, APRN, FNP-BC	• Develop measurable and comprehensive treatment plans for patients with obesity • Apply the latest efficacy and safety data to select antiobesity medications for appropriate patients with obesity
Module 3: Building a Comprehensive Obesity Care Clinic Faculty: Caroline Apovian, MD; W. Scott Butsch, MD, MSc; Daniel Zalinov, PA-C	• Design a collaborative care initiative to improve long-term weight loss in patients with obesity
Module 4: Application of Motivational Interviewing and Shared Decision-making Techniques in Obesity Management Faculty: Megan Adelman, PharmD, BCPS, BCGP, CDCES; Donna Ryan, MD; Daniel Zalinov, PA-C	• Apply techniques to actively engage patients in the long-term management of weight loss

QI Case Examples

The following brief QI case examples are meant to illustrate how teams may develop interventions to address specific problems. The examples have been simplified and are reflective of the application of QI concepts and methods.

Example 1

Problem: Patients are frequently missing their appointments for weight checks. Some patients have limited transportation. Some would prefer a telehealth appointment. Some feel ashamed about their recent weight gain. The no-show rate for weight checks has been 35% over the past 4 weeks.

Intervention: Offer different options for weight checks and follow-up visits:

- Option 1: In-person visit. The patient is weighed in the clinic and receives counseling face to face.
- Option 2: Live telehealth visit. The patient weighs at home and receives counseling via telehealth.
- Option 3: Asynchronous. The patient weighs at home and uploads weight log via the patient portal. Communication with the HCP is via secure messaging.

Healthcare Quality Domains: This intervention enables timely care and patient-centered options and may enable more equitable care for patients who have difficulty with transportation to the clinic.

Outcome: After 6 months, the clinic finds that patients like having multiple follow-up options, and this helps them stay engaged in their obesity care. More patients remain committed to their obesity care plan and feel empowered to achieve and maintain weight loss. As a result of these interventions, the no-show rate for in-person weight check visits reaches 5%.

Example 2

Problem: Patients report a lack of social support, which results in poor adherence to lifestyle modifications. Only 5% of these patients have achieved weight loss over the past 6 months.

Intervention: Create a virtual support group that meets monthly. Recruit a licensed mental health counselor to co-lead these sessions. Identify patient advocates who are willing to share their success stories during these meetings. Invite a motivational speaker for one of the sessions.

Healthcare Quality Domains: This intervention enables more equitable care for those who may have limited access to mental health resources. This also demonstrates efficiency by having a single intervention that affects multiple patients.

Outcome: After 6 months, the team finds that patients feel more motivated and empowered. Several patients receive antidepressant therapy after recognizing how their mental health affects their ability to make and sustain lifestyle modifications. After 9 months, your team finds that 64% of the patients who have been attending support group meetings have achieved weight loss over the past 3 months.

Example 3

Problem: Patients with multiple chronic conditions or complex social needs report having difficulty managing all their health conditions. Only 2% of patients with multiple chronic conditions or complex social needs have achieved weight loss over the past 6 months.

Intervention: Pilot a program with community health workers (CHWs) for patients who have complex needs. CHWs, also called peer navigators, share life experiences with the individuals and communities they serve. Your clinic ran a CHW pilot last year for patients with diabetes and heart failure. This year, your clinic works to recruit CHWs to help patients with obesity who also have other complex needs (eg, multiple health conditions, social needs). The CHWs focus on responding to patients who have complex social needs.

Healthcare Quality Domains: This intervention enables equitable care for patients with complex social needs. The intervention may also help some patients achieve more timely and efficient care.

Outcome: After 6 months, the clinic finds that CHWs were able to strengthen partnerships with community organizations and connect more patients with social services and other community resources. This model of working with CHWs has captured the attention of several health insurance plans in your region and they offer to explore ways to improve access to social resources. After 9 months, your team finds that 23% of the patients working with CHWs have achieved weight loss over the past 3 months.

Example 4

Problem: Your HCPs do not feel comfortable asking patients about obesity care. They report feeling unprepared to answer sensitive questions. They have encountered angry and hostile patients when they have introduced the topic. Because of their hesitancy, HCPs have frequently missed opportunities to document an obesity care plan for each new patient.

Intervention: Offer motivational interviewing training sessions for your staff. Use a templated approach with the 6 “A’s” Model (Ask, Assess, Advise, Agree, Assist, Arrange). Providing coaching and feedback can help to empower HCPs.

Healthcare Quality Domains: This intervention enables a patient-centered approach and demonstrates the application of effective communication skills (motivational interviewing).

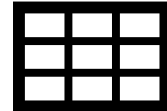
Outcome: After 3 months, your HCPs report feeling more comfortable and confident discussing obesity care with patients. Although some patients may not wish to discuss obesity care, many are eager to try some of the newer therapies. After 6 months, these HCPs complete obesity care plans for every new patient.

Appendix

The following QI resources may guide the team as they work through specific steps of their QI project. Additional QI tools and resources may be found on websites like www.ihl.org and www.ahrq.gov.

Baseline Assessment

One way to perform a baseline assessment is to review patient charts and see how your HCPs are providing obesity care.



- Create a list of 30 adult patients with obesity seen in the past 12 months in your outpatient clinical practice.
- Fill out a baseline data collection spreadsheet.
- Review the data and answer the following questions listed below.

[Baseline Assessment Spreadsheet](#)

Questions that the baseline data will answer:

- What proportion of our patients with obesity have “obesity” listed on their problem list?
- What proportion of our patients with obesity have an obesity care plan documented in their charts?
 - What proportion of those obesity care plans include referrals to other specialists or HCPs (eg, nutrition, surgery, mental health)?
 - What proportion of those obesity care plans include having patients returning at regular intervals for weight checks and/or counseling?
- What proportion of our patients with obesity have been prescribed antiobesity medications?
 - What types of antiobesity medications have been prescribed?
 - How often do patients have trouble obtaining antiobesity medications?
- What proportion of our patients with obesity have lost weight over the past 6 months?
 - How much weight have they lost?

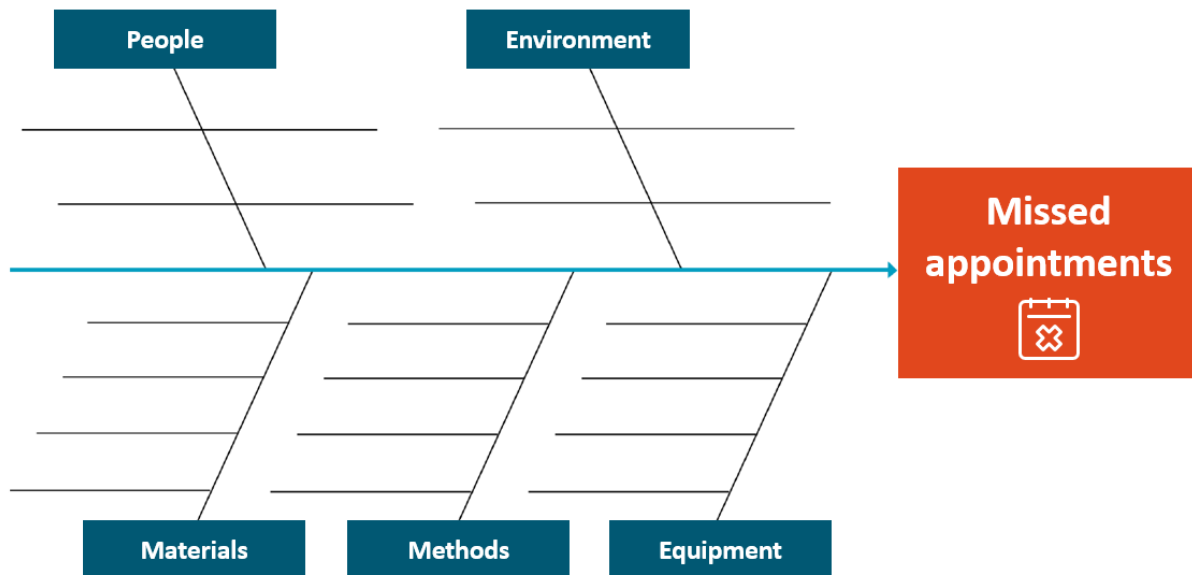
Priority Matrix

After the team has brainstormed a list of possible interventions, place each idea in one of the quadrants based on its potential clinical impact (high vs medium or low) and its feasibility (easy vs difficult to implement). This may help the team prioritize short-term interventions that are most likely to benefit patient care.

Priority Matrix			
Clinical Impact	High		
	Medium or Low		
		Easy	Difficult
		Feasibility (ease of implementation)	

Root Cause Analysis

A fishbone diagram may be used to identify potential root causes behind a problem. This tool may also be called a “cause and effect diagram” or an “Ishikawa” diagram. The root causes for a problem (eg, “missed appointments”) may be grouped into different categories such as people, environment, materials, etc.



Process Mapping

A process map (or flowchart) is a visual representation of steps in a process. This tool can help identify when steps may cause variations in care or when unnecessary work may be occurring. The most common symbols used in a process map are shown below:

Symbol	Name	Function
	Oval	Start/End of a process
	Arrow	Connector/directional relationship
	Rectangle	A process
	Diamond	A decision

PDSA Worksheets

PDSA Worksheet (short version) 1. Define your aim, the overall goal you wish to achieve. 2. Plan the first (or next) test of change toward achieving the aim. 3. Do the test; 4. record and study the results. 5. Act to modify the plan for your next test. Aim: Plan Describe your first (or next) test of change: <table border="1"><tr><td>Who is responsible:</td><td>When is it to be done:</td><td>Where is it to be done:</td></tr><tr><td></td><td></td><td></td></tr></table> List the tasks needed to set up this test: <table border="1"><tr><td>Who:</td><td>When:</td><td>Where:</td></tr><tr><td></td><td></td><td></td></tr></table> Predict what will happen when the test is performed: List measures for assessing the predictions:  Institute for Healthcare Improvement Copyright © 2008 Institute for Healthcare Improvement (IHI). All rights reserved. IHI welcomes the use of this tool, based at IHI.org. Language, field names, and the IHI logo and copyright language must remain intact. Using this form does not imply IHI endorsement. This form may not be reproduced for commercial use without the written permission of IHI.	Who is responsible:	When is it to be done:	Where is it to be done:				Who:	When:	Where:				Do Describe what actually happened when you ran the test: Study Describe the measured results and how they compared to the predictions: Act Describe what modifications to the plan you'll make for the next cycle, based on what you learned:  Institute for Healthcare Improvement Copyright © 2008 Institute for Healthcare Improvement (IHI). All rights reserved. IHI welcomes the use of this tool, based at IHI.org. Language, field names, and the IHI logo and copyright language must remain intact. Using this form does not imply IHI endorsement. This form may not be reproduced for commercial use without the written permission of IHI.
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[https://www.ihl.org/education/IHIOpenSchool/resources/Assets/PDSA_Worksheet\(short\).pdf](https://www.ihl.org/education/IHIOpenSchool/resources/Assets/PDSA_Worksheet(short).pdf)

Obesity Resources

AGA Clinical Practice Guideline on Pharmacological Interventions for Adults With Obesity

[https://www.gastrojournal.org/article/S0016-5085\(22\)01026-5/fulltext](https://www.gastrojournal.org/article/S0016-5085(22)01026-5/fulltext)

AMGA Obesity Care Model Playbook

https://www.amga.org/AMGA/media/Store/Products/AMGA_OCMC-PlaybookFINAL.pdf

Building Successful Models in Primary Care to Improve the Management of Adult Patients with Obesity

<https://www.liebertpub.com/doi/10.1089/pop.2020.0340>

Obesity Definition, Diagnosis, Bias, Standard Operating Procedures (SOPs), and Telehealth: An Obesity Medicine Association (OMA) Clinical Practice Statement (CPS) 2022

<https://www.sciencedirect.com/science/article/pii/S2667368121000048>

Obesity Medicine Association 2023 Abridged Obesity Algorithm

https://obesitymedicine.org/wp-content/uploads/2023/02/Final-OMA-Algorithm_Abridged-Version_2023.pdf

Weight Can't Wait

<https://stoppublichealth9.drupal.gwu.edu/sites/g/files/zaxdzs4356/files/2022-02/wcw-guide-for-the-management-of-obesity-in-the-primary-care-setting.pdf>