Tipping the scales: Improving weight management services in primary care settings

A SHIP multi-grantee project

Prepared for SHIP multi-grantees

Minneapolis Department of Health & Family Support
Bloomington Public Health Division
Hennepin County Human Services and Public Health

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Introduction

An obesity prevention and weight management policy scan was conducted as part of a Minnesota State Health Improvement Program or SHIP multi-grant project. The effort built upon other work and partnerships that had examined coding and reimbursement experiences of primary care clinics throughout the state that offer obesity and chronic disease prevention or management according to recommended guidelines.

The goal of this project was to interview a wide range of experts representing health plans, large health systems, advocacy groups and primary care in an effort to gather insight into current policies and practices when treating overweight and obese patients in Minnesota. A parallel project actually interviewed coding professionals within several clinics to understand their experiences. Both information streams, together, will present a snapshot of our state's current efforts in fighting the obesity epidemic within primary care settings. This report will only report and analyze information shared in interviews with the project consultant contracted specifically for the policy and market scan.

The following report will introduce the methodology of the project and highlight themes that emerged from respondents. It will also highlight possible areas where public health can take some next steps with payers, clinics and providers. For more information on this project or its findings contact the multi-grantee coordinator, Megan Ellingson, MHA at (612) 673-3817 or at Megan.Ellingson@ci.minneapolis.mn.us.

Executive Summary

With rapidly rising rates of obesity, Minnesota's health care communities are actively working to identify ways in which they – whether payer or clinic or advocate organization – can help patients maintain a healthy weight. With 36 percent of Minnesota adults overweight and another 26 percent considered obese, the focus within primary care appears to be in management and treatment of those already at risk. (CDC, 2007 data from the Behavioral Risk Factor Surveillance System)

Primary care and those that reimburse for services agree that the Centers for Disease Control and Prevention (CDC) classification for body mass index or BMI is a very acceptable way to assess a person's weight and identify overweight and obese patients. Yet, they can and do use different terms to describe their efforts. Sometimes the language used varies by audience – such as a way to describe the service to physicians vs. how it is describe to patients. The term "weight management" seems to be the most accurate term at this time.

BMI is a critical measure in preventing and managing obesity. Many advocate that BMI be measured as part of medical visits, especially during annual preventive checkups, but more frequently if able to capture it at other visits – almost like a vital sign. Many clinics have a difficult time measuring and documenting BMI consistently, yet recent pay for performance programs are seeing significant increases in clinics being able to capture BMI for a high percentage of the patient population.

Physicians and other primary care providers typically provide an after visit summary to patients. Patients with a BMI equal to or greater than 25 are often provided some recommendations, referrals, or counseling. Yet, what is shared with a patient is left up to each physician at this time. There is not a uniform approach to talking with patients, or guidance on how to follow up with weight management clinical services, or referrals to community programs such as exercise programs, nutrition classes, or health plan member programs. Even if practices can measure BMI and offer appropriate counseling on diet and exercise, there is not yet a way to determine which approach is most effective in helping patients lose weight and improve health.

Weight management in primary care is inconsistent due to processes and systems like electronic medical records, lack of knowledge of resources, lack of training among physicians on how to approach an overweight patient and offer counseling and guidance, and a coding system that is complicated. If clinics offer some sort of counseling or weight management education they are likely to rely on what they consider "safe" codes for payment rather than coding more accurately for what the service actually was.

Organizations Interviewed

- Allina Medical Clinics
- Blue Cross Blue Shield of Minnesota
- Fairview Health Services
- HealthPartners (enterprise)
- Mankato Clinic Diabetes & Nutrition Education Center
- Medica
- Metropolitan Health Plan
- Minnesota Department of Human Services (DHS)
- Minnesota Medical Association
- Park Nicollet Health Services
- PreferredOne
- PrimeWest Health
- UCare

Despite the barriers and complexities related to offering weight management clinical services, primary care continues to make a difference any way it can. Innovative new care models, unique payer initiatives and out of the box thinking are all taking place – right now – as each organization strives to help reduce the burden of obesity in Minnesota. This is great news and can be even better if we as a state explore how we can collaborate.

Every organization interviewed expressed a desire to learn more about any next steps that may come from this policy scan. They believe they can find some common ground that will increase efficiencies and result in better outcomes for patients struggling to manage their weight. It's possible that public awareness and routine BMI screening could also help prevent weight problems to begin with.

As SHIP grantees work on the obesity epidemic, they will find many organizations that they can support. Interviewees suggested a wide range of ideas such as – organizing access to resources for providers and patients, convening a workgroup to explore what common ground people may want to address collectively, raising public awareness of what obesity looks like, help with addressing denial and a lack of personal accountability that many feel is common among patients. From a prevention standpoint, the respondents felt strongly about outreach and education to help prevent our state's children from becoming overweight.

Everyone welcomes involvement from public health. They recognize our unique strengths as a state that worked so well to improve health – such as tobacco prevention and cessation work. The time is right to explore ways to build collaboration and work together.

Instrument

A written, open-ended survey with 12 questions was developed with input from project stakeholders. The intent was to capture as much policy and program information related to obesity prevention and/or weight management in the primary care setting as possible. Because one survey was developed for multiple audiences, not every question was to be applicable in every interview. (See complete survey in the Appendix.)

The survey was shared in advance of each telephone conversation. It was designed to take 30 to 60 minutes to complete, depending on how many people participated in the call and schedule availability. Interview transcripts were shared with the SHIP project sponsors.

Participating Organizations

From April 22 through June 27, 2011, about 18 organizations (and some individual members of MN Dietetic Association) were contacted to see if they were interested in participating in the survey on behalf of the State Health Improvement Program (SHIP). In some situations, referrals were made to other individuals and organizations. Every organization that responded was enthusiastic about the nature of the project and generous with time and information shared.

In total, 23 individuals participated, representing 13 organizations. In some instances, several representatives gathered together for a group interview, which proved very effective. Only organizations that offered an interview or a written response to the interview guide are included in the alpha-order list below.

- Allina Medical Clinics
- Blue Cross Blue Shield of Minnesota
- Fairview Health Services
- HealthPartners (enterprise)
- Mankato Clinic Diabetes & Nutrition Education Center
- Medica
- Metropolitan Health Plan
- Minnesota Department of Human Services (DHS)
- Minnesota Medical Association
- Park Nicollet Health Services
- PreferredOne
- PrimeWest Health
- UCare

Scheduling Interviews

Given the busy workdays of healthcare professionals working at each organization, finding time free on calendars was a significant challenge. For many interviews, the person initially contacted was not the person actually interviewed. The project contractor relied on names already active with SHIP-related work or published contacts from websites or statewide councils or groups. Most people interviewed fell into three main roles –

1) Medical Directors,

2) Quality and Care Management Directors, and

3) Program and Education Managers.

Persistence was required from April 22 when the email request went out to being able to conduct a phone interview. (Email template found in the Appendix.) When available, executive assistants proved valuable. Scheduling an interview demanded between three and twelve outreach attempts via email and phone. The average was seven contacts for each interview. Given the five* weeks allowed for surveys, that equaled nearly 1.5 contacts per organization per week and about 18 weekly exchanges overall.

**All but one interview were completed between April 22 and May 27th. A final interview was conducted on June 27th.*

Considering the wide variety of organizations and individuals interviewed, it was gratifying that there were consistent themes discussed throughout the interview period. The following section highlights the themes that came up most often and illustrates with examples whenever possible. Organizations' names nor their specific responses are identified here or in other places within this report. Only the project owners, the SHIP multi-grantees, have interview transcripts.

It's important to note, that for every interview, the topic of weight management and/or obesity prevention from either a payer, patient or population health perspective was indeed a priority for the organization. And, that not every organization thought about the questions or solutions the same way. Some of that variety in response will be included in the following section.

There is not a common language used.

One of the documents guiding this project was the Institute for Clinical Systems Improvement (ICSI) guidelines for obesity prevention and management and chronic disease prevention. Each interview spent some time discussing language and what terms are used inside the organization, as well as consensus in the state – if any – for terminology being used.

- "Obesity prevention" as a term can be interpreted in many different ways.
- Weight management appears to be a more accurate reflection of what is taking place – helping people lower weight via a variety of clinical services, pilot programs, member benefits and community resources.
- Primary prevention is important to the interviewees and deals with actually preventing the population from becoming overweight and obese with an emphasis on children as the place to truly prevent obesity.
- Some organizations use one term for providers and another for patients when referring to weight management. It may or may not make sense to have two variations in language to describe the same thing.
- For some organizations obesity is being viewed as a chronic condition or disease, like any other. But some of the treatments and care management offered via primary care is not consistently recognizing obesity as a disease or covering treatments consistently (e.g., bariatric surgery is not covered by all payers despite it being an effective treatment for a disease).

Most organizations are actively offering weight management services.

Managing obesity and its costly health risks associated with the condition is a priority for nearly every interviewee's organization. There is wide agreement that capturing body mass index or BMI according to the national guidelines published by the CDC (Centers for Disease Control and Prevention) at every visit will help patients with awareness and ultimately management or prevention of obesity.

- A wide variety of formal programs including telephonic coaching, print and electronic member education information, disease and care management programs, online coaching, fitness center discounts, worksite health promotion services, individual and group nutrition counseling, and much more are available to clinic patients and health plan members, including public programs. Even with a plethora of programs in place, most are opt-in by the patient/member and rarely do physicians or clinics refer patients to these resources – because it is difficult and confusing to know a patient's eligibility to services based on insurance coverage.
- Even with consensus around the value of BMI measured at primary care visits, there are many systems issues related to successfully capturing it. BMI screening and counseling is a HEDIS measure and one plan reported 43% documentation as a favorable direction.
    - Some electronic medical records are not set up to calculate BMI at every visit, and if height is required at every visit, many adult clinic procedures do not routinely capture height.
    - In chart audits for BMI for bariatric surgery authorization, some clinics find it nearly impossible to adequately document BMI for morbidly obese patients, leaving more questions than answers. Is it awkward and uncomfortable for patients and providers to capture and discuss weight when it is obviously unhealthy? At a certain point do clinics stop measuring?
- In clinics where BMI is routinely captured in a preventive visit and a patient care plan or after visit summary addresses weight management, most recommendations or referrals are left up to the provider. There does not appear to be a consistent approach to this part of the patient visit, though several payers and clinics are in the process of defining the service and standardizing as part of risk-based payment models.

- There is a great deal of innovation and pilot programs taking place right now across the state as payers and providers try to find effective ways to engage patients in losing weight. Most acknowledged that codes for reimbursement lag behind the new programs and services adoption, if any pilots become more widespread. Examples of pilot programs include:
    - Health plan staffing a health coach at specific clinics to work with patients 1:1 in scheduled sessions, as many as needed
    - Medical weight management program, mostly paid out of pocket by patients
    - Testing how to use other clinicians such as social workers, lifestyle coaches, counselors and registered dieticians in primary care settings
    - Group obesity management programs taking place on a regular basis for a year
    - Family nutrition and weight management for low-income pregnant women
- Clinic fax program unites payers and clinics across the state in helping patients gain access to tobacco cessation services and could serve as a model for coordination of varied weight management services.
- Several organizations cited the emerging Patient Protection and Affordable Care Act (PPACA) and stated that they intend to follow and comply with it for any obesity related clinical services or interventions.

There is confusion on how to code and pay for weight management-related patient care.

This interview project did not do a deep dive into clinic coding for obesity prevention or management and related services. (*Note the parallel work effort mentioned in the Introduction does focus on coding*.) However it did ask payers about how often they see certain codes and inquire about policies around payment. It also asked interviewees responsible for providing patient care or education how they typically code for obesity prevention services including things like nutrition counseling.

- If not part of diabetes management, many providers will use E/M codes because they are "safe." And others are becoming more familiar with the 99401-04 codes and using them for preventive counseling. Several payers mentioned that they don't plan to "quibble" about what level provider delivers the service, though many policies as written would exclude registered dieticians.
- In general, the payers interviewed did not perceive heavy use of codes for weight management services. In at least one interview, a clinician noted that it is common for patients to report that not all the educational services were covered.
- Clinics that offer weight management services in competition or cooperation with all of the other consumer programs available in the marketplace, community, or from the heath plan, wrestle with the challenge of patients' willingness to pay for a service. It's feared that while patients pay for some weight management programs they have a perception barrier when required to pay out of pocket for a similar service delivered inside the primary care clinic facility.
- The ICSI guidelines are not necessarily followed to the letter of the law by payers or clinics. Payers appear very familiar with the guideline and providers less familiar. In the actual ICSI document there is a great deal of data and recommendations for physicians to consider when offering counseling and/or treatment options to patients that are overweight and obese.

The idea of an agreed upon minimum clinical intervention for overweight and obese adult patients resonated with interviewees.

One of the more interesting parts of each dialogue was around what if any minimum level of care is desirable for our state. By and large everyone agreed that a minimum is a good thing and that primary care physicians have an important role, albeit not the only role in fighting the obesity epidemic. Some ideas shared are listed below.

- Measure BMI at every visit, like a vital sign. And, have the physician mention weight loss as important to the patient's health if overweight or obese. It's believed that this acknowledgement, even without concrete follow up interventions, is a powerful step in raising awareness.

- Create a consistent after visit summary or patient care plan with recommendations and resources available (in community, clinic, health plan, etc.)
- Deliver clinic-based interventions and counseling to patients using appropriate clinicians/resources and existing codes.
    - Segment the level of the intervention because it is critical to cost/benefit and to scalability. For example, if BMI is 25 to 30 offer self-directed programs or web-based tools in addition to a patient care plan. If BMI is over 30 automatically refer patient to a formal program or to a registered dietician.
    - Interventions and counseling must avoid shame or guilt and could address all treatment options including surgery when appropriate.
    - Draw upon health coaching concepts like goal setting and motivational interviewing.
- Treat obesity like any other disease and educate providers to think of it and treat it while considering lifestyle change, genetics, medication, and surgery as options.

Collaboration with public health and one another is welcomed.

Every interview closed with a creative discussion of what public health and the state overall (all parties) can do to support an organization's goals around obesity prevention. Every single interview welcomed a collaborative and expanded effort to address overweight and obese patients in our state's clinics, schools, and communities. As one person stated, "The door is open to working together."

Several times, a contributor made a parallel to what Minnesota did around tobacco control over the last decade. Several cited that it was a successful way to work together for greater effectiveness. It also allowed competitors to work together in safe and collaborative environment. The interviews also noted that relying solely on physicians and clinics to address the problem is short-sighted and unrealistic; that this is a true public health challenge and requires everyone including public health leadership. Below are some specific ways the interviewees thought public health could support their work.

- Raise public awareness of what overweight and obese looks like. Ads or campaigns with visuals could help break through the denial many physicians experience with adult patients (and the parents of children) who think they are fine and look like everyone else.

- While every group of people is important, if a target audience had to be selected, respondents favored children, low-income families, and obese diabetics.
- Convene meetings or "working groups" for all organizations addressing overweight and obesity in clinical and community settings – much like the tobacco efforts.
- Build consensus around a common definition of what an action plan or care plan should be, as well as language and terminology. Consider how to scale these plans and interventions using some sort of risk criteria to segment patients in order to support delivery of services and costs.
- Find ways to heighten personal accountability for overweight/obesity.
- Support physician training efforts with information on counseling, motivational interviewing, goal setting, etc.
- Identify services for underinsured and uninsured citizens so that along with the health plans all offering programs, every person in Minnesota has access to weight management support.
- Assist providers with understanding resources in the communities. For example, some communities have school nutrition programs and some don't. How to understand what is available when and where.

Nobody focused on coding and reimbursement during this part of the interview. Yet the SHIP multi-grantee coordinator for this project is also gathering information directly from clinics around coding and reimbursement. It could be that that is an important recommended focus area for public health and the state overall. The policy interview represented in this report did not include actual clinic staff working in coding.

Recommendations

Each interview ended with a discussion of, "What can public health do to help support your efforts?" Every single person involved in the discussion could site numerous benefits of collaborating with public health – as well as other organizations throughout the state. The sentiment of "the door is open" was both literally and figuratively expressed.

Building upon extensive community based initiatives to curb obesity, the state's pubic health system has a great opportunity to partner with public and private entities delivering care to the 2.2 million overweight obese Minnesotans. (Blue Cross Blue Shield of Minnesota and the Minnesota Department of Health, 2010) The following recommendations are offered for consideration and further analysis if appropriate for public health.

1. Organize a weight management focused work group comprised of the organizations interviewed for this project and others working in or through primary care clinics to help health care organizations with obesity prevention and weight management policies and programs.
    a. Considered a safe venue for collaboration – even among competitors
    b. Tobacco control coalition cited many times as one that worked and could be used as a model for weight management / obesity prevention
    c. Determine focus of coalition after sharing more (and listening to participants) about the themes that emerged from this project – may be opportunity to work on nomenclature or coding education or public awareness campaigns, or other aspect of weight management
2. Consolidate weight management programs (established and pilot) available throughout the state so that clinicians can better refer patients to resources – without needing to know patient-specific insurance or eligibility criteria.
    a. Include payer programs, public programs, free and fee-based community resources, public health campaigns in schools and communities – along with information on eligibility, duration, fees, contact information, region/location, etc.
    b. Consider a professional version and a patient version. Professional version could highlight data, best practices and results of various programs and initiatives.
    c. Determine if a "clinic fax" program model used for tobacco cessation would support weight management efforts and coordination.
3. Offer assistance in measurement and / or guideline implementation. ICSI has very clear recommendations, but some clinics lack clarity in what to include in practice protocols, patient education, and after visit care plans.

a. If possible, offer insight into after visit summaries (or obesity care plans) being discussed as part of health care reform as well as risk-based provider contracts.

b. Participate in panels or work groups that meet to modify or update guidelines used by payers and providers. While it seems most payers agree in theory on the ICSI guidelines, it appears that reimbursement related to the various aspects of the guidelines is not entirely consistent across the state payers.

c. Identify ways public health can raise patient awareness of BMI and improve the measurement of it during primary care visits. Explore opportunities for measurement with groups like Minnesota Community Measurement.

Working together with public health seems appealing to the organizations interviewed. Working with each other in this type of collaboration feels appropriate and less competitive. Should a primary care clinic system or other organization wish to work on obesity prevention and weight management on its own, there are some questions that emerge from this market scan, that could be considered such as:

- Ask if your organization is treating obesity like other chronic conditions? If not, are there areas for education, policies or system changes to facilitate better patient care management and health outcomes?
- Is your organization placing an unrealistic burden on clinics by requiring counseling or other interventions be done a specific way or by a specific level provider when the other options are of high quality and equal effectiveness?
- If not done routinely, does appropriate staff receive education on weight management and treatment, guidelines like CDC and ICSI and current lists of community resources to help patients.
- Examine engagement rates in patient care, programs and pilots underway. Is the effort reaching the right people and making an impact? If all the individual efforts were added up, is it enough to produce healthy changes in the population?

Minnesota is fortunate to have a history of collaboration within its own health care systems. As a leader in public health, it is apparent that many of our clinics, payers, employers, and community programs are actively involved in reducing the health and cost burden the obesity epidemic places on our citizens and our children. Some consensus building on how to best work with patients in primary care – regardless of insurance – is likely to help health care organizations improve efficient use of resources and if done right will help doctors help their patients lose weight – or prevent obesity altogether.

Interview Guide

Questions for Experts

Ideal interviewee is aware of what the organization is doing today in the area of obesity prevention and management for patients/members AND has some responsibility for these policies or initiatives in the next two years. For some organizations, more than one person may be sought to get replies to the following questions.

1. **Does your organization define overweight and obese for the purpose of delivering or reimbursing services? (Yes/No) If so, how do you define it?**

   For example, this is the CDC classification using height and weight to calculate Body Mass Index or BMI.

BMI	Weight Status
Below 18.5	Underweight
18.5 - 24.9	Normal
25.0 - 29.9	Overweight
30.0 and above	Obese

2. **Do you use the term *primary prevention* or *obesity prevention* or a different term altogether when it comes to obesity related health issues? Explain.**

   a. What is your main focus related to member/patient health and obesity?
   b. How do you determine if your efforts are working?
   c. What departments or individuals are involved in the effort from your organization?

3. **Are you aware of coding activity at clinics for *obesity prevention* services? What is your perception of how it is going today? Do you find this coding to be done consistently or inconsistently by clinics?**

   a. Which codes do you accept/use related to obesity prevention and management? Provide artifacts if appropriate.

4. **What *obesity prevention* services do you provide coverage for (or deliver) at the primary care clinic setting? Do you consistently reimburse (or get reimbursed) for these services, please provide detail if you have it.**

   a. Are covered services limited to certain conditions? For example BMI >29.9 and a comorbid condition? Explain.
   b. Are reimbursed services limited to specific types of clinicians or educators based on licensing, training or supervision? Explain.
   c. What is the general policy for services reimbursement for the following types of populations –
      i. Medicare

ii. Medicaid
iii. Fully insured groups
iv. Self-insured groups (please share any trends or areas of interest among employers if appropriate)
v. Other

d. Could the 99401 codes for Individual Preventive Medicine Counseling be used for a patient with obesity? Specific question directed at nature of what is "prevention?"

5. **What do you envision the future – next few years – bringing when it comes to supporting clinics helping their patients prevent and/or manage obesity?**

   a. Impact of health care homes?
   b. Team approach to care delivery?
   c. Payment models?
   d. Other?

6. **Which *obesity prevention* services do you offer or endorse that can be accessed by patients, outside of the clinic? How do patients know about these services/eligibility? How do healthcare providers know if a patient is eligible for the service?**

7. **In researching actual clinics' experiences with delivering *obesity prevention* services, we've gathered some experiential data that includes:**

   a. Sample experiences shared here.
   b. What is your reaction to it?
   c. If relevant, what do you expect to be happening in primary care clinics serving overweight and/or obese patients?

8. **As a state, do you foresee any ways or have any ideas for how we can collectively come together to address the obesity epidemic together? ("We" includes public health, health plans, health systems, advocacy groups, healthcare providers, clinics, citizens, etc.)**

   a. What if any "minimum" services or healthcare practices do you think could work?
   b. Is there a single (or limited) population to focus on first (e.g., public programs only, or obese *and* comorbid, or overweight before they become obese...)?
   c. Are there ways public health / MN Dept. of Health can support you and your efforts to prevent obesity in MN? What role could they play?

9. **What was not covered during our interview that you would have liked to address?**

10. **Is there someone else in your organization that you suggest I reach out to and interview as well as yourself? If so, provide contact information.**

11. **Please share any parting thoughts, comments, or reactions.**