Group Sessions Model Training

NOVEMBER 13, 2023

HOPE
Helping Our Patients Engage In Weight Management

Agenda

Introductions (10 minutes)

Brief overview of project (5 minutes)

Behavior change 101 (45 minutes)

Break (10 minutes)

Curriculum overview (10 minutes)

Exploring a few sessions

Practice/questions

Welcome!

A little about me:

Graduated from medical school in 2000, then completed an internal medicine/pediatrics residency in 2005

Practiced primary care medicine in Grand Junction, CO for 10 years

Made a career shift to primary care-related research in 2015

Interested in figuring out how issues like obesity and chronic disease management can be addressed more effectively in primary care settings

Also interested in how SDOH impact health behaviors

Tell me about you!

Name

Practice

How is it that you ended up being here today?

What, if any, personal interest do you have in this topic?

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Why are we doing this project?

Obesity is a prevalent health problem

Primary care is endorsed by patients and clinicians as a place where patients should get help to prevent and manage obesity

Evidence-based treatments for obesity are available

Most primary care practices do not have the personnel, training and resources to help patients with obesity

This project is to help you and your staff overcome barriers so you can help your patients with managing their weight

HOPE
Helping Our Patients Engage In Weight Management

HOPE (Helping Our Patients Engage)

The name is the overall goal: *hope* – that something will work to support patients in developing health-promoting habits

Supportive way to encourage overall health improvement through behavior/habit change, not just for the sake of weight loss

Takes a continuity approach with the patient's practice team, doesn't have to be seen as a separate "program" from the health care you are already providing

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Project Aims

Implementation Project, Funded by the **Patient Centered Outcomes Research Institute (PCORI)**

Intended to further implementation of evidence from PCORI-funded studies based on Intensive Behavioral Therapy (IBT) for Obesity

Goal: Help patients get the help they need to successfully manage weight by supporting primary care practice teams in delivering evidence-based obesity care

Aims:

1. Implement evidence-based approaches to obesity care through care delivery models
2. Evaluate the 1) adoption, implementation and maintenance of the IBT for obesity models at the practice level and 2) reach and effectiveness of weight loss and maintenance at 6, 12 and 18 months at the patient level.
3. Determine factors associated with successful implementation including contextual factors (external environment as well as organizational, practice and patient characteristics), IBT for obesity models and their components, and implementation strategies.

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How it works

In the end: Patients get IBT for obesity delivered by your practice

Practice personnel pick a model to deliver the IBT with patients

- Individual visits | Billing clinician
- Individual visits | Health coach
- Group visits | Practice clinician

Those doing the delivery, get training on obesity treatment in general and with that specific model

Start delivering the care to patients in 2024

- Track how it is going and patient data

Try to get 50 (or more) patients within 18 months of enrollment

What is IBT for Obesity?

IBT = Intensive Behavioral Therapy

Consists of frequent visits/contact over at least a year

“Ideal” schedule of visits is:

- Weekly x 4 weeks
- Biweekly months 2 through 6
- Monthly for months 7 through 12

Uses the 5As approach to addressing obesity/weight management

Focuses on diet and physical activity change through goal setting

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=353

Behavior change – what does it take?

Is knowledge enough to support behavior change?

Short answer is NO!

Knowledge alone does not lead to attitude or behavior change for most people

Many people have tried to lose weight over and over again

Many people know the basics of weight loss and weight loss maintenance, and the curriculum CONTENT may not be that new

We know that knowledge is not typically enough to bring about sustained habit change

Habit formation

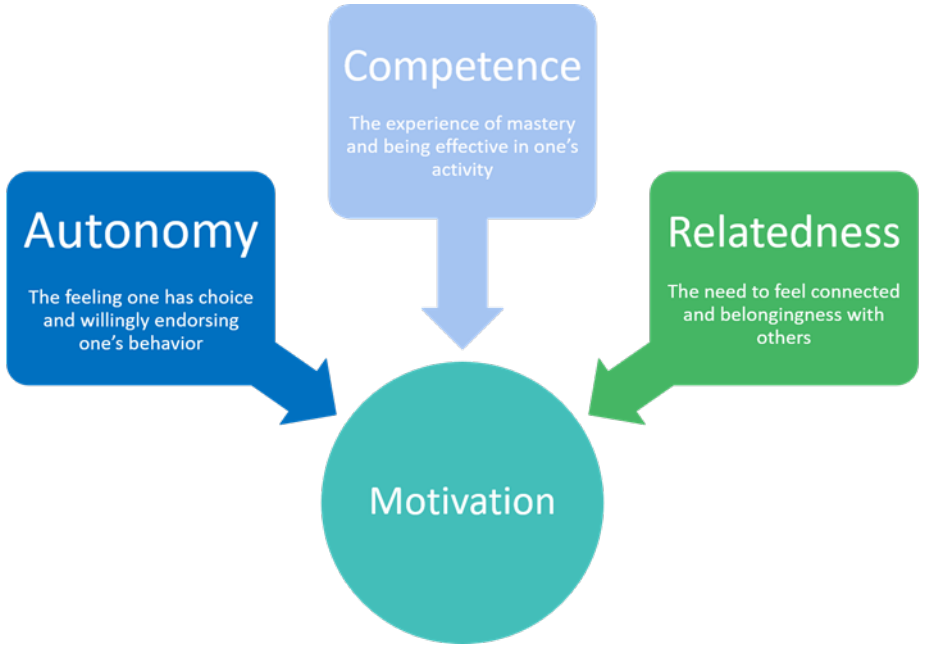
https://medschoolinsiders.com/video/how-to-change-your-behavior-and-master-your-habits/

What struck you?
How does what this relate to working with patients?

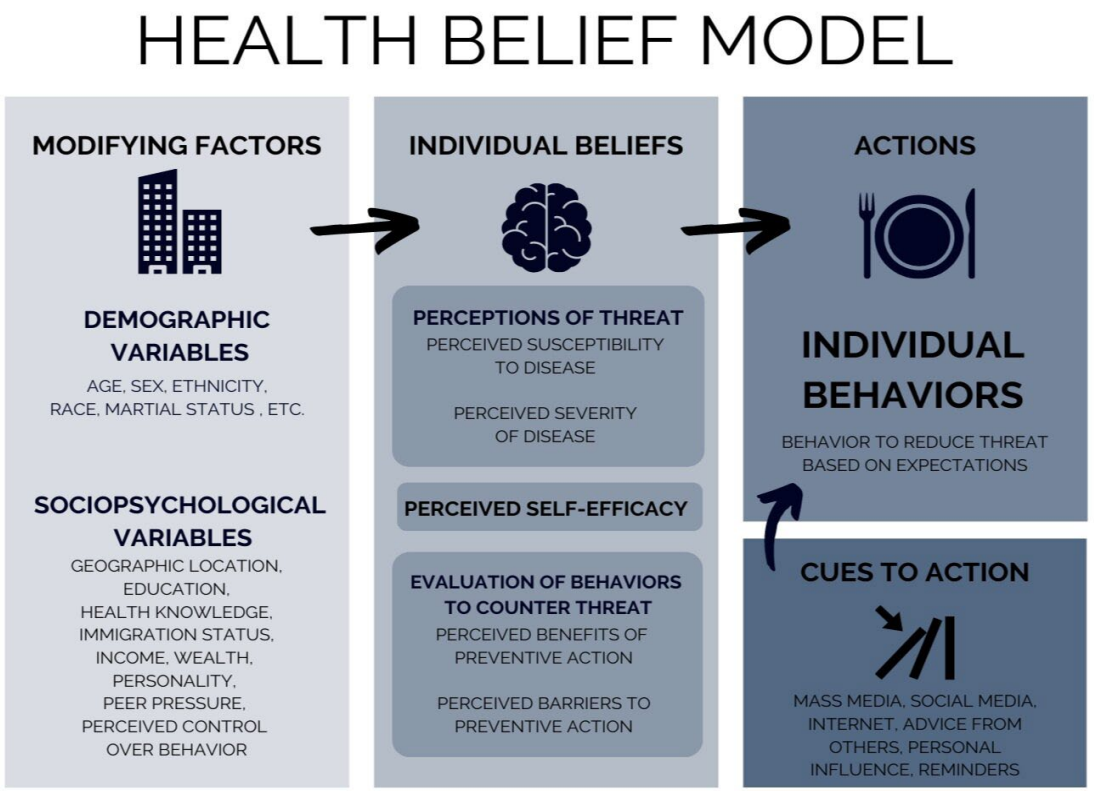
Behavior Change Theories

Self-determination theory

https://www.youtube.com/watch?v=BUr42fXDbTY

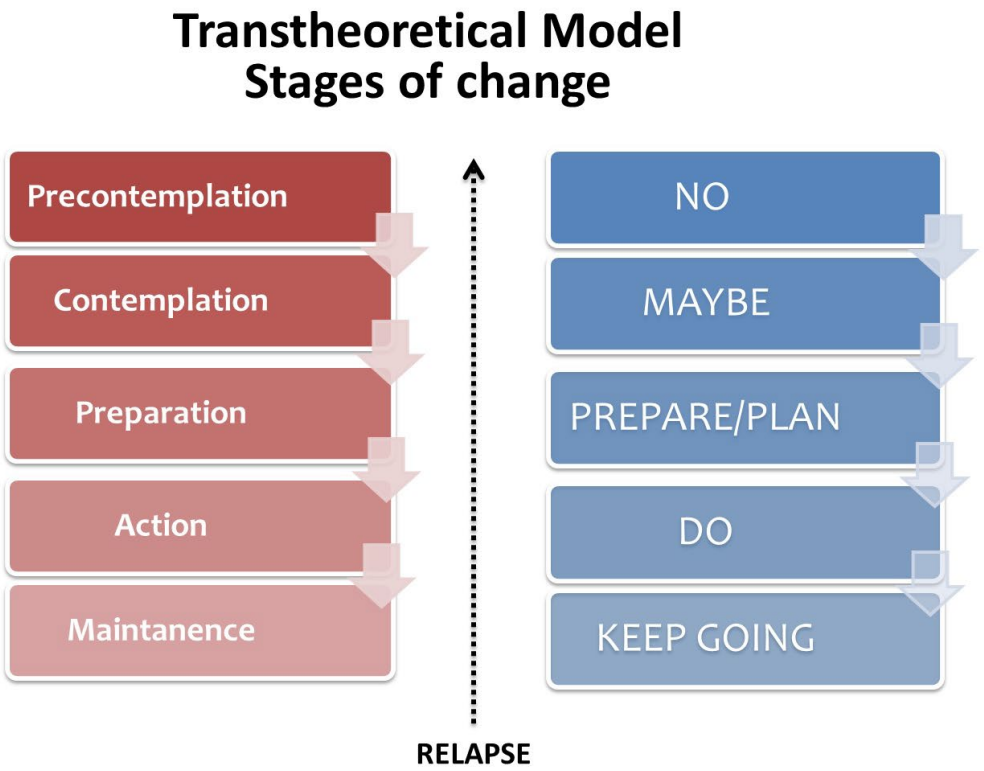


Health Belief Model



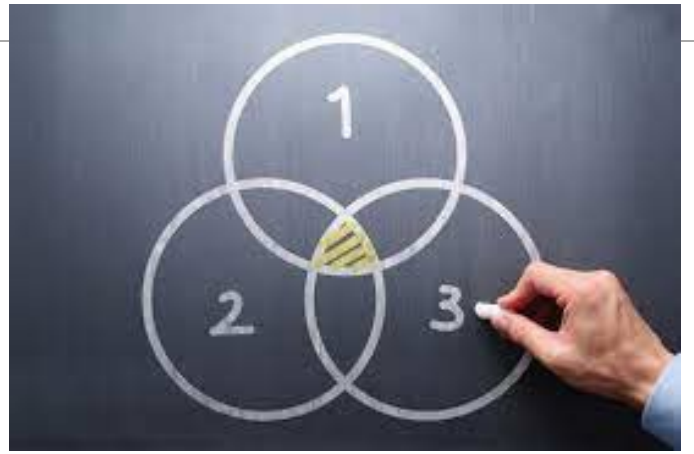
https://www.youtube.com/watch?v=Knedre8Ul60

Stages of change



https://www.youtube.com/watch?v=ayjXMix-nMw

What commonalities do you see?
What can we take away from these theories?



Important points

Knowledge alone is not enough

Change has to be more important/valuable than staying the same to the person

People have different motivations, and it's important to understand these motivations

Set it up so the "right" choice is the easy choice

Small, specific goals

People need support and relationship over time to make lasting change

Communication approaches

Five As – IBT required approach

Ask
- Ask permission to discuss weight

Assess
- Assess what participant is currently doing, has done in the past, overall journey with weight
- Clinical parameters

Advise
- Important information about weight management
- Treatment or intervention options

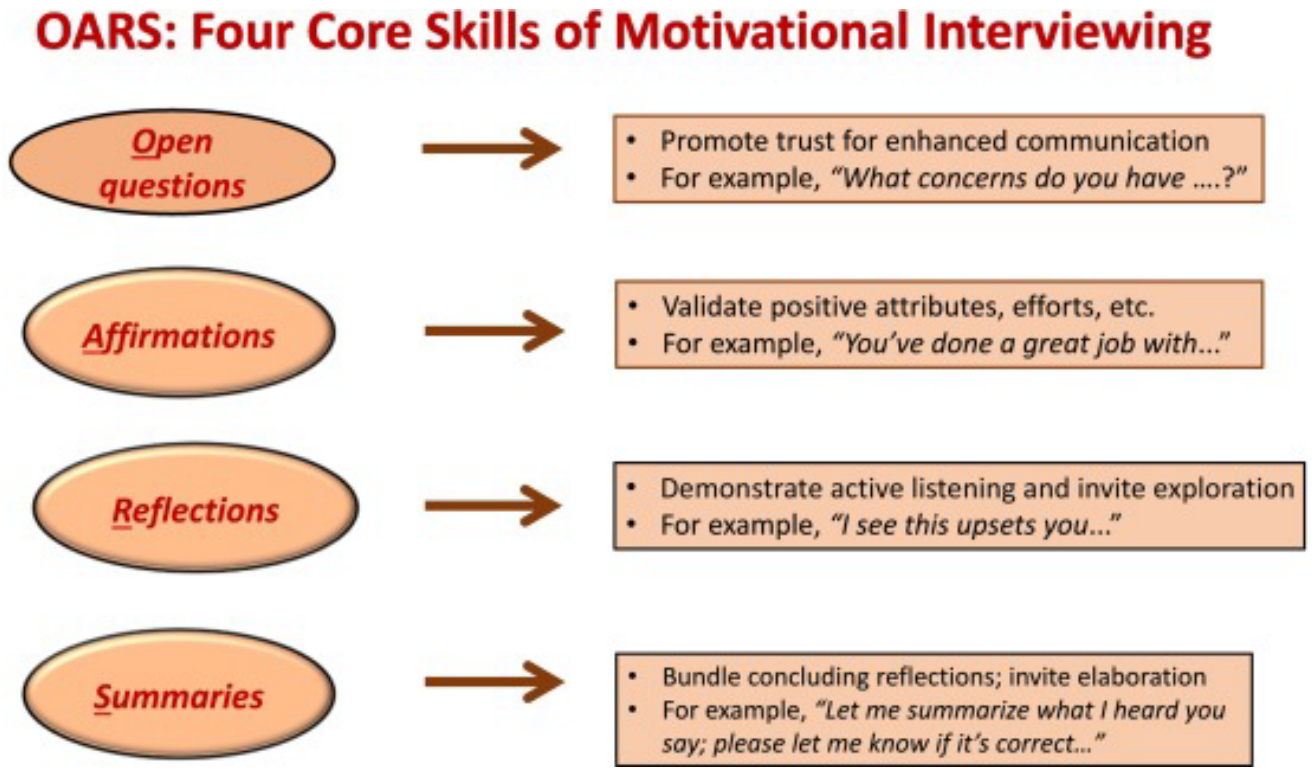
Agree
- Treatment plan or approach, SMART goals

Assist
- With follow up appointments, connection to resources, referrals

What is motivational interviewing?

https://med.stanford.edu/visit/the-clinical-encounter/treatment-options/motivationalinterviewing.html

Motivational Interviewing



Motivational interviewing

Processes	Objectives	Questions to address
Engaging	Strengthen the link, show empathy and interest	What is the actual reality of the individual?
Focusing	Define and focus the discussion on the target of change	What should we address as a target of change?
Evoking	Objective 1: Reasons and abilities to change (the importance of change) Objective 2: Change talk (the confidence to change)	How relevant would it be to go towards change? What abilities, strengths does the individual have to get there?
Planning	Engagement talk. How to change	How will the individual get there?

What habit changes impact weight management?

What **habits** do we know work in the long run?

Diet tracking of some kind

Physical activity

Monitoring weight

Setting small goals on the way to bigger ones

Making the “right choice” the easy choice– setting up systems that work for people (not the same for everyone!)

SMART Goals:

SMART goals are:

Specific: what someone will do and how and where they will do it

Measurable: how will people know if they've achieved the goal

Achievable: something that the person can realistically attain

Relevant: related to the overall goal

Time-bound: for how long and over what period of time

Let’s make these goals SMART

I am going to exercise more

I am going to eat healthier foods

I am going to sleep more

I am going to relax more

Break!


May your morning coffee give you the strength to make it to your mid-morning coffee.
someecards

Group sessions for HOPE

Why group visits?

One strategy for improving ambulatory care

Part of the chronic care model

Provide more attention, information, and support than people can receive in individual visits; patients may feel that no one is listening or explaining things clearly

This is particularly true for chronic diseases; without this support, patients often become high-utilizers and have worse outcomes

This model dates back to at least 1990 when John Scott, M.D., of Kaiser Permanente Denver created the Cooperative Health Care Clinic (CHCC) for groups of 25 chronic care patients, 65 and older, who were high users of health care.[1]

Patients benefit from the support and shared-experiences of their peers

Evidence for group visits

Shown to be more effective/have better outcomes than individual care for diabetes, cardiac disease, and prenatal care

Specifically for obesity, the VA study MOVE showed improved patient knowledge and satisfaction

The study that led to HOPE showed increased weight loss in group participants compared with individual (Rural Engagement in Primary Care for Optimizing Weight Reduction (REPOWER))

Diabetes Prevention Program/NDPP – began in 1996, has showed continued benefit over time

Benefits of group visits

Extended time with patients

- More time for education
- Can include demonstrations (how to access resources, exercise demonstrations, food tastings)
- Peer support

Increased ability to provide team-based care

- Group visits often include other team members
- Interdisciplinary facilitation

Allows understanding of patients' social context and experience of social determinants of health

- Patients may be able to share successful strategies
- May allow discussion of other community resources to address social needs

Challenges of group visits

Staffing and coordination

Scheduling

Recruitment and retention

Facilitation of the visits

- Content delivery
- Participant engagement (some people talk a lot, some people don’t talk!)

HOPE Curriculum for group visits

Based on National Diabetes Prevention Program Curriculum

- Has been used in hundreds of sites across the country
- Is the basis for most IBT curricula (including the studies the led to HOPE)

Adjusted for obesity

- Still focusing on diet/calorie tracking, increasing moderate physical activity, target percent weight loss
- Not specific to preventing diabetes
- Some content modified and additional resource options added

Long-standing, significant evidence for effectiveness

Topics – First six months

Foundational:

Introduction to the program

Burn More Calories than you Take In

Eat Well to Manage your Weight

Track your Food

Get Active to Manage your Weight

Track your Activity

Get More Active

Deeper dive:

Shop and Cook to Manage your Weight

Manage Stress

Find Time for Fitness

Cope with Triggers

Keep your Heart Healthy

Take Charge of your Thoughts

Get Support

Eat Well Away From Home

Stay Motivated to Manage your Weight

Topics – second six months (or longer)

When Weight Loss Stalls

Take a Fitness Break

Stay Active to Manage your Weight

Stay Active Away from Home

Learn About Obesity and Health

More About Carbs

Have Healthy Food You Enjoy

Get Enough Sleep

Get Back on Track

Manage your Weight —for Life!

If possible, use a team approach

Group visits are sometimes easier if multiple staff participate

Team members can include billing clinicians, nurses, health coach, medical assistants

Can alternate facilitation

Consider inviting guest speakers

Facilitation principles

Active listening

Effective communication

Create a safe and comfortable environment

Encourage participation

Manage group processes/plan ahead

Watch the time

Promote creativity (for yourself, too!)

Respond to conflict

Support people's decision-making

General facilitation techniques

You may already be a skilled facilitator and can do this any way you want!

Some things to consider:

- Setting group norms – discussing obesity and health behavior can be touchy
- Not everyone participates in the same way
- Not everyone will have the same goals or priorities
- Avoid any shaming or comparing of weight loss
- Consider having a “parking lot” where you can put questions or topics that arise that aren’t part of that day’s session

Each session, you will review previous SMART goals, and adjust/set new ones

Encourage and praise!

Review progress as a group, but don't force reporting if someone is uncomfortable

Keep the SMART goals in line with overall goals of:

- Increasing physical activity
- Tracking diet/calories
- Weight loss
- Improving diet quality
- Stress management/self-care: need to replace unhealthy eating or PA behaviors with something – improve sleep, meditate, reward with other things, increased social connection, etc.

Options for tracking diet

Most intensive: Calorie counting on paper or app

- Help people determine their calorie needs: https://www.mayoclinic.org/healthy-lifestyle/weight-loss/in-depth/calorie-calculator/itt-20402304

Apps like MyFitnessPal or MyNetDiary

- https://www.myfitnesspal.com/

My Plate

- https://www.myplate.gov/myplate-plan

Easiest: Portion size (patient handouts to cover this) and ensuring 5 servings of fruit and vegetables per day

Paper tracking materials in curriculum as well

Options for tracking physical activity

Paper tracking materials in curriculum

Fitness tracker (FitBit or similar)

App like myfitnesspal

Curriculum

This is a guide, you can follow as closely as you want to but can change as well

Emphasize the seven foundational sessions

- For some these may be basic
- Important to be sure that people have the basic concepts of diet change necessary for weight loss and how to increase and track PA
- Can pick and choose other sessions based on group needs and interests

There are patient handouts that cover the topics for each session, you can decide if you want to give all to people at the first session or hand them out at each session

Feel free to use any other handouts you like

Session structure

Each session is designed to last about an hour

There is didactic information, but most of the learning comes from facilitated discussion

There are optional activities that you can do if you want

You are free to add content or come up with your own activities

You can consider other activities outside the group sessions

- Grocery store visits
- Group walks or other exercise
- Potlucks
- Buddy activities

Before each session

Reserve a space if needed (well in advance)

Try to develop a reminder system (texts, phone calls) and remind people a day or two before the session

Review the session content and practice if you want to

Gather any supplies you need for facilitation and for activities (pens, flipcharts, name tags, etc.)

Make copies of materials – have extra diet, activity and SMART goal worksheets available

Set up the room so that people are in a circle if possible

Take a deep breath!

At each session

If in person, consider weighing: may want to discuss with people whether they want a weigh in each time. We only need weights (for data collection) a few times over the course of the intervention, but not every time

Review with the group how things went since last visit, especially how participants did with their SMART goals

Cover the new session information

Wrap up with setting new SMART goals and ensuring everyone knows when and where the next session will take place

After each session

Record who was present

Complete notes/documentation needed if you are billing for these sessions

Make notes for yourself about what went well, what you would change next time, etc.

Consider calling or following up in some way with participants who missed the session

Session examples:

Review of curriculum online

Who wants to practice?

ACTIVITY: Discussion of why people decided to participate in HOPE. Participants may be there to:

· Get active and improve health and well-being

· Lose weight

· Prevent obesity related health conditions

· Any number of other personal rea

SAY: Now let's spend a few minutes talking about why you're here. I'd love to understand why people decided to participate in this program.

DISCUSS: Open question to the group: Why did you join this program?

SAY: Thank you for sharing that with the group. We will get to know each other well over the coming weeks and months and support each other along th

Who wants to practice?

SAY: Evidence supports tracking food intake and physical activity as a strategy that helps people lose weight and prevent regaining weight.

An important part of this process is tracking your activity and food intake each week.

There are many ways to track both diet and physical activity. We have provided paper tracking forms in your notebook, but you may prefer some other method.

ASK: What experience do people have with tracking diet or physical activity? What are some ways you have tracked this (if any) in the past?

SAY: For now, we will start with basic tracking of your diet and physical activity. We have provided paper trackers in the Participant Notebook. Some of you might already track these things in another way – like an app (MyFitnessPal or similar). That is fine! If you are already tracking, you can continue to do that. If not, you can start with paper. This will help you track your progress. We will discuss tracking diet and physical activity more in upcoming sessions when we will talk about and explore other ways to track and gradually increase the amount and intensity of your physical ac

Questions?