OBESITY MANAGEMENT: SUCCESS OF CME AT PROMPTING CHANGES IN PRACTICE

Amy Larkin, PharmD1, Robert Braun1, Mary Kathryn Van Kleunen2, Karen Badal, MD, MPH1

Medscape Education, New York, NY
1Healthcare Performance Consulting, Statesboro, Georgia

INTRODUCTION
Obesity continues to be a public health concern on a worldwide scale. In the United States, roughly 1 in 3 adults is obese. With national attention increasingly focused on health and economic costs associated with obesity, efforts to reduce obesity must be a priority for the medical community. This study measured the impact of education on various aspects of clinician self-reported obesity management-related practice behaviors.

METHODS
An online, video-based, roundtable discussion among 3 experts was developed with a focus on several aspects of obesity management, including patient communication, utilization of a team approach, taking procedures, and comprehensive obesity treatment plans. Four panel discussion was accompanied by synchronous slides presenting the experts’ perspective. The roundtable was designed for physicians, nurse practitioners (NPs), physician assistants (PAs) who treat patients who are obese. The effects of education were assessed using an internet-based Practice Change Assessment (PCA) survey. The PCA process allows for an immediate assessment of planned changes and a delayed measure that identifies actual behavior change. It allows learners to self-report and clarify the practice changes and barriers they encountered. Changes and a delayed measure that identifies the extent to which the changes were made, how the changes took place, and barriers to making the changes. These qualitative responses were evaluated to identify and clarify the practice changes and actual barriers.

FOLLOW-UP ASSESSMENT: The follow-up survey was a delayed assessment of the current state of standard changes identified in the initial PCA questionnaire. The follow-up survey was administered approximately 6 weeks after the launch of the activity. All components of the initial survey (as of that date) were sent in email format and links to the follow-up survey were included. The follow-up survey included questions about completed changes and about barriers to changes that learners may have encountered in their daily practice. Use of a unique respondent identifier on both the initial PCA and the follow-up assessment allowed for direct matching of individual participant’s responses to both assessments. Although not all learners completed both assessments, the duration of the survey did not change. There was an increase in the reduction of the choice of sampling frame, when comparing the results of the assessments. Completers of the follow-up assessments were invited to opt in to the follow-up interview.

FOLLOW-UP INTERVIEWS: Telephone interviews were conducted with a sample of learners from attendees who opted into the follow-up assessment. The interviews included questions about why specific changes were selected, whether the changes were made, how the changes took place, and barriers to making the changes. These qualitative responses were evaluated to identify and clarify the practice changes and actual barriers.

RESULTS

KNOWLEDGE GAINS
2. Implement a team approach to managing patients with obesity to assist in keeping patients engaged and motivated and to improve follow-up
3. Incorporate intensive behavioral therapy for obesity
4. Engage patients with obesity in more frequent follow-up visits to address weight loss and adjust treatment plans
5. Use communication tools such as the 5As (Ask, Advise, Assess, Assist, Arrange)
6. Engaging patients with obesity to assist in keeping patients engaged and motivated
7. Stop a weight loss medication or switch patients to a different weight loss medication
8. Using communication tools such as the 5As and/or motivational interviewing when discussing obesity with patients

Practice Changes
9. This program confirmed my existing practices
10. I feel more comfortable discussing obesity with patients
11. I am more aware of obesity as a disease, and more aware of treatment options—surgical, pharmacological, and behavioral. It is important for patients with obesity
12. I am now a little more aggressive in managing obesity.
13. I am more comfortable managing patients with obesity to assist in keeping patients engaged and motivated and to improve follow-up
14. I am now a little more aggressive in managing obesity (II) (Clinical pharmacists)
15. I now have the information and resources to make my practice differently. I will try to force the patient bring up the topic (through questioning) and can more effectively motivate the patient

CONCLUSIONS
The study is a strong indicator that the educational programs successfully prompted changes in clinical performance, showing that appropriately designed, practical education on successful strategies for obesity management is a useful way to effect changes in practice.

The highest percentages of change were in the areas of utilizing pharmacotherapy and following up with patients more frequently on weight loss

Future needs for education include promotions for optimal patient management related to obesity and evidence of the safety and efficacy of weight loss medications, including information on weight loss after discontinuation.

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Notes
For more information contact Amy Larkin, PharmD, Director of Clinical Strategy, Medscape, LLC. at alarkin@medscape.net

FIGURE 1. Demographics

FIGURE 2. Flow Chart of Design and Participants

FIGURE 3. Anticipated Practice Changes

FIGURE 4. Follow-Up Assessment: Changes Made in Practice

FIGURE 5. Change Comparison: Immediate Post-Activity vs Long-Term Follow-Up

*Percentages may not add up to 100% due to program cost (2.7/5 average impact)

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BARRIERS TO CHANGE

Financial constraints such as weight loss medications not being on formulary, financial constraints such as weight loss medications not being on formulary, or patients simply not being able to afford weight loss medications prevent me from using preferred medications to treat obesity (3.5% average impact)

PHARMA EXPERTS
Financial constraints such as weight loss medications not being on formulary, or patients simply not being able to afford weight loss medications, lead to program cost (2.7% average impact)

PHARMACISTS
Patients are unable to participate in commercial insurance programs (eg, Jenny Craig). Weight Management services are expensive (2.9% average impact)

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