Obesity management: What primary care is doing well, and future opportunities

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Every week, over 2 million Australians visit a GP
GPs deal with individuals day to day; therapeutic relationship of trust, rapport etc
Primary care often has a deep understanding of the individual’s circumstances & the communities they work in
GPs are well placed to intervene at key times in an individual’s life
Measure waist circumference (WC) and calculate BMI:

- every 2 years in all patients (screening)
- annually for adults:
  - with diabetes, CVD, stroke, gout, liver disease, or
  - from high risk groups (eg Aboriginal, Torres Strait, Pacific Islands)
- every 6 months for those with overweight or obesity
As GPs we need to do more

Turner et al MJA 2015 study found that:

- 22.2% of pts had BMI documented
- 4.3% of pts had WC documented

If we’re not measuring it, how can we diagnose & treat it?
General practice activity in Australia 2015-16: Bettering the evaluation and care of health (BEACH):

- 2.6% of total “problems” dealt with in consultations related to diabetes; Only 0.5% related to obesity

HOWEVER

- approximately 6% of the population has diabetes (excluding GDM, according to ABS (2014-15) on self reported data) cf 28% adult population having obesity (AIHW 2018)
People with class III (previously morbid) obesity

Prevalence of severe obesity i.e. BMI ≥40, has almost doubled in last 15 years
Aboriginal and Torres Strait Islanders

The prevalence of obesity in Aboriginal and Torres Strait Islander communities is alarming. Obesity is thought to contribute to 16% of the health gap between Aboriginal and Torres Strait Islander people and the total Australian population.

The inequity in health service access provision for Australians with obesity is further accentuated in those from Aboriginal and Torres Strait Islander communities.

Opportunities

Healthy communities: Rates of overweight and obesity across Australia, 2014-15

- The number of individuals with overweight or obesity is **over represented** in rural and remote areas of Australia.
- In the scope of health service provision for obesity management, these areas are often **under-serviced** and **under-resourced**, further exacerbating the inequity between the two.
Change the weight gain trajectory

Make a difference for the individual, but also the next generation

Prevent +/- defer onset of complications and comorbidities of obesity


Medical and surgical induced weight loss: Importance of aftercare

Achieve optimal health benefit from therapy
Ongoing delivery of education and support to patient and their carer
Prevention of or early diagnosis of complications
Ongoing education of patient and carers

- Reduce stigma
- Increased access to treatment and support services
- Improved patient outcomes

It is very difficult to lose weight once an individual has developed obesity
A Clinician’s perspective

Discrimination and weight bias even amongst HCPs
Time constraints-remember doesn’t have to be done in one consult*
Fear of billing too many “long consults” and possible ramifications

GP Management Plan (GPMP)

Chronic medical condition or terminal illness that has been (or is likely to be) present for six months or longer ✓

Patients require ongoing care from a multidisciplinary team ✓

GP Management Plans and Team Care Arrangements

If a patient has a chronic medical condition, they may be eligible for services under a General Practitioner Management Plan (GPMP) or Team Care Arrangement (TCA). Chronic medical conditions are those that have been, or are likely to be, present for at least 6 months. Examples include:

- asthma
- cancer
- cardiovascular disease
- diabetes
- kidney disease
- musculoskeletal conditions
- stroke

GPMPs and TCAs help practitioners coordinate the care of people with chronic conditions. They also help to reduce the need for ad hoc consultations. Care plans are useful for recording comprehensive, accurate and up-to-date information about a patient’s condition and treatment.

Developing a care plan can also help encourage your patient to take responsibility for their care. Patients may be able to identify things they could do to achieve the goals of the treatment.
### Table 6.4  Summary of effects of weight management interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Summary of effect</th>
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<tbody>
<tr>
<td>Lifestyle change (see Tables C5–C9; Appendix C)</td>
<td>Least effective (&gt;10% weight loss in few studies; weight loss not likely to be maintained in most participants)</td>
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<tr>
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<td>Dietary change—3–5 kg at 12 months; 0 kg at 5 years</td>
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<td>Dietary change and exercise—5–10 kg at 12 months; 0–3 kg at 5 years</td>
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<tr>
<td></td>
<td>Exercise—0 kg at 12 months; 0–5 kg at 5 years</td>
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<td>Lifestyle change and psychological intervention—3–4 kg at 5 years</td>
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<tr>
<td>Combined lifestyle change and pharmacotherapy (see Tables C10 and C11)</td>
<td>Moderately effective (&gt;10% weight loss across some but not all studies; weight loss maintained &gt;5 years in some but not all participants)</td>
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<td>Medication (e.g. orlistat) and dietary change—6–10 kg at 12 months; 2–3 kg at 5 years</td>
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<td>Bariatric surgery with maintained lifestyle changes (see Tables C18–C20)</td>
<td>Most effective (consistently &gt;10% weight loss across studies; weight loss likely to be maintained &gt;5 years)</td>
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<td>Laparoscopic adjustable gastric banding—20% at 12 months; 12% at 10 years; 6% at 5 years</td>
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<td>Vertical banded gastroplasty—20% at 12 months; 15% at 10 years; 5% at 5 years</td>
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<td>Roux-en-Y gastric bypass—33% at 12 months; 30% at 60 months; 0% at 10 years</td>
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**Threats**

Healthy Profession. Healthy Australia.
Current initiatives

RACGP: Obesity Position statement on prevention and treatment of obesity
SI Obesity Management Network

The Obesity Collective

Healthy Heart Partnership

Shaping a healthy Australia pilot project

Better access to public bariatric metabolic surgery taskforce

Supporting the Senate Obesity Enquiry final report December 2018, Canberra
What we need?

• GPs need to be supported to provide effective, evidence-based management to patients with obesity.
• There needs to be clarity about what MBS supported services people with obesity are entitled to access and more support in place; this includes clarification on use of chronic care plans
• Better access to public obesity clinics and/or bariatric services, in particular in regional areas, with easily identifiable entry criteria
What do we want?

- Greater education and support of practicing GPs and also GP registrar training
- Shared care pathways
- Greater remuneration for the longer consults required when dealing with the complexity of obesity and its complications and comorbidities
Take home messages

1. Commit to using people first language and to ending the use of stigmatising images and messages.
2. Re-think “failure” as it adds to stigma/shame
3. GPs are well placed to intervene at various critical time points in an individual’s life
4. Clinician’s mantra: “measure, identify, treat”