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

Dr Georgia Rigas

RACGP Specific Interests Obesity Management Chair

Obesity Summit

15 February 2019, Canberra

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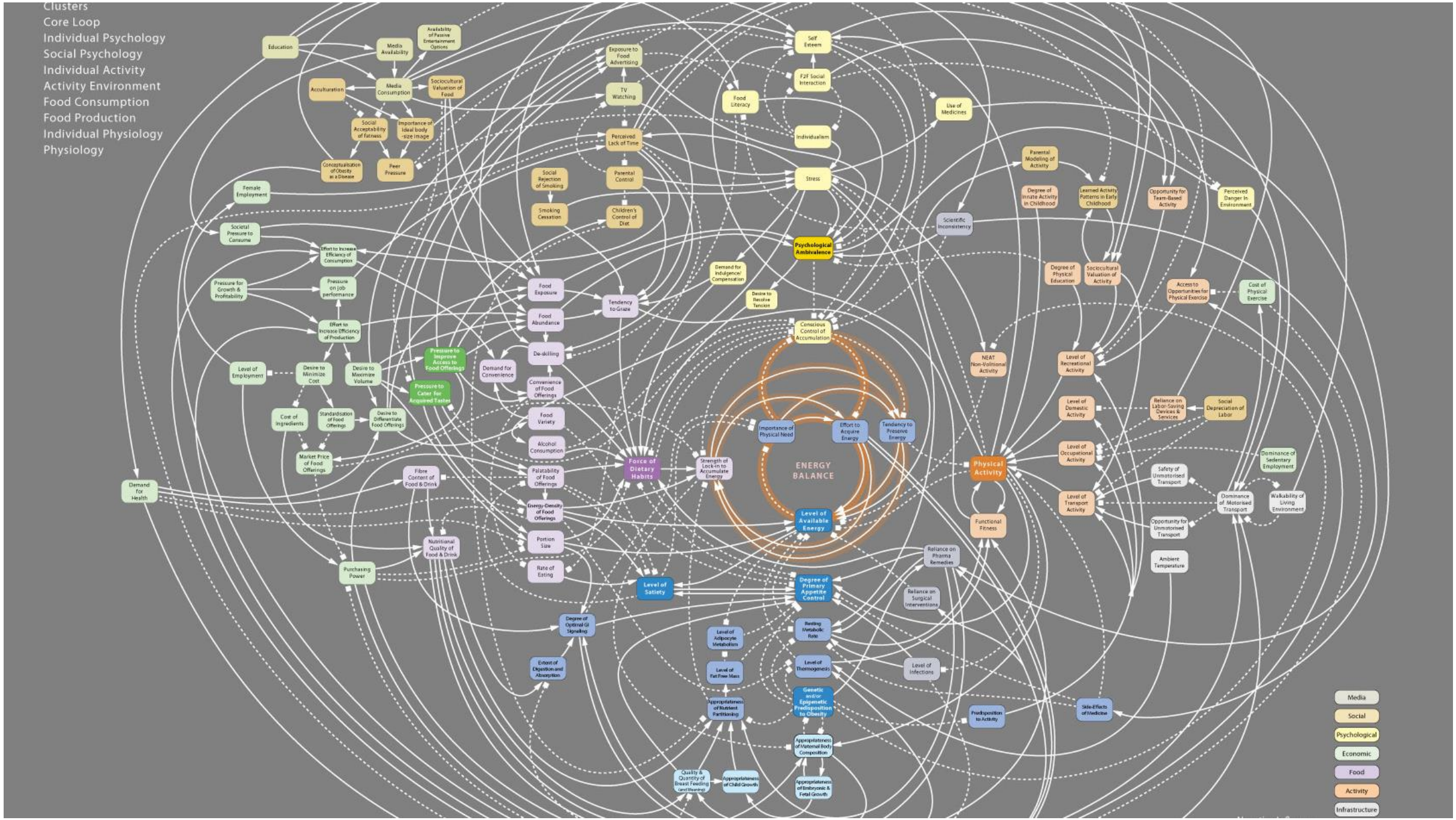
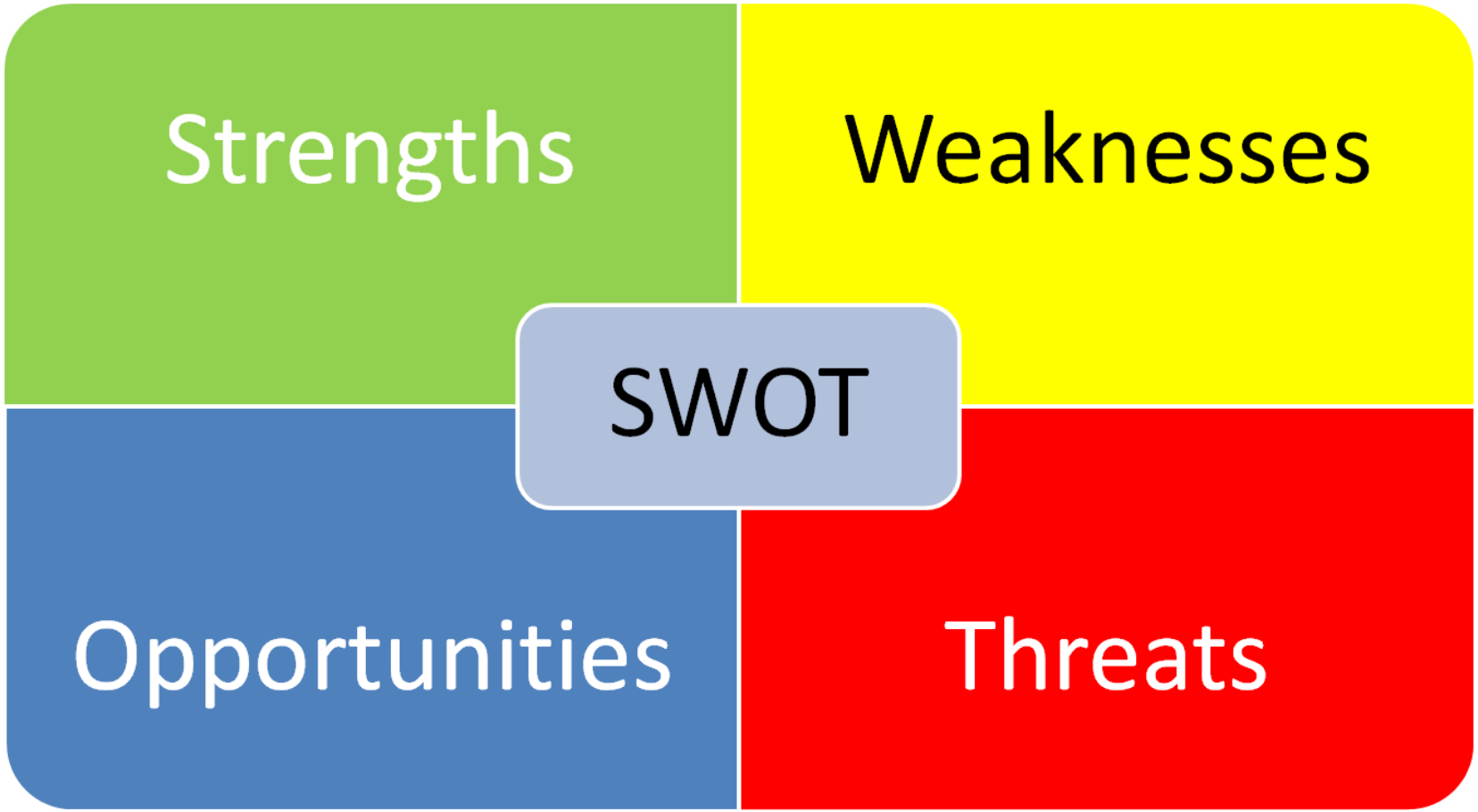

Clusters
Core Loop
Individual Psychology
Social Psychology
Individual Activity
Activity Environment
Food Consumption
Food Production
Individual Physiology
Physiology
Education
Media Availability
Availability of Passive Entertainment Options
Media Consumption
Sociocultural Valuation of Food
Acculturation
Social Acceptability of Fatness
Importance of Ideal body -size Image
Conceptualisation of Obesity as a Disease
Peer Pressure
Female Employment
Societal Pressure to Consume
Exposure to Food Advertising
TV Watching
Perceived Lack of Time
Parental Control
Social Rejection of Smoking
Smoking Cessation
Children's Control of Diet
Self Esteem
F2F Social Interaction
Food Literacy
Individualism
Stress
Use of Medicines
Psychological Ambivalence
Demand for Indulgence/ Compensation
Desire to Resolve Tension
Scientific Inconsistency
Parental Modeling of Activity
Degree of Innate Activity in Childhood
Learned Activity Patterns in Early Childhood
Opportunity for Team-Based Activity
Perceived Danger in Environment
Degree of Physical Education
Sociocultural Valuation of Activity
Access to Opportunities for Physical Exercise
Cost of Physical Exercise
Effort to Increase Efficiency of Consumption
Pressure for Growth & Profitability
Pressure on Job performance
Effort to Increase Efficiency of Production
Level of Employment
Desire to Minimize Cost
Desire to Maximize Volume
Cost of Ingredients
Standardisation of Food Offerings
Desire to Differentiate Food Offerings
Market Price of Food Offerings
Pressure to Improve Access to Food Offerings
Pressure to Cater for Acquired Tastes
Demand for Convenience
Food Exposure
Food Abundance
Tendency to Graze
De-skilling
Convenience of Food Offerings
Food Variety
Alcohol Consumption
Palatability of Food Offerings
Energy-Density of Food Offerings
Portion Size
Rate of Eating
Fibre Content of Food & Drink
Nutritional Quality of Food & Drink
Demand for Health
Purchasing Power
Force of Dietary Habits
Strength of Lock-in to Accumulate Energy
Conscious Control of Accumulation
ENERGY BALANCE
Importance of Physical Need
Effort to Acquire Energy
Tendency to Preserve Energy
Level of Available Energy
Level of Satiety
Degree of Primary Appetite Control
Degree of Optimal GI Signaling
Extent of Digestion and Absorption
Level of Adipocyte Metabolism
Level of Fat Free Mass
Resting Metabolic Rate
Level of Thermogenesis
Genetic and/or Epigenetic Predisposition to Obesity
Appropriateness of Nutrient Partitioning
Appropriateness of Maternal Body Composition
Quality & Quantity of Breast Feeding (and Weaning)
Appropriateness of Child Growth
Appropriateness of Embryonic & Fetal Growth
Level of Infections
Reliance on Pharma Remedies
Reliance on Surgical Interventions
Side-Effects of Medicine
Predisposition to Activity
Physical Activity
NEAT Non-Volitional Activity
Functional Fitness
Level of Recreational Activity
Level of Domestic Activity
Level of Occupational Activity
Level of Transport Activity
Reliance on Labor-Saving Devices & Services
Social Depreciation of Labor
Dominance of Sedentary Employment
Safety of Unmotorised Transport
Dominance of Motorised Transport
Walkability of Living Environment
Opportunity for Unmotorised Transport
Ambient Temperature
Media
Social
Psychological
Economic
Food
Activity
Infrastructure



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Strengths

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

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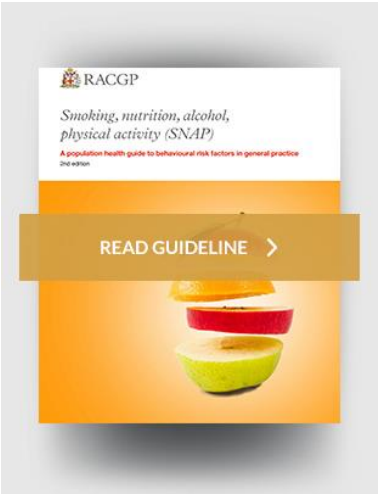
Strengths

RACGP Red Book 9th edition

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



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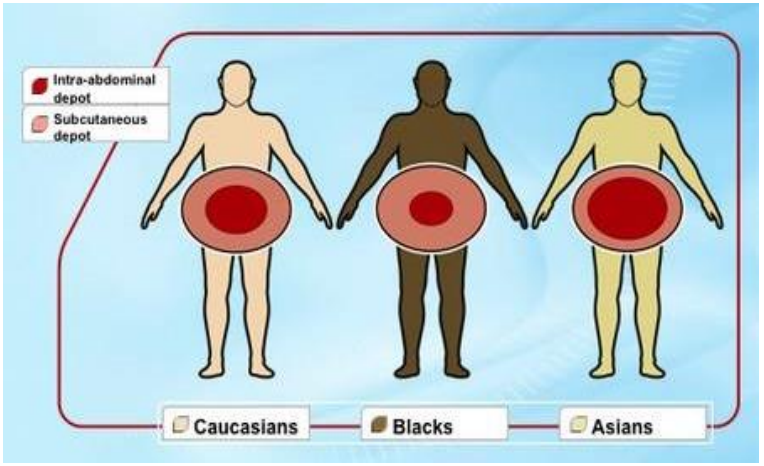
As GPs we need to do more

Weaknesses

Turner et al MJA 2015 study found that:

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



Patient groups	Waist circumference threshold	
	Women	Men
South Asian, Chinese, Japanese adults	≥ 80 cm	≥ 90 cm
Other ethnic groups, e.g. Pacific Islanders	Higher than those of European descent, not yet determined	

If we're not measuring it, how can we diagnose & treat it?

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Table 7.3 (continued): Problems managed by ICPC-2 chapter and frequent individual problems within chapter

Problem managed	Number	Per cent total problems[a] (*n* = 150,279)	Rate per 100 encounters (*n* = 97,398)	95% LCL	95% UCL	Per cent of encounters[b] (95% CI) (*n* = 97,398)
Immunisation/vaccination – respiratory	2,946	2.0	3.0	2.5	3.6	—
Asthma	1,942	1.3	2.0	1.8	2.1	—
Acute bronchitis/bronchiolitis	1,935	1.3	2.0	1.8	2.2	—
Sinusitis acute/chronic	1,229	0.8	1.3	1.1	1.4	—
Chronic obstructive pulmonary disease	863	0.6	0.9	0.8	1.0	—
Tonsillitis*	750	0.5	0.8	0.7	0.9	—
Musculoskeletal	**17,597**	**11.7**	**18.1**	**17.5**	**18.6**	**17.1 (16.6–17.6)**
Arthritis – all*	3,438	2.3	3.5	3.3	3.7	—
Osteoarthritis*	2,548	1.7	2.6	2.4	2.8	—
Back complaint*	3,045	2.0	3.1	2.9	3.3	—
Bursitis/tendonitis/synovitis NOS	1,277	0.8	1.3	1.2	1.4	—
Sprain/strain*	1,205	0.8	1.2	1.1	1.4	—
Osteoporosis	977	0.7	1.0	0.9	1.1	—
Fracture*	843	0.6	0.9	0.8	0.9	—
Injury musculoskeletal NOS	805	0.5	0.8	0.7	0.9	—
Skin	**16,961**	**11.3**	**17.4**	**16.8**	**18.1**	**16.4 (15.8–16.9)**
Contact dermatitis	1,721	1.1	1.8	1.6	1.9	—
Skin disease, other	1,144	0.8	1.2	1.0	1.3	—
Laceration/cut	1,084	0.7	1.1	1.0	1.2	—
Solar keratosis/sunburn	1,067	0.7	1.1	1.0	1.2	—
Malignant neoplasm, skin	1,042	0.7	1.1	0.9	1.2	—
Skin symptom/complaint, other	806	0.5	0.8	0.7	0.9	—
Circulatory	**14,678**	**9.8**	**15.1**	**14.4**	**15.8**	**14.1 (13.5–14.7)**
Hypertension*	7,289	4.9	7.5	7.0	7.9	—
Atrial fibrillation/flutter	1,234	0.8	1.3	1.1	1.4	—
Ischaemic heart disease*	868	0.6	0.9	0.8	1.0	—
Cardiovascular check-up*	833	0.6	0.9	0.7	1.0	—
Endocrine and metabolic	**13,151**	**8.8**	**13.5**	**12.9**	**14.1**	**12.3 (11.7–12.8)**
Diabetes (non-gestational)*	3,896	2.6	4.0	3.7	4.3	—
Lipid disorder	2,956	2.0	3.0	2.8	3.3	—
Vitamin/nutritional deficiency	1,419	0.9	1.5	1.3	1.6	—
Hypothyroidism/myxoedema	909	0.6	0.9	0.8	1.0	—
Obesity (BMI > 30)	736	0.5	0.8	0.6	0.9	

Weaknesses

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)

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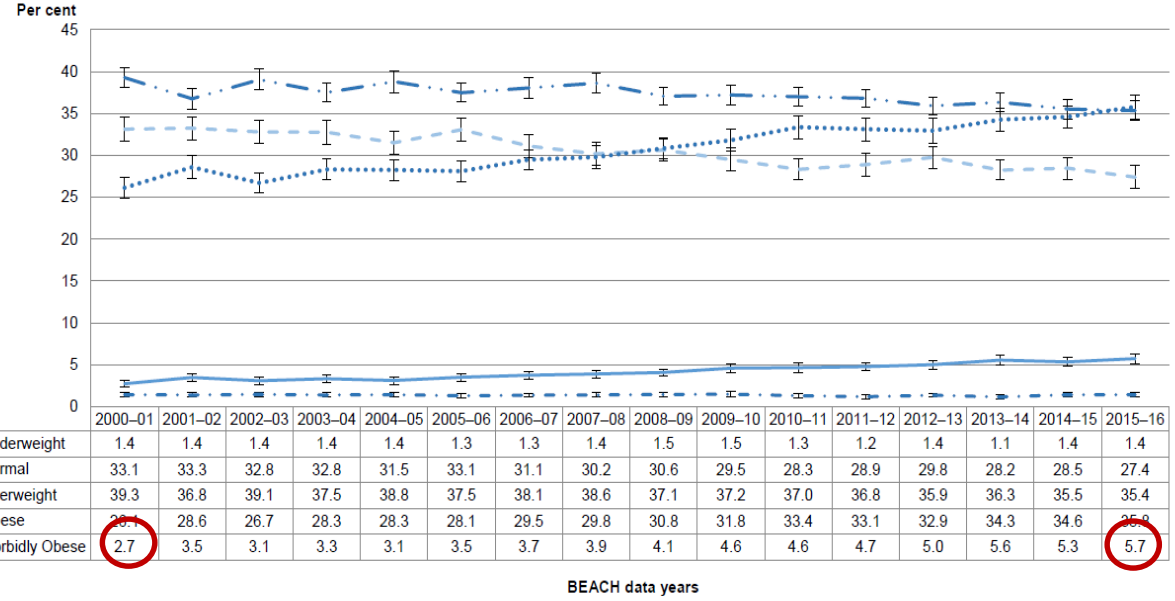
People with class III (previously morbid) obesity

Weaknesses



	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Underweight	1.4	1.4	1.4	1.4	1.4	1.3	1.3	1.4	1.5	1.5	1.3	1.2	1.4	1.1	1.4	1.4
Normal	33.1	33.3	32.8	32.8	31.5	33.1	31.1	30.2	30.6	29.5	28.3	28.9	29.8	28.2	28.5	27.4
Overweight	39.3	36.8	39.1	37.5	38.8	37.5	38.1	38.6	37.1	37.2	37.0	36.8	35.9	36.3	35.5	35.4
Obese	29.1	28.6	26.7	28.3	28.3	28.1	29.5	29.8	30.8	31.8	33.4	33.1	32.9	34.3	34.6	35.8
Morbidly Obese	2.7	3.5	3.1	3.3	3.1	3.5	3.7	3.9	4.1	4.6	4.6	4.7	5.0	5.6	5.3	5.7

BEACH data years

Note: BMI – body mass index. Underweight – BMI <18.5, normal – BMI 18.5–24.99, overweight – BMI 25.0–29.99, obese – BMI 30, morbidly obese – BMI 40+.
Columns will not total to 100% as the obesity category includes morbid obesity.

Figure 14.6: Proportion of patients at encounters aged 45–64 years in each body mass index group with 95% confidence intervals (2000–01 to 2015–16)

Prevalence of severe obesity
ie BMI ≥40,
has almost doubled in last 15 years

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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

Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report. Canberra: AHMAC 2015

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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

Opportunities

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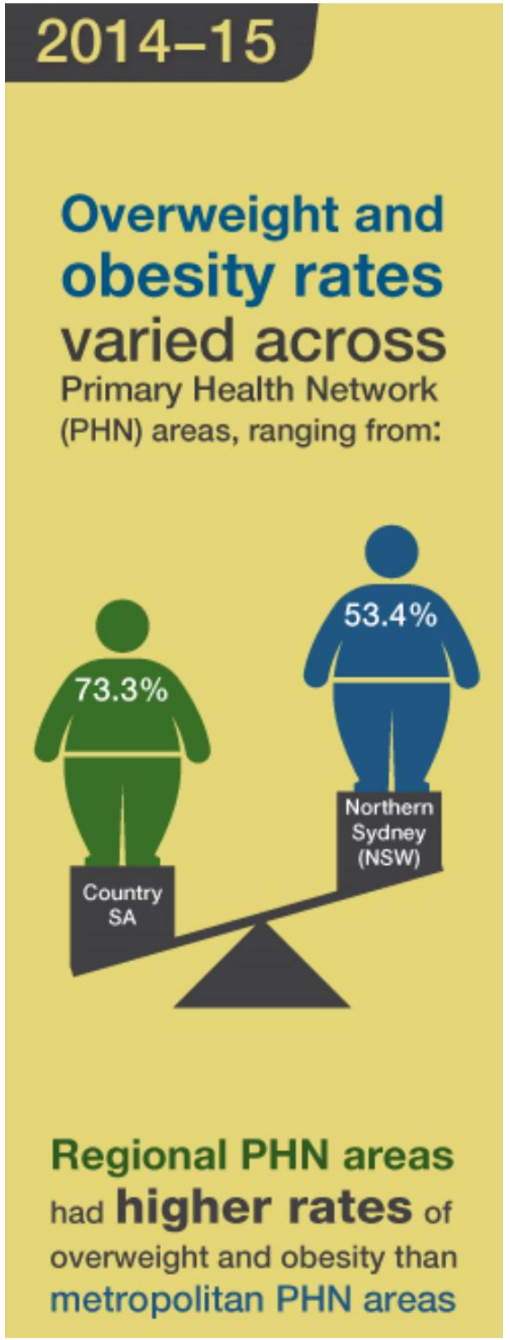


Change the weight gain trajectory

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

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

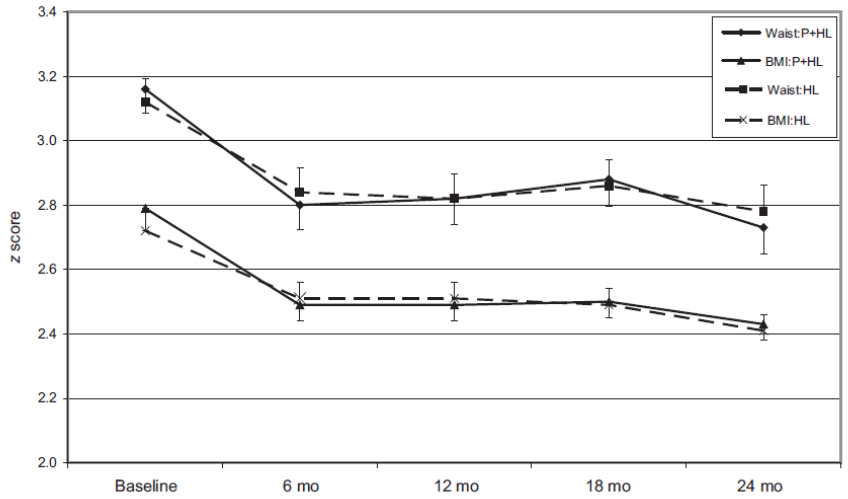
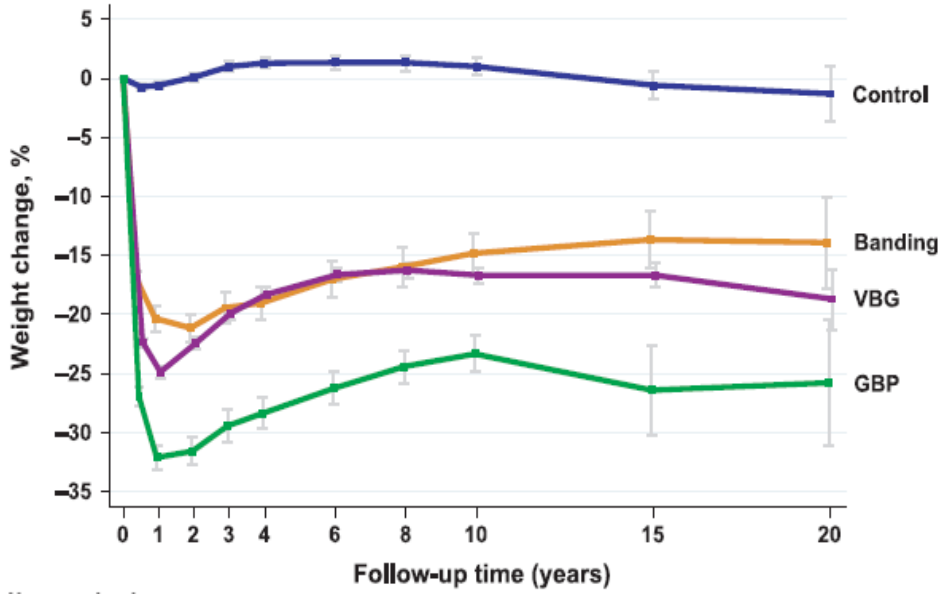


FIGURE 2
BMI and waist *z* scores (adjusted mean ± SEM) according to allocated treatment group (P+HL or HL) in overweight children aged 5 to 9 years ($n = 169$ at baseline). Linear mixed model: BMI and waist circumference *z* scores, main effect of time $P < .001$, posthoc analysis (Bonferroni method) $P < .001$ for baseline versus all other times. *P* was not significant for main effect of group and group-by-time interaction.

Magarey AM, Perry RA, Baur et al. A parent-led family-focused treatment program for overweight children aged 5 to 9 years: The PEACH RCT. Pediatrics. 2011;127(2):214-22.



Sjöström L, Peltonen M, Jacobson P et al. Bariatric surgery and long-term cardiovascular events. JAMA. 2012;307(1):56–65

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Opportunities

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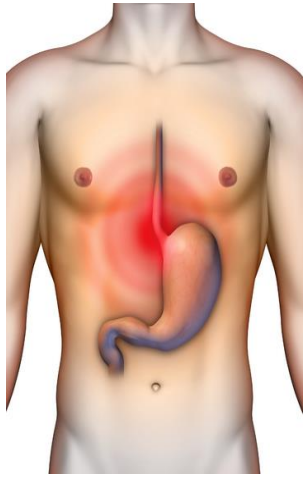
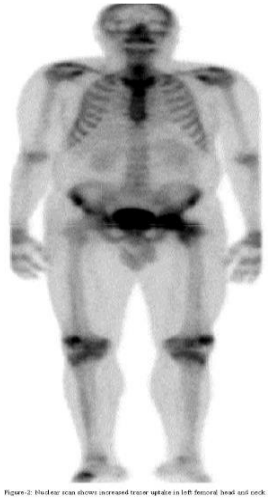
Medical and surgical induced weight loss: Importance of aftercare

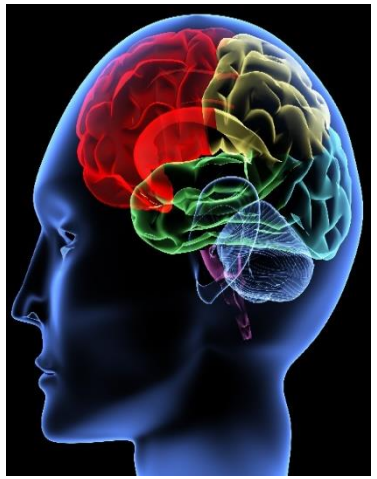
Achieve optimal health benefit from therapy

Ongoing delivery of education and support to patient and their carer

Prevention of *or* early diagnosis of complications







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Opportunities

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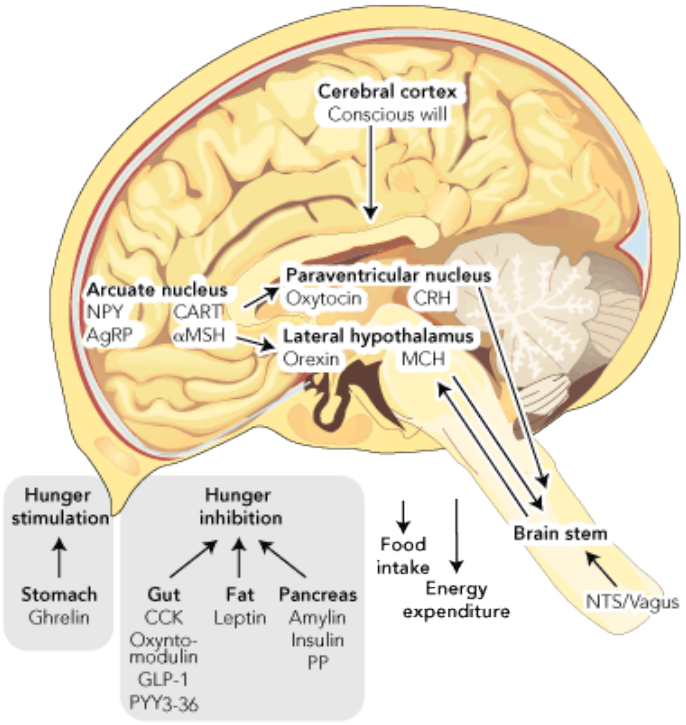

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Long-Term Persistence of Hormonal Adaptations to Weight Loss

Priya Sumithran, M.B., B.S., Luke A. Prendergast, Ph.D., Elizabeth Delbridge, Ph.D., Katrina Purcell, B.Sc., Arthur Shulkes, Sc.D., Adamandia Kriketos, Ph.D., and Joseph Proietto, M.B., B.S., Ph.D.

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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

Opportunities

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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

*Forgione N, Deed G, Kilov G, Rigas G. Adv Ther. 2018;35(2):191–198. Managing obesity in primary care: Breaking down the barriers.

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Australian Government
Department of Health

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.

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NHMRC Guidelines June 2013

Table 6.4 Summary of effects of weight management interventions

Intervention	Summary of effect
Lifestyle change (see Tables C5–C9; Appendix C)	Least effective (>10% weight loss in few studies; weight loss not likely to be maintained in most participants) Dietary change—3–5 kg at 12 months; 0 kg at 5 years Dietary change and exercise—5–10 kg at 12 months; 0–3 kg at 5 years Exercise—0 kg at 12 months; 0–5 kg at 5 years Lifestyle change and psychological intervention—3–4 kg at 5 years
Combined lifestyle change and pharmacotherapy (see Tables C10 and C11)	Moderately effective (>10% weight loss across some but not all studies; weight loss maintained >5 years in some but not all participants) Medication (e.g. orlistat) and dietary change—6–10 kg at 12 months; 2–3 kg at 5 years
Bariatric surgery with maintained lifestyle changes (see Tables C18–C20)	Most effective (consistently >10% weight loss across studies; weight loss likely to be maintained >5 years) Laparoscopic adjustable gastric banding—20% at 12 months; 12% at 10 years ≈16kg Vertical banded gastroplasty—20% at 12 months; 15% at 10 years ≈20kg Roux-en-Y gastric bypass—33% at 12 months; 30% at 10 years ≈40kg

Threats

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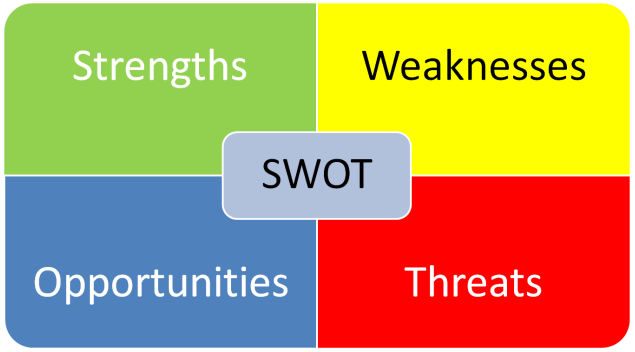
Current initiatives



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

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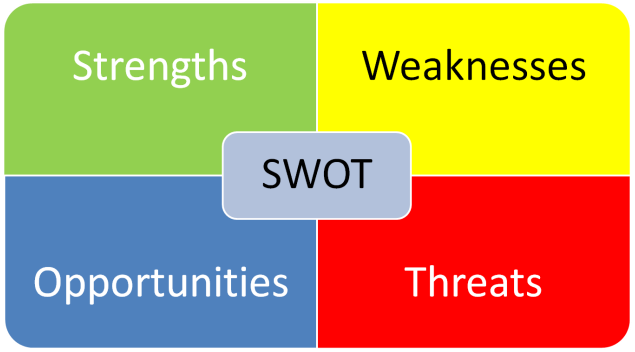
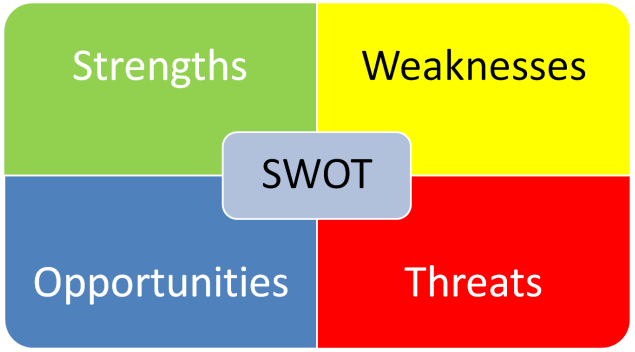
What we need?



- 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

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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”