Capital Health Network gratefully acknowledges support from the following sponsors.
Trusted information at the point of care

Evidence based and easy to use

Developed for local health professionals, by local health professionals

Clear, local and relevant referral options
Trusted information at the point of care

Register and access ACT & SNSW HealthPathways today

https://actsnsw.healthpathways.org.au
Assoc Prof Paul Dugdale
Director Chronic Disease Management, Canberra Hospital and Health Services

Clinical Management of Obesity
Introductory remarks
Clinical Management of Obesity
Introductory remarks

1. Prevalence
2. Prevention
3. Approach to medical management
4. Surgical management
5. Take home messages
1. Prevalence of Obesity in Australia

- BMI is a very useful measure for population analysis.
- BMI is a somewhat useful measure, with others, for clinical analysis.
- More men are overweight than women (BMI>25).
- Men and women have the same rate of obesity (BMI>30).
- More men than women have Class I Obesity (BMI 30-35).
- But more women than men have Class II Obesity (BMI 35-40).
- *Twice* as many women than men have Class III Obesity (BMI>40).
Distribution of Australian Adult BMI by Gender

ABS NHS 2014-15
Distribution of Adult BMI by Gender
Source: ABS National Health Survey 2014-15 Data Cube Table 8

<table>
<thead>
<tr>
<th>BMI</th>
<th>Male%</th>
<th>Female%</th>
<th>Total%</th>
<th>Male '000</th>
<th>Female '000</th>
<th>Total '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>2.9</td>
<td>7.6</td>
<td>5.2</td>
<td>246.9</td>
<td>687.9</td>
<td>931</td>
</tr>
<tr>
<td>20-24.9</td>
<td>26.5</td>
<td>36.1</td>
<td>31.4</td>
<td>2309.6</td>
<td>3255.3</td>
<td>5567.4</td>
</tr>
<tr>
<td>25-29.9</td>
<td>42.4</td>
<td>28.8</td>
<td>35.5</td>
<td>3694.9</td>
<td>2593.9</td>
<td>6297.1</td>
</tr>
<tr>
<td>30-34.9</td>
<td>20.1</td>
<td>16.6</td>
<td>18.3</td>
<td>1757.1</td>
<td>1492.6</td>
<td>3251</td>
</tr>
<tr>
<td>35-39.9</td>
<td>6.1</td>
<td>6.6</td>
<td>6.3</td>
<td>530.7</td>
<td>595.4</td>
<td>1119.9</td>
</tr>
<tr>
<td>&gt;40</td>
<td>2.1</td>
<td>4.2</td>
<td>3.2</td>
<td>185.6</td>
<td>382.6</td>
<td>571.7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>8724.3</td>
<td>9006.6</td>
<td>17733.3</td>
</tr>
</tbody>
</table>

Mean BMI 27.8kg/m² 27.2kg/m² 27.5kg/m²
Median BMI 27.1kg/m² 26kg/m² 26.6kg/m²
Obese BMI>30 28.40% 27.40% 27.90% 2474.3 2466.1 4943.9
2. Support for prevention measures is high

<table>
<thead>
<tr>
<th>Support Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96%</td>
<td>Support ACT Government to ensure school canteens offer a wide range of healthy food and drinks</td>
</tr>
<tr>
<td>90%</td>
<td>Support limiting the sale of unhealthy food and drinks in school canteens</td>
</tr>
<tr>
<td>95%</td>
<td>Support the promotion of active transport for children, such as riding or walking to school</td>
</tr>
<tr>
<td>94%</td>
<td>Support the promotion of physical activity in workplaces</td>
</tr>
<tr>
<td>93%</td>
<td>Support increasing healthy food and drink options in workplaces</td>
</tr>
<tr>
<td>88%</td>
<td>Support restricting advertising of unhealthy food, especially around child-oriented places</td>
</tr>
<tr>
<td>87%</td>
<td>Support reducing the amount of unhealthy food advertised and displayed around supermarket checkouts</td>
</tr>
</tbody>
</table>
3. Management of Class III Obesity must be about more than weight loss

- Weight loss is a worthy gain, but we must be realistic about the effectiveness of our current strategies
- The idea of a set point for weight, and of the factors that do or don’t influence the set point, is a strong guiding idea
- The vicious cycles between co-morbidities and obesity drive weight gain
- Virtuous cycles between self-managed dietary and physical activity changes drive weight stabilisation and improvement in risk profiles
- Understanding and coordinating care for co-morbidities also drives the virtuous cycles that reverse the risks associated with obesity
**ACT OMS** (BMI>40) Co-Morbidities

- The first 50 patients had **303** comorbidities between them
- Mean 6.1 per patient, Range 1 to 21
Ethics of Obesity Management

• Many think that obesity is due to laziness and greed.
• While moralising about disease was common in the 19th century, it is now quite rare, with some notable exceptions (eg STDs and addictions).
• It is now counterintuitive to take a moralistic approach to disease.
• So why does it still happen with some diseases?
  • It may be an expression of stigma, or of frustration with the lack of effective therapy, or of the doctor’s need for authority
  • But moralising is counter-therapeutic: it reinforces stigma, undermines the therapeutic relationship, reduces medical authority
• Telling people not to be moralistic appears to be no more effective than the moral instruction to lose weight.
• Perhaps moralising can be displaced with different ways of thinking, and knowledge of rational effective practice
Shame is not a therapeutic modality
Will-power cannot be prescribed

- The power of the will is quite limited
- As Spinoza said in his critique of free will, the exercise of our will is rarely solely determined by our free thought.
- Dietary and physical activity patterns are an excellent illustrations that ‘free will’ is largely illusory.
- His point was that there needs to be investigation of the constraints and careful thinking for us to freely imagine and decide what we want to do.
Australian Algorithm for the Management of Obesity (ADS, ANZOS, OSSANZ 2016)

- **Obesity classification**
  - BMI 30-40 Kg/m² (Population specific BMI 27.5-37.5 Kg/m²)
  - BMI >40 Kg/m² (Population specific BMI >37.5 Kg/m²)

- **Baseline assessment for complications**
  - Medical: diabetes; cardiometabolic; NASH; sleep apnoea; PCOS
  - Psychological: eating disorders; depression; low self-esteem; stigmatisation
  - Physical: osteoarthritis; personal hygiene; breathlessness

- **Obesity related complications**
  - Nil
  - Present

- **Target weight loss**
  - >10%
  - >10%
  - >15%

- **Health service setting**
  - Primary care
  - Specialist care

- **Weight loss strategies**
  - Supervised lifestyle interventions
  - Reduced Energy Diet
  - Low Energy Diet
  - VLED
  - Pharmacotherapy
  - Intensive interventions
  - Very Low Energy Diet (VLED)
  - Pharmacotherapy
  - Bariatric surgery
  - Intensive medical interventions
  - Pharmacotherapy and/or VLED
  - Bariatric surgery
4. Bariatric Surgery numbers in Australia

- In 2014/15 the AIHW reports there were 17,945 bariatric procedures (excluding band adjustment and revisions) across all hospitals in Australia, growing at 7%pa.
- 15,359 (86%) of these were private patients (claimed on the MBS), (ie public sector is 14%)
- In comparison, 66% of ALL elective surgery in Australia is done in the private hospitals (ie public sector is 34%)

Private Bariatric Surgery in Australia

MBS items 31569(Band), 31572(RenY), 31575(Sleeve)
5. Take Home Messages

• 2/3 of the 600,000 Australians with Class III Obesity are women
• Weight is not a behavioural risk factor; invoking shame is not a therapeutic strategy.
• Gastric sleeve surgery is becoming more popular, but access for public patients is poor.
Dr Carol Huang
Senior Staff Specialist, Obesity Management Service, Respiratory & Sleep Medicine, Canberra Hospital

Managing Obesity in General Practice
Obesity

- Excessive fat accumulation that presents a risk to health
- Not necessarily a problem of eating too much
- Widespread in our community
- Associated with substantial burden of morbidity and premature deaths
- Has been formally recognised as a disease by the American Medical Association
- Causes, exacerbates or accelerates 196 significant comorbid diseases
Obesity in Australia

- National Health Survey 2014-5 Estimates, ABS
  - Average BMI of adults 18 years and over
    - Males 27.8
    - Females 27.2
  - 27.9% of Australians adults are obese (BMI ≥ 30) (>4.9 million)
  - 63.4% Australians adults are overweight or obese (BMI ≥ 25) (>11 million)
  - 571,700 (3.2%) Australians have Class III Obesity (BMI ≥ 40)
Obesity Prevalence is Increasing

Obesity: Prevalence Trends. Australian National Preventive Health Agency 2014- Prepared by Boden Institute of Obesity, Nutrition, Exercise & Eating Disorders & Menzies Centre for Health Policy, University of Sydney
Overweight and Obesity is common across all adult age groups.
Obesity in the ACT

Estimated population of adults who were obese in the ACT

69,785

Source: Australia’s Health Tracker, 2017, Australian Health Policy Collaboration
Obesity and Life Expectancy


Data from male subjects.
Obesity and Health Care Costs

Effect of Weight Loss

Benefits of 5% to 10% weight loss

Physiology of Obesity

Is it just physics?
Energy Balance

Energy Expenditure

Food Intake
Energy Balance

• Average adult requires approximately 1300 Calories per day
• Average adult consumes 2000-2500 Calories per day
  – The average adult consumes 1.5-2x as much food as needed
  – Maintaining weight within 10kg between age 21 and 65 requires matching of intake and expenditure within 0.2%
  – Corresponds to an accuracy of 4-5 Calories per day.
    (1g of Smith’s Potato Chips Crinkle Cut = 5.2 Calories!)

Therefore, daily energy balance must be regulated by physiology
Energy Balance

The body seeks a stable adipose tissue mass

Just like other tissues of the body
Obesity

• Results from failure of normal weight and energy regulatory mechanisms

  Leads to an elevated body fat set-point

  And this is strongly defended by the body
  Even it is abnormally high
Weight Regain after Weight Loss

Hormonal Changes with Weight Loss Persist

Weight Regain after Weight Loss

- Increased hunger hormone and decreased satiety hormone levels occur after weight loss and changes persist beyond 12 months after weight loss
  - Contributes to weight regain after weight loss
- Prevention of weight regain after weight loss
  - Strategies must be in place and discussed with the patient
Obesity Management

• Obesity is widespread in our community and managing obesity is the responsibility of all health professionals

• The GP is the ideal person to discuss weight management with the patient
  – Obesity is a chronic disease and requires long term management
  – Continuity of care
  – Can provide holistic care rather than just treating individual diseases or complications
Barriers and Enablers for Obesity Management - Patient Factors

• Barriers
  – Seeing the doctor as the last resort
  – Endless loop of failure
  – View obesity as their own fault
  – In denial about being obese
  – Cost of services

• Enablers
  – Family support
  – Empowered patient
  – Perceived trust
  – Patient recognising the issue
  – Type of health professional
  – Trigger e.g. Diagnosis of diabetes

Gunther et al. Quality in Primary Care 2012; 20: 93-103
Barriers and Enablers for Obesity Management - Practitioner Factors

• Barriers
  – Obesity as a ‘non-medical’ issue
  – Reluctance to take responsibility
  – Lack of time
  – Lack of counselling skills
  – Doubt that consultation could make a difference
  – Passing the problem to someone else
  – Lack of services

• Enablers
  – Confidence and knowledge of the practitioner
  – Easy to follow and implement guidelines
  – Feeling confident to refer to services
  – Peer support groups within a practice

Gunther et al. Quality in Primary Care 2012; 20: 93-103
Goals of Treating Obesity

- Improve health
- Improve quality of life
- Improve body weight and composition
Core Principles of Obesity Management

• Goal of effective treatment is to **reduce the elevated fat mass set-point**
• There is **wide heterogeneity** in the causes and manifestations of obesity
• This leads to **wide patient-to-patient variability** in the response to all anti-obesity therapies
Variable Weight Loss after Diet Therapy

Adapted from Gardner et al, JAMA 2007
Patient Response is Variable to All Types of Obesity treatment

- **Diet (Low-carbohydrate)**
- **Drug (Liraglutide)**
- **Device (Duodenal liner)**
- **Surgery (Gastric Bypass)**
Core Principles of Obesity Management

• Goal of effective treatment is to reduce the elevated fat mass set-point
• There is wide heterogeneity in the causes and manifestations of obesity
• This leads to wide patient-to-patient variability in the response to all anti-obesity therapies
• People who respond to one therapy may not respond to another, and vice versa
• The strategy is to match each patient with the treatment most effective and suited to them.
Obesity is a chronic medical disease and often requires lifelong treatment.
Screening for Co-morbidities

Medical Complications of Obesity

- Pulmonary disease
- Idiopathic intracranial hypertension
- Stroke
- Cataracts
- Coronary heart disease
- Diabetes
- Dyslipidemia
- Hypertension
- Severe pancreatitis
- Cancer
- Breast, uterus, cervix
- Colon, esophagus, pancreas
- Kidney, prostate
- Gall bladder disease
- Gastroesophageal reflux disease
- Severe pancreatitis
- Gynecologic abnormalities
- Abnormal menses
- Infertility
- Polycystic ovarian syndrome
- Osteoarthritis
- Skin
- Gout
- Phlebitis
- Venous stasis
Obesogenic Medications

- Anti-diabetes Therapy
  - Oral Hypoglycemics
  - Insulin

- Steroid Hormones
  - Corticosteroids

- Psychotrophic Agents
  - Antipsychotics
  - Antidepressants
  - Lithium

- Antiepileptic Drugs

- Miscellaneous
  - Antihistamine
  - β and/or α Blockers
## Drugs Commonly Associated with Weight Change

<table>
<thead>
<tr>
<th>Weight Gain associated with:</th>
<th>Weight Loss associated with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amitriptyline (1.8 kg)</td>
<td>Metformin (1.1 kg)</td>
</tr>
<tr>
<td>Mirtazapine (1.5 kg)</td>
<td>Acarbose (0.4 kg)</td>
</tr>
<tr>
<td>Olanzapine (2.4 kg)</td>
<td>Miglitol (0.7 kg)</td>
</tr>
<tr>
<td>Quetiapine (1.1 kg)</td>
<td>Pramlintide (2.3 kg)</td>
</tr>
<tr>
<td>Risperidone (0.8 kg)</td>
<td>Liraglutide (1.7 kg)</td>
</tr>
<tr>
<td>Gabapentin (2.2 kg)</td>
<td>Exenatide (1.2 kg)</td>
</tr>
<tr>
<td>Tolbutamide (2.8 kg)</td>
<td>Zonisamide (7.7 kg)</td>
</tr>
<tr>
<td>Pioglitazone (2.6 kg)</td>
<td>Topiramate (3.8 kg)</td>
</tr>
<tr>
<td>Glimepiride (2.1 kg)</td>
<td>Bupropion (1.3 kg)</td>
</tr>
<tr>
<td>Gliclazide (1.8 kg)</td>
<td>Fluoxetine (1.3 kg)</td>
</tr>
<tr>
<td>Glyburide (2.6 kg)</td>
<td></td>
</tr>
<tr>
<td>Glipizide (2.2 kg)</td>
<td></td>
</tr>
<tr>
<td>Sitagliptin (0.55 kg)</td>
<td></td>
</tr>
<tr>
<td>Nateglinide (0.3 kg)</td>
<td></td>
</tr>
</tbody>
</table>

Clinically important weight change (for either weight gain or loss) as a change >2 kg or >5% from the baseline, defined by: Stevens J, et al. Int J Obes (Lond). 2006;30:391–399.

Lifestyle Intervention

• Identification and intervention of modifiable factors that impact on energy regulation
  – Weight gain promoting medications
  – Diet quality and structure
  – Activity
  – Stress
  – Sleep
  – Circadian patterns
Lifestyle Intervention

• Goal is for durable weight loss
• Pursue sequential application of limited lifestyle changes
  – Determine effectiveness of each individual change
  – Include non-diet, non-exercise interventions e.g. sleep, stress, circadian
  – Use classic strategies for behaviour change
  – Multiple lifestyle changes have additive effects
• Aim for clinically significant weight loss
Pharmacotherapy

• Medications establish a new plateau (set-point)

Pharmacotherapy

- Immediate weight regain after treatment cessation

Smith et al.  NEJM 2010; 363:245-56
Additive Effect of Lifestyle + Drug

• All groups received 500kcal/day deficit diet and increased physical activity

Core Principles of Obesity Management

• Goal of effective treatment is to **reduce the elevated fat mass set-point**
• There is **wide heterogeneity** in the causes and manifestations of obesity
• This leads to **wide patient-to-patient variability** in the response to all anti-obesity therapies
• People who respond to one therapy **may not respond to another**, and vice versa
• The strategy is to **match each patient** with the treatment most effective and suited to them.
Questions/Comments?
Nutrition interventions in obesity:
The current landscape

Holly Smith
Accredited Practising Dietitian (APD)
Obesity Management Service
Overview

- Australia’s dieting culture
- Latest results on Australia’s eating habits
- Putting Australian nutrition guidelines into practice
- Nutrition supports for GPs
"The fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended”

- WHO
GPs: The gatekeepers for nutrition care

- **1 IN 6** overweight or obese Australians were on a diet at the time of the survey

- Nutrition and weight counselling the **most common** preventative activity in general practice
Latest diet trends

“A diet by any other name is still about energy.”
-Linda Van Horn, JAMA. 2014; 312(9): 900-901

“The overriding feature of successful approaches is they include a strategy specifically targeting a reduction in total kilojoules”

DAA Best Practice Guidelines for the Treatment of Overweight and Obesity in Adults. Report to inform the 2011 revision of the 2005 Guidelines

Johnston BC et al. 2014 ‘Comparison of weight loss among named diet programs in overweight and obese adults: a meta-analysis’ JAMA 2014 Sep 3;312(9):923-33
Individual complexity

First 50 patients had a total of 303 co-morbidities

Top co-morbidities:
1. Hypertension
2. Type 2 Diabetes
3. Depression
4. Arthritis
5. Asthma
6. Sleep apnoea

Dietary interventions: Not a one-size fits all
“Current Australian Dietary Guidelines should be used as the basis of advice on nutrition for adults”

- NHMRC Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia

You can find The Australian Guide to Healthy Eating and accompanying materials at: www.eatforhealth.gov.au
**Australian Dietary Guidelines:**

1. Vegetables
2. Fruit
3. Grain (cereal) foods
4. Lean meats and alternatives
5. Dairy and alternatives

*Limit discretionary foods to sometimes and in small amounts*

And drink plenty of water.

According to Australian Health data:

- 7% of Australians ate enough vegetables each day
- More than 50% are not meeting fruit recommendations
- 1 in 4 females and 1 in 2 males got enough dietary calcium
- 35% of total energy (KJ/calories) intake is from non-core foods
- $32 per week spent on alcohol
- $63 per week is spent on takeaway and at restaurants
In Canberra:

Households spend $753 on food and drinks each fortnight

- $435 on discretionary foods (58%)
- $119 for takeaways
- $27 soft drinks
- $87 per week alcohol

Reference: Lee A, Kane K & Lewis M 2016, Healthy Diets ASAP (Australian Standardised Affordability and Pricing) survey, Canberra: the price, price differential and affordability of current (unhealthy) and healthy diets and potential impacts of policy change – Final report 20 May 2016, Queensland University of Technology, Brisbane.
NHMRC Clinical Practice Guidelines for the Management of Obesity in Adults, Adolescents and Children in Australia:

“For adults who are overweight or obese, design dietary interventions for weight loss to produce a 2,500KJ per day energy deficit and tailor programs to dietary preferences of the individual”
– Grade A Evidence

- Education on Australian Dietary Guidelines
- Discretionary foods and drinks
- Portion sizes
- Increase vegetables
- Meal planning and cooking skills
- Meal delivery services
NHMRC Clinical Practice Guidelines for the Management of Obesity in Adults, Adolescents and Children in Australia:

Practice point: “Very low-energy diets are a useful intensive medical therapy that is effective in supporting weight loss when used under medical supervision. They may be a consideration in adults with BMI >30kg/m² . . .”

Figure 3: The Optifast® VLCD® Program

DID YOU KNOW:
2.8% of deaths worldwide are attributed to low fruit and vegetable intakes?
-WHO
**Every change counts**
Resources for GPs:

- Accredited Practising Dietitian (APD)
  - ‘Find an APD’ at www.daa.asn.au
  - GP Management Plan / Team Care Arrangement
- ACT Health: Community Health Intake (02) 6207 9977
- Australian Dietary Guidelines www.eatforhealth.gov.au
- Good Habits for Life www.goodhabitsforlife.com.au
- LiveLighter www.livelighter.com.au
Break
Role of Clinical Psychology in the Treatment of Obesity
What is the role of psychology?
Main Intervention Points

• Reducing non-hungry/emotional eating
  – Many different triggers
  – Commonality: Emotional regulation strategy

• Increasing motivation for exercise
Stress, Eating and Obesity

• Stress $\rightarrow$ HPA axis $\rightarrow$ Hunger and satiety hormones

• Comfort foods (Foster et. al., 2009; Maniam & Morris, 2010; Garg et. al., 2007)

• Abdominal fat (Dallman, 2010; Tomiyama et al., 2011)
• Munsch et al., 2012
Psychological Intervention

• Increase awareness of their emotional eating and
• Learn healthier emotion regulation skills
  – Mindfulness/Distress tolerance skills
  – Urge surfing
  – Self soothing strategies
  – Cognitive restructuring
  – Relaxation techniques
• Stress management skills
  – Time management
  – Body image
  – Interpersonal and communication skills
• Treat any mental health condition
  – Prevalence of depression (23%, Carey, 2014), anxiety (25%), eating disorders (BED: 30%, de Zwaan, 2001), trauma (BMI ≥ 30: 8%; BMI ≥ 40: 17%, Williamson, 2002), are higher among the obese
  – Alcohol and substance use disorders lower in prevalence but interferes with weight management interventions
Case Study

Beryl

• 55 year old female BMI 41
• Long history of obesity, many diets, lack of exercise
• Eats healthily during the day but high calorie snacks at night when bored and lonely
• Depressed, feels sad about her weight and marriage
• Works full-time, 2 adult children and elderly parents
• Good social network and plays bridge

‘Dr, I really want to lose weight but I can’t stop eating chocolate at night’
What to do with Beryl

• Screen for any mental health condition (e.g., self-report, DASS) – Mental Health Plan
• Emotional or binge eating?
  – Describe their diet including 24 hour food recall
  – Do you eat mainly according to hunger and fullness cues?
  – When you’re stressed, bored, do you sometimes eat to feel better? (mood eating)
Some people describe eating large amounts of food quite quickly. Have you ever experienced that kind of thing? (Binge eating)
- Do you ever have the feeling that you cannot stop eating or control what or how much you are eating?
- How often does this happen? (At least weekly)
- How long has this been happening? What sorts of things do you eat during these episodes?
- What happens after these episodes?
- Sometimes people make themselves vomit after eating. Is this something you have ever done? Laxatives? Diet pills? (Bulimia Nervosa)
Qualifies for a Mental Health Care Plan

Yes

- Eating Disorder
  - ACT Eating Disorder Program
  - Private psychology – Better Access to Mental Health Plan and APS Find a Psychologist

- Drug and Alcohol
  - ACT Alcohol and Drug Services
    - 24 hour intake line 6207 9977

- Mood Disorder
  - Private Psychology (Better Access to Mental Health Plan and APS Find a Psychologist)
  - Catholic Care/Capital Psychology Clinic (bulk bill)
  - VVCS - Veterans and families
  - ANU/UC Clinics

No but mood eating

- Trauma
  - Women’s Health Centre
  - Private Psychology – Better Access to Mental Health Programme and APS Find a Psychologist

- Private psychology – Full price
  - ANU Psychology Clinic – $20/$40 per session
  - UC Psychology Clinic – $20/$30 per session
Summary

• Emotional eating and binge eating are common among the obese
• Psychological interventions can help patients reduce emotional eating and increase their physical exercise.
• Mental health conditions can interfere with weight management programs and are higher in prevalence among the obese
• Helpful to treat mental health conditions
References


Obesity Management Service

To improve the health and wellbeing of adult patients with

Ana O’Rourke
Manager and Accredited Practising Dietitian (APD)
Obesity Management Service

Photo’s from the Yale Rudd Centre- positive image gallery
Who is Eligible for the Service?

Patients who have a medical referral and are:
- Aged 18 years and over
- Body Mass Index of 40Kgm$^2$
- At least 1 serious co-morbidity
- Willing and able to change lifestyle
- Able to self manage
- Community dwelling
Who is not suitable for OMS

- Unable or unwilling to change lifestyle
- Severe or unstable psychiatric illness
- Cognitive impairment
- Intellectual disability
- Housebound patients
- Pregnancy
Triage Process

Category 1 (within 30 days)
- BMI > 60
- Requiring semi-urgent and potentially life-saving procedure requiring immediate weight loss
- Recent hospitalisation with life threatening obesity related co-morbidities

Category 2 (within 90 days)
- Newly diagnosed type 2 diabetes and HbA1c > 8.5%
- Newly diagnosed Obesity-hypoventilation syndrome
- Recent or repeated hospital admissions for conditions exacerbated by obesity
- Medical procedure requiring urgent weight loss
- Prader-Willi Syndrome
What does the Obesity Management Service provide

Medical and Nursing

Group Education

Exercise Group

Individual support (Case Management, Nutrition, EP)

+ Referral for weight loss surgery
Flow of the Obesity Management Service

Triage process
▼
Introduction Session (mandatory)
▼
Referral processed, Medical Appointment offered
▼
Patient attends Initial Medical Appointment
▼
Group Education x 4 sessions (mandatory)
▼
Case Management (development of Obesity Management Plan)
▼
Self management with monthly contact from Case manager (or health professional)
▼
6 month Medical Review and OMP review by Case Manager
Service Update

• Service began February 2014, ~1200 referrals received (as of 30/6/17)
• Average of 8 referrals per week.
• Approx 800 New patients seen
• Several medical, allied health, group education, exercise classes and case management clinics offered weekly
• Wait time for initial Category 3 patient is 2 months (as of 30/6/17)

Staffing:
- Medical Director 4 days
- Medical Staff Specialist
- Full time Manager
- Full time Dietitian, Exercise Physiologist, Psychologist
- 2.0 Full time Registered Nurse Level 2
- 4 days Administration Officer
Referrals

Referral Pathway:

- Named referrals to:
  - Dr Paul Dugdale, Director, Chronic Disease
  - Dr Carol Huang, Senior Staff Specialist, Obesity Management Service, CDMU
- ACT Health Electronic Referral system (E-referral/Concerto)
- Directly to the service by email: OMS@act.gov.au or Fax 62051198 or Postal address: GPO Box 825, Canberra 2601
Thank You!
See you again on 13 September.