Clinical Guidelines for Weight Management in New Zealand Adults, Children and Young People

The purpose of the guidelines

- Influence practice, reduce unnecessary variation, and provide a consistent approach.

- The aim is to provide evidence-based guidance for the management of overweight and obesity.

- Primarily used in primary care and community-based initiatives

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- Priority populations – Maori, Pacific, and South Asian.

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Who is involved

- Clinical Trials Research Unit, School of Population Health, University of Auckland
- Synergia Ltd
- Priority population consultants – Maori, Pacific, Asian
- Guidelines Technical Advisory Group (GTAG)
- Maori and Pacific Caucuses
- Literature and Peer Reviewers
- Road testing with frontline providers.

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The process

- Outcome 17 in the HEHA Implementation Plan 2004-2010
- 2007
  - GSG established
  - Literature review/evidence search (CTRU)
- 2008
  - Guideline development and updating evidence search (CTRU)
  - GTAG established
- 2009
  - Draft FULL and SUMMARY guidelines (CTRU)
  - Maori and Pacific caucus involvement
    - Literature review of M&P best practice points
  - Draft Implementation and Training plan (Synergia) – August
  - Feedback on guidelines and implementation – November
  - Release of the guidelines – December

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Weight management algorithm

Improving lifestyles by engaging consumer/whanau's values and beliefs

Achieved through mana enhancing relationships

Adults

1. Raise awareness

Engage and measure BMI

on a regular basis[1] to:

- Raise profile
- Prompt discussion

Engage further if:

BMI >30 (or 25-30 with known risk factors or central fatness)[2]

2. Identify need and context for action

Clinical need

Are clinical risks present? (e.g. elevated risks for CVD, diabetes, cancer, etc). See overleaf.

Investigate

- BP/lipid/glucose profile
- Smoking
- Mental illness

Patient's needs and context

Understand patient's lived reality

Understand person's:

- Family/whanau, culture, work, community, and spiritual context
- Weight related concerns
- Nutrition and activities of choice

Discuss

Patient's motivations for action

If weight

And if ...

- **BP/lipids**
- **Smoking**
- **Glucose**
- **Nutrition/PA**

...then

Use existing clinical guidelines[3]

3. Options for action

BMI without complications: 25 – 30 – 40+

BMI with co-morbidities (e.g.diabetes): 27 – 35

Change lifestyle

FAB trio of 1. Food/diet, 2. physical Activity and 3. Behaviour strategies

Adapt for patient's lived reality
Consider individual, whanau, community settings

May consider adding drugs[4]

May consider surgery[4]

Monitor progress
Measure weight weekly
Realistic goal of weight loss is up to 1.0 kg/week

DRAFT

Adults

4. Maintain contact and support

Maintain
Healthy diet.
Physical activity 30-45 minutes/day

Patient Monitoring
Of progress - measure weight weekly
Arrange continued contact

Reassess and/ or restart
if actual weight >2.0kg of goal weight

Reassess if other risk factors present

1. Primary health care, community health workers, secondary care, marae, places of worship, adults/ whanau measuring their own

2. Use BMI to classify overweight and obesity with a BMI of 25-29.9 kg/m2 for overweight and ≥ 30 kg/m2 for obesity

3.
- If BP/Lipids – Guidelines for Assessment and Management of CVD Risk
- If Smoking – Smoking Cessation Guidelines ABC
- If Glucose – Management of Type II Diabetes Guidelines
- If Nutrition/PA – Food and Nutrition Guidelines for Healthy Adults and Physical Activity Guidelines

4. Drugs and surgery only used in addition to lifestyle changes when other attempts have failed. Not a substitute for lifestyle change.

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Making it work for priority populations

- Disproportionately prevalent in Māori and Pacific

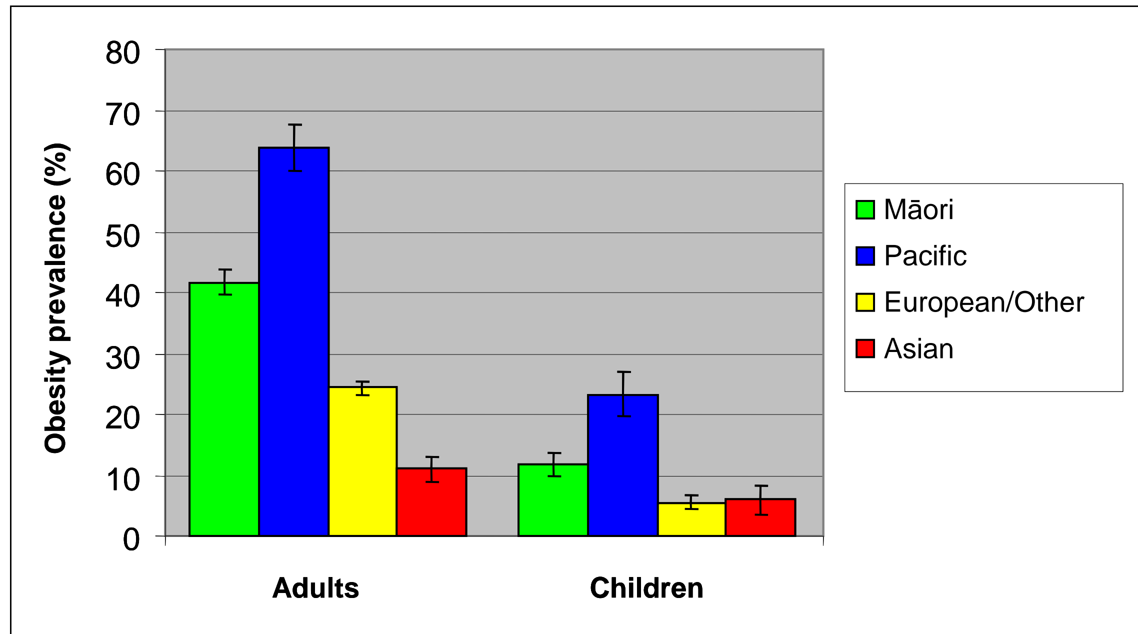

Figure 1.0: Comparison of obesity rates in 2006/07 for Māori, Pacific, European/Other and Asian – based on results from the 2006/07 New Zealand Health Survey.

- Limited evidence base for Maori, Pacific and South Asian priority populations

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Improving the health of priority populations

- Concepts of ‘lived realities’ and ‘mana enhancing relationships’
- Health services to be coordinated around the needs and realities of whānau
- Services need to incorporate cultural views, beliefs, and practices, and be guided by Māori, Pacific and other models of health.
- Implemented in a way that meets the social and cultural realities
- Cultural competence is integral to understanding these “lived realities”

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Good practice points – priority populations

- Providers should proactively develop their cultural competence
- Ensure an empathy with the cultural, social and socio-economic circumstances of the consumer
  - Understand *their* needs within *their* context ("lived realities")
- Explore opportunities for adapting traditional activities for exercise
- Be aware of and refer to local community options
- Be sensitive to communication needs - provide resource material and information the whānau/family's preferred language if possible.

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How to use the guideline

- Each section in this guideline is structured in the following manner:
  - A brief overview of the evidence
  - A recommendation or recommendations
  - Good practice points to provide additional guidance.

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Feedback on the guidelines

- Targeted online survey monkey completed in November 2009
- Formalised importance of treating obesity as a serious health concern
- Most agreed with BMI as a starting point – health provider can then add waist measurement
- Highlights included:
  - Evidence based
  - Food Activity and Behaviour (FAB)
  - Consistent approach

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Feedback continued…

- Improvements suggested:
  - More information on how to affect behaviour change and assessment of readiness
  - Changes to wording around Diet
  - Some disagreed with use of palm as portion size
  - Need to define ‘adult’ i.e 18 – 64 years
  - Did not include/ address prevention

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Feedback on implementation priorities

- Training and education
- Collaboration and coordination of services
- Distribution and promotion of guidelines
- Funding for community based dietitian services
- Coordinating a multi-disciplined approach
- Pilot in a range of settings.

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Implementation priorities continued…

- Identify national and local champions
- Limited supply of effective community based programmes
- Not all programmes are available in all areas
- People and providers have different starting points
- Strengths based approach
- Tax unhealthy food and ban TV advertising.

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Conclusion

- Implementation and training needs have been considered throughout development of the guidelines.
- Alignment with the Cardiovascular Disease guidelines and the upcoming revised Diabetes guidelines.
- Guidelines will be available as an online resource.
- Key challenge for implementation is to support intervention design, skills, and approaches that achieve sustained behavior change.

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