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# Increasing Participants in the Obesity Management Program

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## Background/Problem

- Obesity is a pandemic in the United States.
- Obesity is directly linked to a higher incidence of diabetes, heart disease, stroke, and cancer.
- Evidence shows that the multi-disciplinary intervention approach is most effective in treating obesity.
- A streamlined team approach in healthcare is known to improve patient's overall health and contain medical costs.
- A non-profit organization (NGO) in Montgomery County, Maryland, started a free obesity management program.
- Services provided at this NGO were fragmented, and providers were not working as a team.

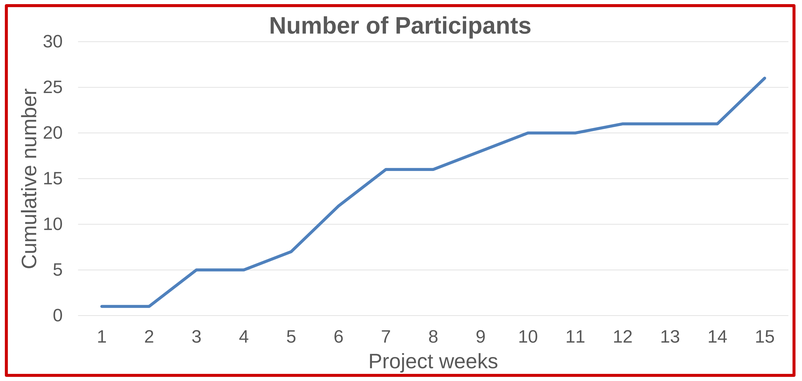
## Purpose and Goal

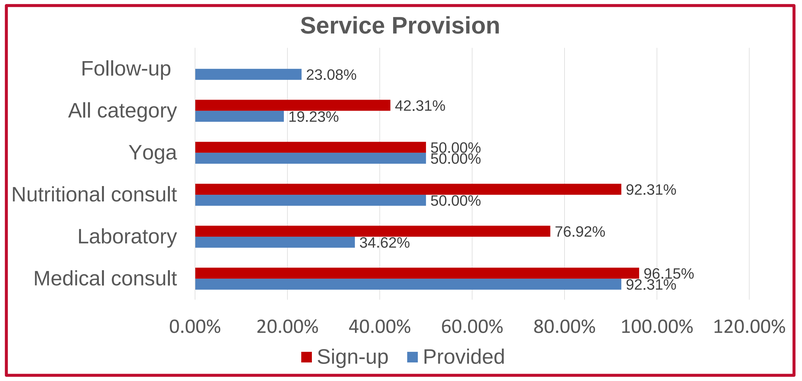
- To increase the enrollment of participants in the multidisciplinary comprehensive obesity management program by providing more structure, stability, and sustainability.
- The uninsured or underinsured individuals with obesity in the community were the primary target for this project.

## Methods

- The quality improvement project was implemented for 15 weeks during the fall of 2023 in a non-profit organization free clinic.
- Patients presented to the clinic with a body mass index equal to or over 30 were encouraged to participate in the obesity management program.
- Participants were enrolled in the four pillar services (Nutritional consultation, medical consultation, laboratory services, and yoga lessons)
- To ensure participation, each participant was given a program schedule form for dates of their service provision, and progress form to record weight, blood pressure and lab results.
- The service providers were given participant lists to estimate the volume of participants for the services they were providing.

## Results




## Key Findings

- A total of 26 participants were recruited during the 15-week project improvement period
- Mean age of participants was 54.65 (SD=14.92)
- Mean BMI of participants was 32.81 (SD=5.37)
- Majority of participants was female (69.23%)
- All participants were minorities (African American=15.38%, Hispanic=42.31%, Asian=42.31%)
- Almost half of participants were hypertensive (46.15%)
- Many patients also had diabetes (diabetes=19.23%, pre-diabetes=11.54%)
- Among all participants who signed up for the obesity program, 19.23% received all four pillar services.
- Among all participants, 23.08% of them received follow-up care.

## Discussion

- The program continued to grow and attract more participants throughout the project.
- Many participants presented with co-morbidity such as hypertension and diabetes.
- Only 23% of participants returned for follow-up.

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**Limitations:**

- Laboratory and nutritional services were popular among participants but not provided consistently.
- Constant changes in volunteer staff made project dissemination a challenge.

## Conclusion

- Coordination among service providers was crucial to the success of the program.
- Consistency in service provision is needed.
- Follow-up mechanism for the program needs to be mainstreamed and strengthened.
- The program will make more impact if expanded to hypertension and diabetes care as many participants had co-morbidity.

## Acknowledgement

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## Reference

Scan for the complete reference list