Improving Obesity Management in Adult Primary Care
Executive Summary

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Overview

The United States is experiencing an obesity epidemic. According to the Centers for Disease Control and Prevention (CDC), nearly 34 percent of American adults are obese.[1] And in nearly two-thirds of states, more than 25 percent of the adult population is obese.[2] Obesity rates have contributed to worsening health outcomes and an explosion of health care costs, as overweight and obesity significantly increase the risk of developing more than 20 different diseases and health conditions, including Type 2 diabetes, hypertension, metabolic syndrome, cardiovascular disease, specific cancers, and osteoarthritis.[3] A recent study published in the journal *Health Affairs* estimates that obesity accounts for 9.1 percent of annual health care spending in the United States, costing our nation up to $147 billion in 2008 alone.[4]

In August 2009, the Strategies to Overcome and Prevent (STOP) Obesity Alliance convened an expert roundtable to discuss effective and innovative obesity treatment practices in the primary care setting.

To complement the roundtable discussion, the STOP Obesity Alliance research team at The George Washington University School of Public Health and Health Services reviewed existing literature on obesity management in primary care, including issues regarding patient-physician relationships and potential solutions to common problems. The results of this review were summarized for the participants.

"Improving Obesity Management in Adult Primary Care" is a paper based on the literature review, expert roundtable discussion, and in-depth interviews with a small number of providers. The findings from the roundtable and resulting paper focus on five "themes" with regard to improving obesity and weight-related disease management in primary care settings.

Key Findings

The participants in the roundtable identified five overall "themes" with regard to treatment practices for obesity in primary care settings:

1. Monitoring Weight, Health Indicators and Risk
2. Assessing Patient Motivation
3. Defining Success
4. Increasing Integration and Care Coordination
5. Implementing Electronic Medical Records

Monitoring Weight, Health Indicators and Risk

Monitoring weight and health indicators and explaining risk factors is an important part of patient engagement in the treatment of obesity. Although basic counseling about healthy behaviors takes less than five minutes, providers often do not incorporate this counseling into a visit.[5,6] In addition, in a recent study looking at medical records, nearly 50 percent of primary care visits did not include a record of the height and weight data necessary to calculate body mass index (BMI).[7] Approximately 70 percent of clinically obese patients did not receive a diagnosis of obesity and 63 percent did not receive counseling from their physician about this issue.[8] Because the odds of receiving weight loss counseling are best when patients' obesity is documented, roundtable participants agreed that consistent tracking of height and weight data, along with BMI, may generate more patient-provider conversations on the topic. There are multiple ways to improve tracking of these measurements including having BMI assessment be included as a quality measure, and on the individual practice level, establishing clear office policies and procedures to require these measurements. Finally, roundtable participants agreed that focusing on health indicators such as blood pressure, glucose, and cholesterol levels also may be an effective way for providers to discuss and motivate their patients to lose weight.

Assessing Patient Motivation

Successfully motivating patients to lose weight is a fundamental challenge for physicians. While both roundtable and provider interviews discussed the concept of "readiness for change," the overall discussion frequently returned to the importance of the provider-patient relationship in both assessing and creating the readiness for change in overweight and obese patients. Roundtable participants and interviewees had wide-ranging opinions on the applicability of these approaches for provider-patient discussions of long-term weight loss. Providers agreed that patient willingness to attempt small lifestyle changes, such as not drinking sugar-sweetened beverages, was a stronger indication of their readiness than a positive finding from a formal assessment, such as a questionnaire. Many roundtable participants maintained that encouraging patients to focus on making a few small lifestyle changes sets them on the right track for weight management. Finally, participants agreed that family-centered changes, along with accounting for ethnic and cultural differences, play a significant role in patient motivation.

Defining Success

Another important component of maintaining patient motivation to lose weight is defining success in realistic and achievable terms. According to the National Heart, Lung, and Blood Institute, a modest weight loss of five to ten percent of total body weight significantly improves health outcomes, including reducing the risk of developing Type 2 diabetes, dyslipidemia, hypertension, and cardiovascular disease.[9,10] Roundtable participants agreed that redefining success is essential in obesity management. In some cases, weight stabilization (i.e., preventing additional weight gain) may be a good initial step for some individuals while setting realistic expectations for a weight loss of five to ten percent should be the goal for others. Concentrating on the benefits of modest weight loss may also motivate both providers and patients to think about obesity management in terms of health rather than appearance.

Increasing Integration and Care Coordination

Because there is no "one solution fits all" answer to treating obesity, patients are often more successfully treated by coordinated, simultaneous interventions from health professionals across multiple fields or disciplines. Roundtable participants agreed there are benefits for the treatment of obesity in clinically integrated systems of care due to the often complex, multi-specialty resources involved in treatment of the obese patient. One such obesity-focused practice discussed by the participants included physicians, nurse practitioners, psychologists or other mental health professionals, dietitians, physical therapists, and bariatric surgeons. However, areas of the United States in which clinically integrated systems are not accessible or feasible require alternative models. These models include the Medical Home approach, where a primary care physician coordinates a patient's care among a shifting group of specialists brought on board as needed, or the more informal "Health Care Plus" approach where primary care providers refer patients to community-based resources, obesity specialty practices, or technological resources such as on-line or telephonic programs.

Implementing Electronic Medical Records

Health information technology (HIT) and electronic medical records (EMRs) have the potential to improve collection and documentation of patients' information and, therefore, improve treatment consistency and potential for success. Several findings on electronic medical records emerged from the roundtable and follow-up interviews with a few providers. First, electronic medical records have the potential to improve the consistency of information gathering, BMI calculation, and trend information for individual patients. Second, use of EMRs allows the aggregation of patient data to examine treatment effectiveness for the patient population for an individual physician or across the practice as a whole. Third, for integrated practices, EMRs allow all physicians involved in a patient's care to see the entire picture of that person's health, not just the information on a referral form – improving coordination and potentially creating a better program for the individual. Finally, EMRs can ease the referral process outside of integrated practices and, for some systems, allow coordination with the receiving practitioner. While not all of these applications are possible for every practice, each has the ability to improve obesity care individually or in combination with the others.

Conclusion and Next Steps

These five themes represent opportunities to improve the treatment of obesity in primary care and could lead to significant advancements in patient outcomes. Mitigating the health and productivity costs of obesity and its co-morbidities will require adopting a definition of success that is focused on health rather than appearance and will ensure that providers have the most effective tools to assist their patients.

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