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Weight Loss Communication and Treatment in Primary Care

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Executive Summary

Problem

Obesity is a prevalent issue in healthcare today, affecting more than 42.4% of the population (CDC, 2021). Obesity in primary care is one of the most undertreated medical conditions. Between 2011 and 2018, only 40% of patients with obesity received help from their providers to address their weight (Tucker et al., 2018). There is an evident lack of clinical support to identify a gold standard of practice or communication tools to help providers manage obesity.

Literature Review

An abundance of literature exists regarding obesity management and supporting communication tools' benefits. However, there is no identifiable gold standard of practice in place for providers to utilize to communicate with patients about weight management. Providers must improve obesity and weight loss conversations with patients during wellness exams. Consequently, there is an additional need for implementing a communication tool to help providers acknowledge, address, assess, and further manage the care of obese populations.

Obesity management is under-coded and not documented or identified as a significant health problem (Matter et al., 2017). A cross-sectional analysis performed by Pantalone et al. (2017) concluded that less than 50% of patients with obesity were not documented with a formal ICD diagnosis code for obesity. A different study revealed that in a patient sample of 3,686 patients, 2,004 patients met the criteria for obesity, but only 112 of those 2,004 patients' records had obesity documented in their problem list (Matter et al., 2017). Obesity is both a preventable chronic disease and a leading cost for healthcare in the United States, costing an estimated $147 billion to $210 billion annually, yet it is often undocumented (Matter et al., 2017). There is a

significant need for change when addressing the needs and management of patients with obesity. There are many obstacles that providers must overcome to improve care for patients with obesity, including time constraints and subsequent deprioritizing of obesity during office visits (Kaplan et al., 2017). By not treating obesity as a medical issue, providers are allowing patients to be placed at high risk for obesity-associated health problems (Fruh, 2017). Obesity leads to comorbidities and complications for patients and is associated with stigma, bias, and judgment from providers.

Currently, there is no universally used communication tool to help guide the care of patients with obesity. Motivational interviewing tools can be implemented to steer the conversation between the patient and provider. These tools can also help identify patients' readiness to change behaviors and identify a personalized approach to weight management and guide providers to address weight management (Barnes et al., 2018). Motivational interviewing helps providers overcome barriers, including limited time and resources, when caring for patients with obesity (Barnes et al., 2018). The Five A's Conceptual Framework is a motivational communication tool providers use to discuss challenging topics with patients (Welzel et al., 2018). The Five A's tool is a brief but effective tool to incorporate motivational interviewing (Freshwater et al., 2022). The Five A's is a patient-centered mnemonic, 'Ask, Assess, Advice, Agree, and Assist' (Freshwater et al., 2022) that physicians can follow to determine a patient's comfort level discussing their current weight (Welzel et al., 2018). The tool can help determine the appropriate weight management steps for the patient to lose weight and improve overall health successfully (Welzel et al., 2018). There is a lack of consistent use of interview tools for providers to navigate the necessary discussions with patients to identify which patients are willing to make lifestyle changes and improve their overall health. Motivational interviewing has

proven successful in reducing BMI compared to educational tools about diet and exercise alone in primary care (McNeil et al., 2017).

Project Methods

The purpose of this project was to develop and implement a communication tool that fits the needs of a rural healthcare facility. Identifying patients ready to implement lifestyle changes will assist providers in initiating early discussion and personalized treatment plans with patients. Monitoring and modifying food intake, increasing physical activity levels, and recognizing and controlling cues that trigger over-eating are examples of positive lifestyle changes (McKinney et al., 2013). The project site currently had no assessments or tools to address the readiness to make lifestyle modifications in those who are overweight or obese. Patients who presented to the clinic for an annual wellness exam were given a communication tool upon arrival and asked to answer questions regarding current lifestyle habits and their comfort level addressing their weight during their wellness exam. The communication tool included yes and no questions for patients to answer before seeing their healthcare provider face-to-face. The goal of the patient analysis was to determine if patients are more willing to discuss weight and weight management issues with their providers when the topic is presented in a therapeutic and non-bias format and to develop a treatment plan based on their results.

Evaluation

Our study surveyed a total of 30 Caucasian patients, all of whom were over the age of 18. Most patients (63%, n=19) were categorized as obese based on their presenting BMI. Eighty-six percent of the patients (n=26) were comfortable discussing their weight with their provider. Thirteen patients (43%) answered no when asked if they were interested in becoming more physically active. More so, 10 of the 30 patients (33%) could not walk for 20-30 minutes a day,

five days a week. When asked if patients viewed improving their current physical activity level as important, 96% (n=29) answered yes yet only 56% (n=17) wanted to receive more information about weight management and their specific medical problems. To identify possible barriers to weight management success, researchers addressed support systems currently in place for patients. Sixty-six percent (n=20) agreed that they had a support system to help make dietary changes and implement exercise into their daily routine. The 34% of the patients who answered no were then prompted to answer additional questions for providers to assess specific needs regarding weight management support. Ninety percent (n=27) of the patients reported that their families would be willing to help them implement necessary lifestyle changes. Approximately half of those 27 patients whose families would be willing to help implement lifestyle changes were interested in receiving resources to help attain weight loss goals. Lastly, and most significantly, when the sample population was asked if they would like to receive additional resources, including information regarding weight loss centers in the surrounding area, 72% answered no.

Limitations were identified during the implementation and data collection phase of the project. The project site was in a small, rural town of predominantly Caucasian patients, causing a lack of diversity in the patient population. In addition, the time of the year did not yield a large sample size as initially expected. The implementation phase was conducted in the summer months during routine annual wellness exams. A larger sample size could have been obtained if the survey had been distributed at the start of the calendar year when many patients were completing their yearly health maintenance visits. The physical activity level of surveyed patients was not considered when determining a patient's willingness to implement changes in their lifestyle. Alternative questions should have been identified for patients who felt they could

not complete the 20-30 minutes of exercise five days a week to assess their current physical activity level better. Doing so could have yielded more specific data for the patients who had answered no. For example, asking these patients who responded no if they could complete alternative forms of exercise or if their inability to perform specific activities directly physically affects their willingness to discuss weight management with their provider. These questions better reflect patients' attitudes regarding weight management, and do not focus on physical ability alone. The surveyed patients were chosen randomly, with no control on physical fitness level, BMI, economic status, or access to care.

Due to the small number of providers involved during the implementation phase, providers were not officially surveyed on their evaluation of the communication tool. An evaluation was informally obtained from the providers during conversations with the researchers throughout the implementation phase and after completion. All of the providers agreed that the tool allowed them to address weight during annual wellness visits in a structured manner that allowed patients to be the driving force of how the conversation occurred, therefore building trust and rapport.

Impact on Practice

Directly following implementation, the rural healthcare facility could better identify patients willing to address their weight during their annual wellness exam, allowing providers to feel more comfortable addressing weight management. Our communication tool allowed providers to identify areas where a patient required additional resources or education to aid in weight management goals. Feedback provided by the providers explained that having the patients answer these questions before entering the room for the exam it allotted them more time for those patients seeking additional resources or guidance for weight management. Long-term

changes at the clinical site have not yet been identified. Researchers hope to see a similar tool implemented as a regular part of annual exam screenings based on the positive provider response. The long-term goal would be for providers to utilize the Five A's communication tool to guide patient interviews during wellness exams. Future implementation could include improvements such as larger sample sizes, more diverse populations, expanding the physical activity portion of the tool, and implementing the Five A's communication tool during other types of patient visits, such as medication checks for co-morbidity conditions, as this subset of patients would benefit from weight management discussions during their follow-up visits.

Conclusions

Initial data suggests that patients are willing to discuss their weight during their annual wellness exams and view improving their weight as an essential part of their healthcare. To make this communication tool successful, providers must take those positive responses and determine ways to help patients implement attainable, realistic changes in their daily lives. A communication tool will help provide all of the following: documentation for addressing patients' obesity and BMI, the ability for patients to identify reasons for weight gain, aiding providers in assessing patients' readiness to lose weight, identifying barriers associated with weight loss, helps providers understand patient's weight-inducing behaviors, and playing a role in developing a realistic weight management plan. Improving provider-patient communication can help patients build rapport, enhance their comfort level in discussing weight management, and improve patient satisfaction while improving their overall health. Primary care providers can positively impact their practices by creating patient-specific care plans utilizing tools, such as the Five A's communication tool, to help patients achieve their weight loss goals, improving their overall health, morbidity, and mortality.