STOP Obesity Alliance Primary Care Roundtable
Summary of Transcript
August 5, 2009

The STOP Obesity Alliance hosted a roundtable on adult primary care treatment and management of obesity August 5, 2009 on The George Washington University campus. Attendees included leading health experts, academics and providers from a cross-section of organizations including the Centers for Disease Control and Prevention, Harvard University, Geisinger Health System, Holston Medical Group, CalorieKing Wellness Solutions, Inc., University of Maryland, Society for Women's Health Research, The University of Vermont, and several Alliance Steering Committee and Associate Member organizations including American Heart Association, The Obesity Society, American Medical Group Association, Obesity Action Coalition, American College of Sports Medicine and the Commissioned Officers Association. Below is a recap of the major discussion points as taken from the recorded transcript of the roundtable.

Panel One: Lessons from Pediatrics
Moderator: Brook Belay, MD, Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, Overweight and Obesity

The discussion in Panel One focused on key differences between pediatric and adult health care delivery systems. Roundtable participants reviewed promising approaches for the treatment of obesity and related chronic diseases in both fields. Below are key points from Panel One:

Key Differences Between Treatment of Obesity and Other Chronic Diseases in Adult and Pediatric Primary Care

Pediatric practice is about disease prevention and health promotion. It is fundamentally prevention-focused, with annual well-child checkups. The hallmark of well-child visits is growth (weight and height are measured at every visit); thus, the pediatrician has more opportunities to focus on the particular issue of weight and weight management. Because of the emerging evidence of obesity-related disorders in children, many suggest that pediatricians take a more aggressive stance toward obesity.

In contrast, in the adult primary care setting, there is lack of consistency in measuring height and weight. Adults also tend to go to the doctor for acute care rather than wellness checkups.

A key difference in pediatric treatment is the coordination of care and presence of a "medical team" at birth, with the pediatrician working with colleagues in obstetrics/gynecology. The focus is on being born healthy, followed by an emphasis on breastfeeding as an early and important intervention for healthy growth and development. There is also a strong emphasis on play as physical activity for children.

The pediatric setting also has a family-oriented dynamic where both parents and the patient are critical to care. Children are uniquely vulnerable to their environments, being at a stage in life where habits are established. The child is helpless in that he or she must observe and live in the family culture with regard to eating and activities. This gives pediatricians a

unique opportunity to adopt a multigenerational focus to promote healthy habits and possibly impact the health of adults (parents or grandparents) as well as children.

Standards of Care for Obesity among Nutritionists and Pediatric Specialists

- Pediatricians promote good food choices and food counseling as a major part of care in infancy, from determining whether to use formula or breastfeed, to deciding when to introduce foods and how much food to provide.
- The American Academy of Pediatrics (AAP) provides guidance on the assessment of weight and the introduction of graduated interventions on food choices, as well as dietary and physical activity guidelines for children.
- Pediatricians take height and weight at every well-child visit, with defined standards for measuring growth.

Lessons from Pediatric Care Applicable to Adult Primary Care

The "community" or "family" outlook in the pediatric setting may be useful for adult primary care. No pediatric intervention can be successful without family investment. Parents may change habits when they realize the health impact on their children. For example, a woman who has been a smoker all her life may decide to finally quit after getting pregnant, not for her, but because she understands the impact on her child. The same is often true in obesity, so the "family support concept" could potentially be incorporated into the adult primary care setting.

Panel Two: Delivery System Changes, Barriers
Moderator: Morgan Downey, JD, STOP Obesity Alliance

Panel Two focused on barriers in the adult primary care setting, which inhibit the discussion about weight between patients and physicians. The panel also explored overcoming these barriers and creating opportunities to streamline primary and secondary prevention and services.

Communication Barriers between Physicians/Health Care Providers and Patients Regarding Weight

The various experts discussed communication barriers believed to hinder conversation between providers and patients about weight. Major barriers for physicians include lack of:

- Access to care and treatment, as well as integration of services within medical groups.
- Education among providers about how to treat obesity and overweight.
- Current information regarding latest research and treatments.
- Interventions and evidence-based programs focused on the moderate end of the weight continuum. Bariatric surgery is a successful intervention for extreme obesity, but few options exist for the overweight and moderately obese end of the continuum; most of the available options are consumer products.
- Follow-up for measuring weight loss progress, partly stemming from lack of reimbursement.
- Time during office visits.
- Reimbursement for counseling patients about weight.

- Patient relationships with physicians, which are essential for patient comfort in raising issues around weight.

Other major barriers include:

- Stigma: Physicians may have negative attitudes toward their obese patients.
- Physicians may hold the perception that obesity is a lifestyle/behavior problem, not a medical issue.
- Physicians do not want to risk offending patients by bringing up weight.
- Patients may think that physicians do not understand how difficult weight loss is to achieve. Patients may also be offended when the provider blames all of their medical problems on their weight (even if there is a weight connection).
- Difficulty finding and recommending evidence-based programs that work.
- Sense of futility: The lack of tools and lack of education about obesity treatment causes frustration for the physician, which may in turn lead to subliminally blaming the patient if the physician feels that he/she has no control over the patient's weight loss outcomes. The rate of weight regain may also cause physicians to feel they have failed.

Physician Motivation to Address Patients' Weight

The group suggested that addressing weight should become a quality measure for physicians. In smoking cessation, studies have found that smokers whose physicians address their smoking are more likely to feel they are getting higher quality care than smokers whose physicians ignore smoking. Similarly, obesity should be a priority for physicians. Developing measures that define quality care for obesity can provide a helpful reference point for physicians. The group also cited the need for more adequate reimbursement for weight counseling to increase physician ability and motivation to address and treat overweight and obesity.

Optimum, Cost-Efficient Methods for Delivering Obesity Management Programs

The ideal place to coordinate care is multidisciplinary, integrated medical groups incorporating primary care physicians, nutritionists, nurses and other health professionals to help with nutrition and weight management. However, large multidisciplinary groups are not practical for some areas of the country.

In the more common small or solo practices, providers should be encouraged to link to the wider community. In this "Health Care Plus" model, the health care provider would refer patients to community resources or technological resources (e.g., online or telephonic programs) for weight management. Building or identifying community networks is a major facet of this model, as many physicians are either unfamiliar with community resources or unsure of their reliability and appropriateness. One idea offered was to accredit community facilities and resources, such as gyms, health centers, and YMCAs that offer programs and resources to address obesity. To be accredited, the centers would need to have appropriate programs and trained staff.

Common Pediatric and Adult Primary Care Goals to Improve Care for Obese Patients

Common goals included:

- Educating patients about the connection between weight and health, focusing on how improving lifestyle and weight can lead to improved health outcomes.
- Reinforcing that obesity is a medical and not a cosmetic issue.
- Tying health readings (such as blood pressure) to weight loss, to help patients see improvements in health outcomes related to weight loss.
- Motivating patients to lose weight with realistic expectations of success.
- Explaining realistic expectations to patients by clearly defining an acceptable weight loss goal of 5 to 10 percent of baseline weight, explaining the value/importance of weight maintenance, and offering weight stabilization or small increments of weight loss as a clear initial goal.
- Connecting motivated patients with resources that can help them obtain better outcomes and then following up with the patient regarding outcomes.
- Obtaining reimbursement for initial and follow-up visits that focus on weight.
- Improving reimbursement for counseling by tying it to accountability, quality and appropriate outcomes which are within the domain of the health professional (this will require defining appropriate outcomes).
- Developing family-oriented practices by recognizing that adults are role models for children.
- Developing focused programs for obesity management in primary care and tracking outcomes using simple and practical tools.
- Improving nutritional information for clinicians.
- Funding more evidence-based obesity treatment research.
- Developing better mechanisms to develop evidence-based protocols, educate providers, and track and report outcomes to other providers.

Optimal Professionals for Delivery of Care: Physicians vs. Other Health Providers

For women, obstetrics/gynecology may be the optimal place to address obesity, since many women use obstetricians/gynecologists as their primary care provider. Obstetricians/gynecologists could also address weight using a maternal health focus, as there is mounting evidence that the mother's health during prenatal development dramatically affects the future risk of obesity in the next generation.

As for the population as a whole, other health professionals (e.g., nutritionists, registered nurses) may be best equipped to work closely with patients to manage obesity and nutrition, especially for more intensive behavioral counseling.

Panel Three: Emerging Trends in Obesity Management
Moderator: George Blackburn, MD, PhD, Harvard Medical School, Division of Nutrition

Panel Three focused on new trends and opportunities in quality improvement, care coordination and technology to improve management of obesity and chronic disease.

Personalized Medicine, Medical Homes & Electronic Medical Records: Applications for Obesity Management

Personalized medicine has real potential to improve treatment and management of obesity given that biological variation means that individual responses to and need for certain types of diets and interventions vary significantly. There is, however, a definite need for more research in this area.

Medical homes offer strong potential to be an environment where patients feel more comfortable raising weight issues with their physicians, given the closer physician/patient relationship fostered by this model. In addition, medical homes can offer greater integration of care with other specialists.

Electronic medical records (EMRs) could be used to close the gap between clinical settings and community resources, both by facilitating referrals and by allowing doctors to track patient progress in weight loss programs. EMRs could help track and identify changes in vital signs in the patient record over time, including weight. In addition, EMRs would help to aggregate data on outcomes within a practice, helping physicians better understand their patient population and identify areas for improvement.

Lessons on Assuring Patient Safety and/or Adherence Using Innovations

Many patients now need ongoing care post-bariatric surgery, and there is a need for increased primary care provider education on bariatric procedures. There are additional safety issues to consider for patients who undergo malabsorptive procedures, because they need a lifetime of vitamin supplementation and other follow-up care. Contact with a physician is necessary to ensure that patients are following the treatment regimen; however, better physician reimbursement for follow-up visits is required to ensure patient safety.