Developing the Workforce and Competencies for Weight Management And Physical Activity Care

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Changes in the Prevalence of Severe Obesity among Adults

Fryar CD et al. NCHS Health E-Stats September 2014
Challenges with the Science around Obesity Treatment Options

• No established and evidence-based standard of care
  - USPSTF sets the intensity of care
  - Early consensus on pediatric care delivery
  - Obesity in primary care rarely studied

• Mismatch of disease burden and provider capacity

• Need for integration of clinical and community services

• Summary
Pediatric
• Moderate to high intensity behavioral intervention including dietary, physical activity, and behavioral counseling; ≥ 26 contact hours

Adult
• Behavioral intervention including self-monitoring delivered in 12-26 visits over the course of a year
AHRQ Consensus Committee
Recommendations for Pediatric Care Delivery

- Family-based multicomponent behavioral treatment
- Medical oversight
- Integrated clinical and community care
- Treatment $\geq 26$ hours

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• Summary comments
Distribution of Adults and Youth with Severe Obesity among Primary Care Physicians

Adult physicians include family practitioners, general practice, internal medicine, and ob/gyn (n = 197,853)

- \( \text{BMI} \geq 35 \) - 164 people/practitioner
- \( \text{BMI} \geq 40 \) - 89 people/practitioner

Pediatric physicians include pediatricians and family practitioners (n = 125,000)

- \( \text{BMI} \geq 120\% \text{ 95}\text{th }\%\text{tile} \) - 50 youth/practitioner
What Do Adult Primary Care Providers Know about Recommendations for Obesity Care?

Among family practitioners, internists, ob/gyn, and nurse practitioners:

• 49% knew that 150'/w is the level of PA necessary for health benefits
• 33% knew that multiple dietary choices could be used for weight loss
• 16% knew that recommended counseling for patients with obesity is 12-26 sessions

DocStyles 2106; Unpublished data
Organizations Engaged in the Development of Obesity Competencies

- Academy of Nutrition and Dietetics
- Accreditation Council for Graduate Medical Education
- American Association of Colleges of Nursing
- American Association of Colleges of Osteopathic Medicine
- American Association of Colleges of Pharmacy
- American Board of Family Medicine
- American Board of Internal Medicine
- American Board of Pediatrics
- American Council of Academic Physical Therapy
- American Dental Education Association
- American Kinesiology Association
- American Psychological Association
- Association of American Medical Colleges
- Council on Social Work Education
- National Organization of Nurse Practitioner Faculties
- Physician Assistant Education Association
- YMCA of the USA
Obesity Care Competencies

1.0: Framework of obesity as a medical condition

2.0: Epidemiology and key drivers of the epidemic

3.0: Disparities and inequities in obesity prevention and care

4.0: Interprofessional obesity care

5.0: Apply skills necessary for integration of clinical and community care for obesity
Obesity Care Competencies

- 6.0: Use patient-centered communication
- 7.0: Recognition and mitigation of weight bias and stigma
- 8.0: Accommodate people with obesity
- 9.0: Strategies for patient care related to obesity
- 10.0 Acute warning signs of obesity care
The Importance of Language

Language to Use
Overweight
Increased BMI
Severe obesity
Unhealthy weight
Healthier weight
Improved nutrition
Physical activity

Language to Avoid
Fat
Obese
Morbid obesity
Diet (or dieting)
Exercise
Obesity Care Competencies

- 6.0: Use patient-centered communication
- 7.0: Recognition and mitigation of weight bias and stigma
- 8.0: Accommodate people with obesity
- 9.0: Strategies for patient care related to obesity
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## Major Reasons to Lose weight

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve overall health</td>
<td>77%</td>
</tr>
<tr>
<td>Improve appearance</td>
<td>66%</td>
</tr>
<tr>
<td>Become more physically active</td>
<td>62%</td>
</tr>
<tr>
<td>Live longer</td>
<td>61%</td>
</tr>
<tr>
<td><strong>Interferes with</strong></td>
<td></td>
</tr>
<tr>
<td>• Romantic relationships</td>
<td>21%</td>
</tr>
<tr>
<td>• Goals and aspirations</td>
<td>20%</td>
</tr>
<tr>
<td>• Family life</td>
<td>11%</td>
</tr>
</tbody>
</table>

[www.norc.org/Research/Projects/Pages/the-asmbsnorc-obesity-poll-aspx](http://www.norc.org/Research/Projects/Pages/the-asmbsnorc-obesity-poll-aspx)
Interactive Barriers to Care

From the patient side
• 73% of overweight patients or patients with obesity spoke to a provider about their weight
• Of these, 40% (55% of total) received a diagnosis of obesity
• Of the total, 24% scheduled a follow-up visit, but only 2/3 (16% of total) kept that appointment

From the provider side
• 52% reported lack of time
• 45% stated more important issues to discuss
• 27% did not believe their patient was motivated
• 26% did not believe that their patient was interested

Kaplan LM. National ACTION Study. 2016; in preparation
The STOP Obesity Alliance’s “Why Weight Guide”

- Sensitivity to stigma and bias
- Accommodation
- How to open the conversation
- Appropriate language
- Communication strategies
- Barriers
- Shared decision making

http://whyweightguide.org/
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- Summary
Benefits of an Integrated System

- Activated people and patients – shared decision making
- Fosters increased investment in upstream determinants of health
- Buttresses value-based care
- Improved outcomes and reduced costs
- Advocacy - improved community services and resources
Summary

Double burden of stigma and bias
Priorities and perceptions of patients and providers
Lack of knowledge
Provider’s BMI, diet, and physical activity
Care delivery
- Lack of trained providers
- Time for counseling
- Reimbursement