

NEW PERSPECTIVES: PART I

Obesity-related Attitudes and Practice Patterns of Primary Care Providers in an Urban Safety Net Public Hospital

Tanu S. Pandey, MD, MPH, FACP; Anthi Katsouli, MD, MPH; and Sarah Imran

Dr. Pandey is assistant professor of medicine at RUSH University Medical Center and patient safety officer at John H. Stroger Jr. Hospital of Cook County. Dr. Katsouli is a hospitalist at Loretto Hospital, and Ms. Imran is a pre-med student at University of Illinois at Urbana Champaign.

Obesity in the United States is approaching epidemic proportions with 70% of the adult population being considered overweight (body mass index (BMI) 25-29.9) or obese (BMI > 30).¹ Inadequate physical activity and poor dietary habits are important contributors to this condition. Obesity increases the risk of diabetes, hypertension, coronary artery disease, arthritis, depression, and many cancers. It results in 300,000 deaths annually and costs \$16 billion dollars in direct medical expenses every year.² However, a substantial proportion of such individuals do not have an appropriate diet or physical activity plan.³ Primary care physicians (PCPs) most often encounter overweight patients and are perfectly placed to influence their lifestyle. Research reveals that only 42% of obese patients get weight loss advice from their physicians.⁴ The US Preventive Services Task Force (USPSTF), American Heart Association, and American Diabetic Association recommend that all patients be screened for obesity and that PCPs provide counseling for obesity as a modifiable risk factor for coronary artery disease.⁵⁻⁷ The USPSTF recommends intensive counseling for obese patients; however, there is lack of evidence regarding the effectiveness of low or moderate counseling.⁵

Practice patterns among primary care physicians have been studied in the United States as well as Europe.⁸⁻¹⁰ Barriers to optimum obesity management include lack of time, inadequate training, negative health beliefs about weight, and lack

of motivation.¹¹ There are few studies that examine the attitudes of resident physicians toward obesity counseling.¹² In one study, 31% of internal medicine residents believed that treating obesity was futile, and only 44% felt qualified to treat obese patients.¹³ The perspective of PCPs on obesity-related care is vital to improving outcomes, and the challenges associated with day-to-day management of obesity can be understood by investigating provider experiences, attitudes, and values.

Obesity is a common disorder among patients seen at John H. Stroger Jr. Hospital of Cook County in Chicago. However, the attitudes, beliefs, and practice patterns of PCPs in the general medicine clinic (GMC) regarding obesity-related care remain largely unknown. We conducted a simple descriptive study to investigate obesity-related practice patterns among PCPs in the GMC. The objectives of the study were to: 1) examine self-reported weight management practice patterns and competency among PCPs at our institution, 2) describe barriers to effective management of obesity in the GMC, and 3) assess an opportunity for a potential intervention and/or faculty development project to improve obesity care.

The study was conducted at a large safety net hospital within an urban public health care system that serves mostly under- and uninsured patients. In this study, we developed an online questionnaire that was e-mailed as a web link to all attending and resident physicians who have a continuity clinic in

the GMC. Attending physicians in the Division of General Internal Medicine and Primary Care and physicians from other departments who provide direct primary care in the GMC were included. No incentives were given to the respondents. The questionnaire was developed and validated in a focus group of PCPs.

We developed a ten-item survey tool to explore the practice patterns and self-reported competency level of physicians. Survey questions addressed the following domains: participant characteristics, frequency of use of BMI in the clinical setting, comfort level discussing weight with patients, documentation of obesity as a separate problem in the problem list, time spent discussing lifestyle changes with patients, barriers to obesity care in the GMC, suggestions for improving care, self-reported competency in management of obesity, and interest in seeking obesity management training. For barriers to obesity care, we included items similar to those that were previously described in a study conducted at a Veteran's Affairs (VA) medical center, recognizing that the core patient populations at VA institutions are comparable to those at ours.¹⁵ Answers to questions were collected as a percentage range, number, or scale. A standardized set of responses was used to address barriers to obesity care, and up to three choices were requested. Free text was used to collect suggestions for improving obesity-related care in the GMC.

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Two reminders were sent to complete the survey at the interval of two weeks each.

The primary data source was an online web collector that was used to collect and analyze the responses. The survey was anonymous, and no personal identifiers were collected or used. We used descriptive statistics to analyze the responses to each item. The study was approved by the Institutional Review Board of Stroger Hospital.

Initially, 186 providers were invited to respond, of whom 51 were attending physicians, three were mid-level providers, and 133 were residents. The survey was offered in the summer of 2012 when 43 residents graduated, so no reminders could be sent to them as they left the institution or moved on to the next phase of their career within the hospital. Of the 51 attending physicians, two did not provide direct patient care in the GMC and did not complete the survey. A total of 55 respondents participated out of 141 eligible respondents (39% response rate).

Of the 55 respondents, 33% reviewed the BMI of their patients more than 75% of the time, and 56% reviewed it more than 50% of the time. However, only 12.7% discussed the BMI with their patients more than 75% of the time, and 62% discussed it less than 50% of the time. Additionally, 67% of respondents felt very comfortable discussing weight with their patients. Only 22% of respondents documented obesity as a separate problem more than 75% of the time, and 29% documented it less than 25% of the time. Overall, 55% documented it less than 50% of the time. A majority of providers (55%) spent only three to five minutes discussing therapeutic lifestyle changes with their patients, whereas 22% spent less than two minutes, 13% five to 10 minutes, and 11% spent more than 10 minutes.

The providers considered “lack of time for patient counseling” (67%), “high complexity of the patients” (66%), and “lack of infrastructure support of weight-related referral services” (51%) as the

three most important barriers to providing optimal obesity-related care in the GMC. Other factors that were considered barriers are shown in Table 1.

A total of 58% providers did not consider themselves competent in the management of obesity, and 64% were very interested in seeking obesity management training. The suggestions to improve obesity care were many, as expected. The majority of providers felt that a coordinated program of trained staff (i.e. dedicated dietary counselors, nurses, and health educators trained in obesity counseling), support groups, and motivational mentors for all overweight patients in the GMC were critical elements of optimal obesity management. Availability of resources for patients that would not cost them any money were also suggested, like help with buying healthy food in their neighborhood or finding them an exercise program close to home.

Educational materials like posters in the waiting areas, flyers or booklets

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Table 1. Barriers to Obesity Care*

Lack of time for patient counseling	67.3%
Complex patients: more serious comorbid conditions demand majority of visit time, and older patients may have functional limitations that prohibit physical activities	65.5%
Lack of infrastructure support of weight-related referral services	50.9%
Lack of patient interest, resources, and readiness for change	38.2%
Inadequate training in effective weight counseling, nutrition, behavioral modification	30.9%
Lack of knowledge about weight management services	20.0%
Perception that obesity counseling and treatments are futile and ineffective	16.4%
Discomfort discussing weight-related matters with patients	1.8%

*Forman-Hoffman et al. 15

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with healthy diet and exercise instructions, and videos were identified as important tools that would enhance the message of self-care for obesity. A significant number of respondents thought that training for providers was critical and must include an ongoing program of lectures, workshops, and informational material that would be easily available, especially for the resident physicians. Other interesting suggestions included increased taxation for soda and fast food, tax exemption for park district exercise facilities, and a miracle drug.

NHANES (2007-2008) data revealed that 34% of US adults are overweight (BMI 25-29.9), 34% are obese (BMI 30-39.9), and 6% are morbidly obese (BMI \geq 40). The prevalence of obesity in the General Medicine Clinic of John H. Stroger Jr. Hospital of Cook County in Chicago is comparable—32% are overweight, 35% are obese, and 13% are morbidly obese, with the last two indices being higher than the national average. The top three common diagnoses at this clinic are hypertension, diabetes mellitus, and dyslipidemia—all of which are related to obesity.

Our study provides evidence that physicians provide inadequate weight-related counseling to obese patients. There is no standard practice related to obesity by PCPs, and few studies have been conducted at public institutions to address barriers to obesity-related care. Unless we clearly understand how providers practice, effective interventions will not be realized. The USPSTF guidelines recommend screening all patients for obesity,

which is practiced in the GMC as evidenced by documentation of BMI by medical assistants in the electronic medical record. However, the USPSTF also recommends that patients with a BMI of more than 30 be referred for intense lifestyle counseling, which is not practiced by many PCPs due to lack of resources. The initial results suggest that providers understand that obesity is a major problem in the GMC, and a majority of them are interested in receiving further training to address this disorder more effectively. The data also suggest that non-physician services need to be an integral part of daily care in the GMC in order for any intervention to have a positive impact. Contrary to prior studies done,¹⁶ our study did not show that physicians have the perception that obesity counseling and treatments are futile and ineffective, and only one third thought that lack of patient interest and readiness for change was a significant barrier.

This study has several limitations including response bias due to the small number of physicians participating. Responders may be more interested in obesity than non-responders. We were unable to analyze the responses based on whether the respondents were attending or resident physicians due to poor response from resident physicians likely due to their busy schedules and possibly lack of interest in the topic of obesity. We also conducted simple descriptive statistics only and did not analyze in depth the difference in attitudes based on years of experience and/or

training level. Further, we could not precisely determine the physician demographics due to low response rate. The strength of this study was that it represented our first attempt to address primary care management of obesity in the GMC and can perhaps provide a foundation for more profound research as well as clinical interventions to improve overall weight-related care. These findings can be shared with other institutional programs, like “Obesity Awareness Week,” to develop simple patient education tools like banners, flyers, and audiovisual material.

PCPs are well positioned to address the rapidly emerging public health problem of obesity in the United States—even in resource-limited settings. However, many barriers for optimal management of obesity remain ingrained in daily practice. Addressing the attitudes and beliefs of PCPs is likely to provide future avenues for studies to assess their impact on obesity-related care. Valuable obesity management services like dietitians, health educators, peer educators, and educational materials for patients can improve the quality of obesity-related care. A multidisciplinary program modified to recognize provider- and system-related barriers will be critical to incorporate evidence-based practice into a quality improvement initiative.

References

1. Flegal KM, Carroll MD, Ogden CL, Curtin LR. Prevalence and trend in obesity among US

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- adults, 1999-2008. *JAMA* 2010; 303(3):235-41.
2. The Surgeon General's call to action to prevent and decrease overweight and obesity. Rockville, Md.: U.S. Department of Health and Human Services, 2001.
 3. National Center for Chronic Disease Prevention and Health Promotion. Physical activity and good nutrition: essential elements to prevent chronic disease and obesity. *Nutr Clin Care* 2003; 6(3):135-8.
 4. Galuska DA, Will JC, Serdula MK, Ford ES. Are health care professionals advising obese patients to lose weight? *JAMA* 1999; 282:1576-8.
 5. U.S. Preventive Services Task Force. Available at <http://www.uspreventiveservicestaskforce.org> (accessed on August 20, 2012).
 6. Grundy SM, Balady GJ, Criqui MH, et al. Guide to primary prevention of cardiovascular diseases. *Circulation* 1997; 95:2329-31.
 7. American Diabetes Association. Standards of medical care for patients with diabetes mellitus: clinical practice recommendations 2001. *Diabetes Care* 2001; 24(1 suppl):S33-S43.
 8. Smith AW, Borowski LA, Liu B, Galuska DA, Signore C, Klabunde C, Huang TT, Krebs-Smith SM, Frank E, Pronk N, Ballard-Barbash R. U.S. primary care physicians' diet-, physical activity-, and weight-related care of adult patients. *Am J Prev Med* 2011; 41(1):33-42.
 9. Laws R. Counterweight Project Team. Current approaches to obesity management in UK primary care: the Counterweight Programme. *J Hum Nutr Diet* 2004; 17(3):183-90.
 10. Huber CA, Mohler-Kuo M, Zellweger U, Zoller M, Rosemann T, Senn O. Obesity management and continuing medical education in primary care: results of a Swiss survey. *BMC Fam Pract* 2011; 12:140.
 11. Ferrante JM, Piasecki AK, Ohman-Strickland PA, Crabtree BF. Family physicians' practices and attitudes regarding care of extremely obese patients. *Obesity* 2009; 17(9):1710-6.
 12. Huang J, Yu H, Marin E, Brock S, Carden D, Davis T. Physicians' weight loss counseling in two public hospital primary care clinics. *Acad Med* 2004; 79(2):156-61.
 13. Block JP, DeSalvo KB, Fisher WP. Are physicians equipped to address the obesity epidemic? Knowledge and attitudes of internal medicine residents. *Prev Med* 2003; 36(6): 669-75.
 14. Prevalence of overweight, obesity, and extreme obesity among adults: United States, trends 1960-1962 through 2009-2010. Available at http://www.cdc.gov/nchs/data/hestat/obesity_adult_09_10/obesity_adult_09_10.pdf
 15. Forman-Hoffman V, Little A, Wahls T. Barriers to obesity management: a pilot study of primary care clinicians. *BMC Family Practice* 2006; 7:35.
 16. Foster GD, Wadden TA, Makris AP. Primary care physicians' attitudes about obesity and its treatment. *Obes Res* 2003; 11(10):1168-77.

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