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Overcoming Barriers to Weight Loss Practice Guidelines in Primary Care

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ABSTRACT

Obesity as a diagnosis requires assessment, a treatment plan, and follow-up within the primary care setting. Barriers and pitfalls exist in each of these aspects that impede successful management of obesity. This article addresses solutions identified in current research for tailoring weight loss guidelines. Key methods recommended include the use of facilitation taxonomy to guide implementation of a practice process focused on lifestyle management, the 5A's as an approach to creating a guideline, lifestyle counseling and behavioral therapy, increasing physical activity, self-monitoring of nutritional intake, weight loss medications, and addressing the variety of individual barriers to lifestyle change from sociocultural influences.

Keywords: 5 A's, barriers, guideline use, obesity, primary care, weight loss

Obesity continues to grow as a major health concern in the United States. Rising health care costs and shrinking health care resources have only magnified this problem further. More than 78 million adults in the United States were obese in 2009 to 2010, equating to more than one third of the adult population.[1,2] According to the Centers for Disease Control and Prevention, obesity-related conditions are some of the leading causes of preventable death including heart disease, diabetes type 2, stroke, and certain types of cancers.[3] Current research-based updates on recommendations for the treatment of these preventable diseases indicate higher thresholds and parameters to introduce medications for management. With these changes, there has been a treatment gap created. Where it previously was appropriate to prescribe medication at the earlier onset of what was classified as prehypertension, prediabetes, and higher than target lipid levels, providers now have the responsibility to address early prevention and lifestyle modification as first-line prescriptions for management, reserving medications for high-risk groups based on improved overall health that correlates with lifestyle modifications.

These new guidelines have opened the doors to addressing prevention and lifestyle management in the primary care (PC) setting as first steps in many disease management treatment guidelines. In the provider's practice process, the implementation of a lifestyle-wellness-prevention focused (LWPF) guideline will require adjustments in traditional practice habits to include and create a shared accountability, provider-patient approach to addressing and treating early signs of declining health trends. By refocusing on lifestyle management with the emphasis on modifiable risk factors, the outcome goal becomes true prevention of chronic disease.

The literature is consistent in describing the following provider barriers to implementing LWPF counseling in PC: time, incentives, and lack of knowledge to address modifiable risk factors.[4] The following consistent patient barriers are also described repeatedly in the literature: lack of motivation and readiness for change.[5] The purpose of this article is to collectively identify clinically significant findings from current research that have addressed these barriers including the implementation of LWPF guidelines, effective provider-patient interactions that promote collaboration in addressing at-risk health behaviors, evidence-based treatment guidelines for weight loss, and social support needs for sustained lifestyle changes. The end result is an outcome goal,

contributing to the reversal of the obesity epidemic and, ultimately, a decline in preventable chronic disease prevalence in this country.

BARRIERS TO IMPLEMENTATION

Implementation of new LWPF treatment guidelines within the PC setting are challenging. Providers have limited time to meet with their patients; systematic efficiency is essential. The process of gathering the details of a patient's chief complaint, a history of present illness, and updates to past medical history is already time-consuming. The additional task of evaluating and addressing lifestyle habits into current practice routines is a major time commitment challenge. In a systematic review and meta-analysis of controlled trials from 1996 to 2010, Baskerville et al[6] found an increase in the effectiveness of implementation rates of LWPF guidelines in PC with facilitator-guided instructions on the implementation of new protocols. There was a significant increased overall effect when interventions to be implemented were tailored to the specific needs of the practice and provided useful tools.

Three varied intensity approaches to the dissemination of information and facilitation of guideline use into practice were identified in a study of implementation of a smoking cessation guideline: the collaborative model, the practice model, and the self-directed learning model. All models were effective and adaptable to meet the needs of a PC or multidisciplinary team interested in incorporating a guideline into their practice process.[7] The collaborative model offered multiple modalities of training, materials, resources, and a collaborative practice coach. A facilitator guided the practice model by incorporating work flow changes and a multidisciplinary team to implement performance measures. The self-directed learning model used Web-based modules with resources and tools provided for all aspects of implementation. Each model was effective in integrating the new guideline into the current practice process and could be adapted for use by any provider seeking to incorporate an LWPF guideline.

An outline of the concepts of the taxonomy of facilitation, to bridge the gap of research use in the practice setting, has been detailed in a literature synthesis[8] and referred to throughout many studies on guideline implementation.[6] The key framework constructs include (1) increasing awareness of the need and rationale for change; (2) plan development addressing barriers and setting goals; (3) dissemination of information, resources, and tools; (4) identifying leader's roles and responsibilities; (5) providing support to build, organize, and empower the team; (6) monitoring and providing ongoing support, information, assistance with problem solving, and feedback; and (7) evaluation of outcomes and team achievements.[8]

For the provider wanting to incorporate an LWPF guideline into the PC practice process, the use of a facilitation taxonomy and implementation model will aid in developing a plan tailored to meet the individual practice needs and increase the likelihood of success in making these progressive changes.

BARRIERS OF EFFECTIVENESS

When assessing the impact of LWPF interventions, effectiveness is difficult to monitor. Just as checking a blood glucose level or blood pressure cannot be considered a focused nor comprehensive assessment adequate to monitor diabetes or cardiovascular disease status, nor can simply checking a weight provide sufficient information to monitor engagement, lifestyle, or progress.

Physical activity has been established as a key factor in the maintenance of healthy body weight and is recommended for overall health by the Centers for Disease Control and Prevention and the United States Department of Health and Human Services (2008) in the Physical Activity Guidelines for Everyone.[9] Monitoring of progress can easily be implemented by including an assessment of current levels of exercise per week in minutes and by intensity level, as a physical activity vital sign, as part of the check-in process along with vital signs and weight. This measurement collectively can monitor LWPF status and patient engagement in maintaining a healthy lifestyle.[10]

In a review of studies exploring successes in overcoming lifestyle change barriers, the 5A's has been identified as effective for smoking cessation. This guideline, from the CS2day (Cease Smoking Today) national smoking cessation initiative, has been translated into models addressing obesity and modifiable risk factors as a lifestyle counseling outline in