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Provider Perspectives

A qualitative inquiry about weight counseling practices in community health centers

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ABSTRACT

Objective: To use qualitative methods to explore how clinicians approach weight counseling, including who they counsel, how they bring up weight, what advice they provide, and what treatment referral resources they use.
Methods: Thirty primary care physicians, physician assistants, and nurse practitioners from four multi-clinic community health center systems (CHCs) in the state of Georgia (U.S.) completed one-on-one semi-structured interviews. Interviews were digitally recorded, transcribed verbatim, and coded.
Results: Clinicians report addressing weight with those who have weight-related chronic conditions, are established patients, or have a change in weight since the previous visit. Most clinicians address weight in the context of managing or preventing chronic conditions. Clinicians report providing detailed dietary advice to patients, including advice about adding or avoiding foods. Many clinicians base advice on their own experiences with weight. Most report no community-based resources to offer patients for weight loss. In the absence of resources, clinicians develop or use existing brochures, refer to in-house weight programs, or use online resources.
Conclusion: Clinicians use a variety of approaches for addressing weight, many of which are not evidence-based. Linkages with weight loss resources in the health care system or community are not widely reported.
Implications for practice: Clinicians and others from the primary care team should continue to offer weight-related counseling to patients with obesity, however, evidence-based treatment approaches for weight loss may need to be adapted or expanded for the CHC practice environment.

1. Introduction

Two out of three Americans are overweight or obese [1], with significant disparities existing among racial/ethnic minority [2] and rural [3,4] populations. International obesity rates are similar, with the worldwide prevalence of obesity nearly doubling between 1980 and 2008 [5]. Obesity increases the risk of heart disease, diabetes, cancer, hypertension, stroke, liver or gallbladder disease, arthritis, and other respiratory diseases [6], making it an important public health issue to address.

The health care system is an increasingly important setting in which to address weight. Americans visit a health professional an average of four times per year [7], providing an opportunity for routine interventions to promote weight-loss behaviors like diet and exercise. Primary care settings like Community Health Centers (CHCs) comprise the nation's health care safety net, and serve around 25 million patients, many of whom are low income [8]. The Patient Protection and Affordable Care Act (ACA), signed into law in the U.S. in 2010, is anticipated to significantly increase health care coverage, resulting in increased primary care visits, particularly among low-income and minority individuals [9,10]. Furthermore, a number of provisions in the ACA, including the elimination of patient costs related to obesity screening and counseling, provide a natural opportunity for primary care to take a more central role in addressing weight [11].

While obesity is a major cause of preventable death and disease, few interventions have been shown to be effective in promoting and sustaining weight loss [12]. Behavioral counseling delivered by clinicians can motivate changes to diet and physical activity and has been significantly associated with patient weight-loss and weight-loss attempts [13]. A number of practice guidelines now recommend that clinicians provide intensive counseling for obese

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patients [14,15]. However, the intensive interventions recommended by the guidelines are often not possible in primary care settings due to a variety of clinician, patient, and environmental factors [16–18]. Studies suggest that fewer than half of obese patients report receiving clinician advice to lose weight, modify their diet, or increase exercise [19–21]. When counseling does occur, it often lacks the provision of specific weight-loss strategies. For example, one study found that only 5% of patients who reported discussing their weight with a provider received advice about diet and exercise strategies [22]. In CHCs, 34% of overweight or obese patients reported receiving some weight management counseling from their provider, but only about 15% received referral to a nutritionist [23].

While a number of quantitative surveys have measured the frequency and quality of weight-related counseling in primary care, few have focused on understanding clinician's perspectives about their practice decisions [18]. Qualitative research methods can be used to describe complexities of weight counseling that cannot be captured through closed-ended surveys. While some weight-related qualitative studies have recently been conducted with clinicians, most have focused on pediatric obesity issues [24–26] or have been conducted outside of the U.S. [27,28]. Furthermore, few studies have focused on weight counseling practices in CHCs. Accordingly, this study sought to explore how clinicians approach weight counseling in adults, including who they counsel, how they bring up weight, what advice they provide, and what treatment referral resources they use.

2. Methods

2.1. Recruitment and sampling

Thirty-two primary care clinicians were recruited from four multi-clinic community health center systems (CHCs) in Georgia to participate in one-on-one in-depth interviews. Two interviews were excluded from these analyses as they pertained only to pediatric weight counseling, and themes were substantially different from those of clinicians providing care primarily to adults. The four multi-clinic CHCs that Emory University partnered with for recruitment comprised more than 30 individual clinics, many of which were located in rural areas and served a high proportion of African-American patients. Eligible clinicians were recruited by email and had to be either physicians, physician assistants, or nurse practitioners; practice at one of the four CHC systems that Emory partnered with for this study; and speak and understand English. The Emory Institutional Review Board approved this study.

2.2. Interviews and measures

One-on-one semi-structured interviews were conducted with participating clinicians via telephone or in person, depending on their preference. Interviews were digitally recorded and lasted between 25 and 48 min (average 34 min). Clinic leadership (e.g., CEOs, clinical directors, quality managers) at participating CHC systems provided input on the initial interview guide. Topics included asking clinicians to describe how and when they bring up the topic of weight with obese patients; what they say to them about it; how patients respond; what specific tools, strategies or resources they offer patients; what barriers or facilitators impact their counseling; and how they describe a successful weight counseling encounter. Participants also provided demographic information. Participants received a $25 gift card incentive for participating in the study.

2.3. Analysis

Audio-recordings of the interviews were de-identified and transcribed verbatim. Transcripts were coded in MaxQDA (Version 10, 2013, VERBI Software, Berlin, Germany). An initial codebook was developed by reading a selection of transcripts and identifying both deductive and inductive themes. The codebook was further refined by having two researchers (GLS and RCW) separately code and compare codes from six transcripts. Discrepancies in coding were resolved through discussion and codes were amended or added to the codebook accordingly. One coder then coded all transcripts (GLS), with a second member of the team (RCW) coding every third transcript to ensure appropriate application of the codes. Findings were validated by reviewing the codebook and sampling representative quotes with the entire team.

3. Results

3.1. Demographics

Participants for this study were slightly more likely to be female than male (53.3% vs. 46.7%). Most participants (43.3%) were between the age of 36 and 45; 66.7% were white, 16.7% were black, 10.0% were Asian, and 6.6% were Hispanic (Table 1). Nearly half were physicians (46.7%), with 36.7% being physician assistants, and 16.6% being nurse practitioners (Table 1); 40.0% provided care to adults only, and 60.0% provided care to both children and adults. The number of years participants had been practicing medicine ranged from one year to 37 years (mean = 13.3 years), with 40.0% practicing less than 10 years, 40.0% practicing between 10 and 20 years, and 20.0% practicing more than 20 years. No substantial differences in themes were found based on number of years in practice.

3.2. When and to whom clinicians counsel about weight

Many clinicians initially reported that they addressed weight with all patients. However, upon further discussion, a majority

Table 1
Participant demographics.

	n (%) or mean (SD)
Sex (%)	
Male	14 (46.7%)
Female	16 (53.3%)
Race (%)	
White, non-Hispanic	20 (66.7%)
Black, non-Hispanic	5 (16.7%)
Asian, non-Hispanic	3 (10.0%)
Hispanic	2 (6.6%)
Age (in years) (%)	
18–35	6 (20.0%)
36–45	13 (43.3%)
46–55	3 (10.0%)
56–65	8 (26.7%)
Clinician type (%)	
Physician	14 (46.7%)
Physician assistant	11 (36.7%)
Nurse practitioner	5 (16.6%)
Provide care for (%)	
Adults only	12 (40.0%)
Both children and adults	18 (60.0%)
Years practicing medicine	
Range (in years)	1–37
Mean (SD)	13.3 (10.9)
<10 years	12 (40.0%)
10–20 years	12 (40.0%)
>20 years	6 (20.0%)