COPE Webinar Series for Health Professionals

November 11, 2020

Addressing Obesity within Primary Care: Opportunities and a Multidisciplinary Approach

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Today's Webinar Objectives

1. Describe the history of Intensive Lifestyle Interventions (ILIs), such as Intensive Behavioral Therapy for Obesity (IBTO) and effectiveness in primary care.
2. Identify core IBTO services, requirements, and available resources.
3. Review research on physician preferences and interest in integrating RDN/nutrition care within the primary care setting.

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Addressing Obesity within Primary Care: Opportunities and a Multidisciplinary Approach

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Addressing Obesity within Primary Care: Opportunities and a Multidisciplinary Approach

Dr. Lauren Sastre PhD, RDN, LDN

Assistant Professor, Department of Nutrition Science, College of Allied Health Sciences, East Carolina University

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Obesity and Chronic Disease

Obesity- is primarily diagnosed by a Body Mass Index ≥ 30 kg/m^2 The prevalence of obesity was 42.4% in 2017~2018.

Obesity is associated with: heart disease, stroke, type 2 diabetes and certain cancers- all of which are leading causes of preventable, premature death

The estimated annual medical cost of obesity in the United States was $147 billion (2008, $US); and obese patients on average have $1,429 higher in healthcare expenditures.

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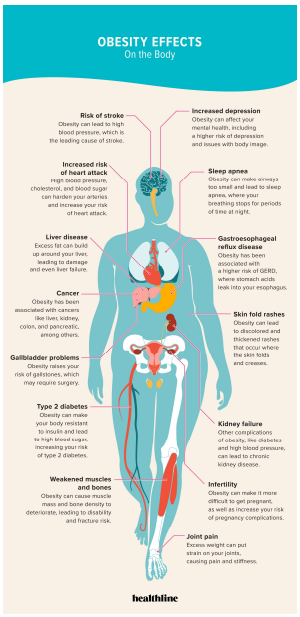
Obesity and Chronic Disease

Updated 2019 American Diabetes Association Consensus guidelines for nutrition and diabetes promotes weight loss for improved glycemic control.

Obesity is associated with elevated cholesterol, triglycerides, blood pressure and overall cardiovascular disease risk (American Heart Association).



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Obesity and Chronic Disease

Obesity- recognized as an individual chronic disease by the Obesity Society in 2018.

In 2018, the USPSTF recommended PCPs refer obese patients for intensive behavioral therapy to other qualified providers (e.g. Registered Dietitian Nutritionists, RDNs) and recommendations were published in JAMA.

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Primary Care: Obesity, Chronic Disease and Multidisciplinary Care

Primary care: The health care setting where preventative services, health promotion, counseling and patient education and management should occur.

Would take a primary care provider (PCP) **21.7 hours** to fulfill the US Preventative Task Force (USPSTF) Recommendations for preventative care/primary care in addition to other clinical tasks. (Yarnall et al.)

Chronic disease care models/guidelines encourage multidisciplinary care- when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible.

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Primary Care and the RDN

In 2017, a systematic review conducted by Mitchell et al., demonstrated significant improvements in weight and HbA1c as well as dietary patterns for patients who received care by an RDN specifically within the primary care setting.

Other studies have also found significant improvements to patient outcomes when RDN care is provided in the primary care setting- even with socioeconomically and racially diverse patient populations (Warner et al., Fiscella et al.)

How many patients have access to an RDN? Billing/reimbursement barriers . . . . No current research on specific obesity treatment- i.e. Intensive Behavioral Therapy for Obesity

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Intensive Behavioral Therapy for Obesity - CMS

In November 2011, The Centers for Medicaid and Medicare Services (CMS), IBTO deemed a billable service under Medicare Part B Plans.

IBTO includes:

1. Screening for obesity in adults using measurement of BMI calculated by kg/m^2
2. Dietary (nutritional) assessment
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

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IBTO Clinical Guidelines

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement as discussed below.

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IBTO Clinical Guidelines

At month 6, total weight loss must be assessed

Beneficiaries must have achieved a documented reduction in weight of at least 3kg over the first 6 months of IBTO.

For beneficiaries who do not achieve -3kg, a reassessment of their readiness to change and BMI is appropriate + 6 months.

IBTO can be repeated each year.

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Delivery of IBTO (settings)

Must be provided **by a qualified primary care physician or other primary care practitioner *and* in a primary care setting**.

RDNs are considered a qualified practitioner to deliver IBTO.

CMS defines a primary care setting as one in which "there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community"

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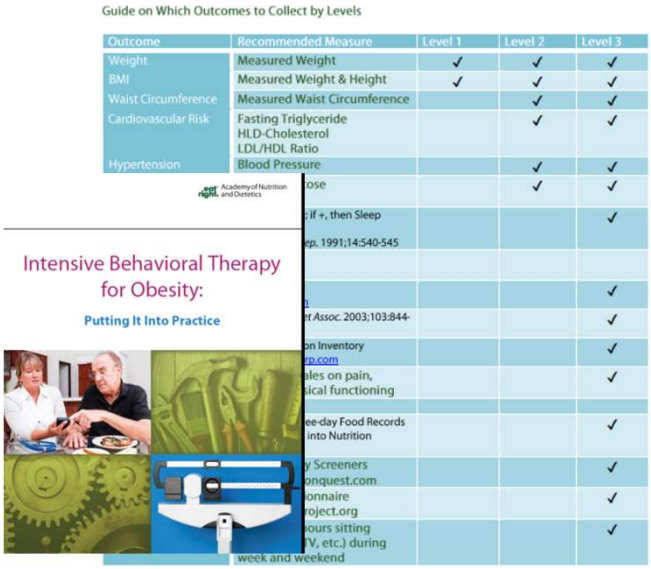
IBTO and the Registered Dietitian Nutritionist (RDN)

The Academy of Nutrition and Dietetics has a tool-kit for RDNs to support provision of IBTO within the primary care setting.

The toolkit is accessible to anyone online (cost varies by membership status)

The tool-kit also makes suggestions for measuring effectiveness of IBTO care . . .



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Study 1: Sharing the 'weight' of obesity management in primary care: integration of registered dietitian nutritionists to provide intensive behavioral therapy for obesity for Medicare patients.

- ***Primary objective:*** *To examine the integration of registered dietitian nutritionist provided IBTO into a primary care setting and evaluate clinic outcomes for Medicare Part B beneficiaries.*
- ***Secondary objective:*** *To examine intensity of IBTO (quantity of IBTO visits) versus clinical outcomes and influence of socioeconomic factors.*

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Design and Methods (cont'd)

Design: A case–control retrospective chart review was conducted at a rural, Academic Family Medicine Clinic in Eastern North Carolina for patients seen between 1 January 2016 and 1 January 2019.

Overall Eligibility: Female, white or black race, have Medicare insurance and a body mass index ≥ 30 kg/m2.

Treatment group: if RDN-provided IBTO was provided during the study duration as identified per an existing G0447 billing code

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Design and Methods

Primary variables of interest: age, insurance provider, race, number of nutritional visits (e.g. G0447 codes) and clinical outcomes. Clinical outcomes included: weight (pounds), BMI, A1C and medication duration.

Statistical analysis: descriptive and mixed model analysis. The following visit groupings were utilized which were previously used by Trevino et al., to categorize IBTO treatment duration: groups—0 visit, 1–3 visits, 4–8 visits, and 9+ visits.

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Results

- Treatment group had overall had higher (non significantly) average age, weight, A1C (7.2 vs. 69), BMI (37 vs. 34) and medication usage at baseline.
- African American (AA) patients were more likely to have participated in IBTO and had higher initial weight, BMI, and AIC but lower age and medication use/duration (n=452 vs. n=234).
- Older patient's had lower reductions in BMI and/or A1C and longer medication duration/use.
- Treated patients on average attended the following number of sessions: 1-3 visits, n=532, 4-8 visits n=93, 9+ visits n=72.

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Results

- IBTO was significantly associated with changes (reductions) in BMI, A1C and medication duration.
- Patients in the IBTO treatment group lost on average 2.66 lbs (1.22 per visit) vs. 0.5 lbs gained in the control
- Patients in the IBTO treatment group on average experienced a 0.152% decline in A1C, and improvements were the highest in those who attended 9+ IBTO treatment visits.
- Patients in the IBTO treatment (69%) discontinued medication use during the treatment window.

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Limitations, Key Points and Conclusions

Limitations: Geography, sex, ethnicity, retrospective chart review limited data collected with regards to socioeconomic variables.

Key Points/Conclusions:

- Intensive behavioral therapy for obesity (IBTO) reduced weight, A1C, medication use.
- IBTO impact was lower in older and African American patients.
- Treatment duration was not predictive of success for weight, but was for A1c reductions (9+ visits, greatest impact)
- IBTO can be delivered by a registered dietitian nutritionist in the primary care setting.

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Discussion- Future Research and Implications

- Visits 1-3 vs. 9+ - characteristics of patients, social support, motivation, information provided early visits vs. behavioral check ins.
- Hybrid approaches to IBTO- early 1 on 1, then group or telehealth? RDN 1st then health coaches?
- Non-adherence to full IBTO treatment? Satisfaction?
- Repeating IBTO . . . long term impact, characterization of patients

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Study 2: Family medicine physicians' report strong support, barriers and preferences for Registered Dietitian Nutritionist care in the primary care setting

Objective: *To explore Family Medicine Provider (FMP) access, referral practices, barriers and preferences for RDN care*

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Design and Methods

Design: A cross-sectional online survey, with content and face validation was conducted with Family Medicine Departments within large academic health care systems in the Southeastern United States.

Eligibility: Physician in a Family Medicine Practice in the Southeastern US (n=151)

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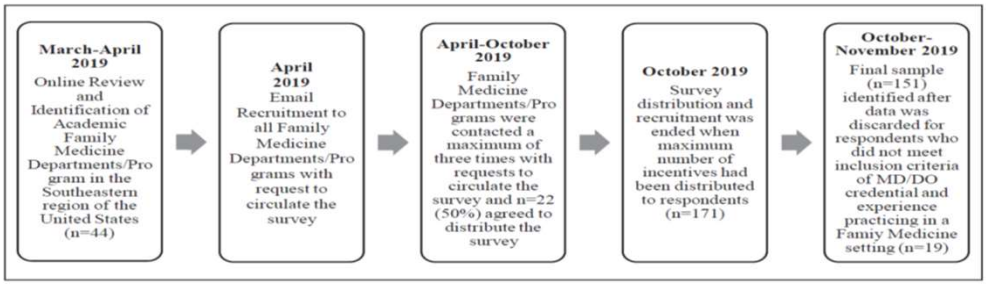
Design and Methods

Main variables of interest: FMP access, interest, current referrals and referral preferences for RDN care, barriers to referrals and overall perceptions regarding RDN care.

Analysis: Descriptive analysis of close-ended responses was performed with SPSS 26.0. Open-ended responses were analyzed using inductive content analysis.



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Results

Highlights:

- Currently has an RDN employed or located on site 36.0% yes, 54.0% no.
- For those with an RDN, 94.2% refer to their RDN at their practice (5.8% do not)
- Top referrals: diabetes, weight, chronic disease specific prevention, renal, general prevention.
- If no current access to an RDN, interest in using an RDN's services? yes 94.9%, no 5.1%
- If no RDN, preference for integrating/referrals: full time on site daily 49.1%, part time on-site 39.5%, off site 11.4%.

Table 1. Provider/facility descriptives from family medicine physicians in Southeastern US, April–October 2019 ($n = 151$)

Survey question	*n* (%)	Mean	SD
What are your credentials?			
MD	131 (86.8)		
DO	19 (12.6)		
MD/MPH	1 (0.7)		
How long have you been in practice? (years)		11.9	11.0
How long have you been employed at your current practice? (years)		3.0	7.2
Which of the following best describes your practice?			
Owned by or affiliated with a larger health care system	105 (69.5)		
Private practice	4 (2.6)		
Public Health Clinic (e.g. FQHC)	14 (9.3)		
Other (e.g. Academic, Residency, Clinic)	28 (18.5)		
Do you have an RDN employed by your practice and/or co-located in your clinic?			
Yes	54 (36.0)		
No	96 (64.0)		
If yes, did you learn about the RDN's services?			
You sought an RDN and located her/him	12 (23.5)		
RDN connected with you	16 (31.4)		
Other (e.g. RDN already at practice)	23 (45.1)		
Do you refer patients to the RDN at your practice?			
Yes	49 (94.2)		
No	3 (5.8)		
If yes, is he or she:			
Part time	13 (25.0)		
Full time	36 (69.2)		
Other (e.g. unsure)	3 (5.8)		
If you have an RDN on-site or refer to an RDN off site which of the following reasons, do you refer for? (select all that apply)			
Diabetes management	122 (80.8)		
Weight management	118 (78.1)		
CD specific prevention (e.g. pre-diabetes, pre-hypertension/elevated BP	63 (41.7)		
Cardiovascular disease/hypertension	53 (35.1)		
Renal disease	38 (25.2)		
Preventative (general heath)	37 (24.5)		
Other (open ended)[a]	15 (9.9)		
If you do not currently have an RDN working with your patients would you be interested in using the services of an RDN			
Yes	94 (94.9)		
No	5 (5.1)		
If yes, which of the following would you prefer:			
Prefer to refer patients to an off-site RDN	13 (11.4)		
Have a part-time RDN on-site (1–2 days a week)	45 (39.5)		
Have full-time RDN on-site everyday	56 (49.1)		
Which of the following services offered by an RDN do you believe would be the most beneficial for your patients?			
Weight management	128 (84.8)		
Diabetes management	125 (82.8)		
Cardiovascular disease/hypertension	97 (64.1)		
CD specific prevention (e.g. pre-diabetes, pre-hypertension/elevated BP	96 (63.6)		
Renal disease	69 (45.7)		
Preventative (general heath)	84 (55.6)		
Other[b]	13 (8.6)		

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Results

Table 2. Physicians barriers and interests in RDN care from family medicine practices in the United Sates Geographic Southeast, April–October 2019 (n = 151)

Survey question					
If you currently do not refer to an RDN, which of the following describes why?	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Lack of patient interest/value	20 (27.8)	14 (19.4)	17 (23.6)	19 (26.4)	2 (2.8)
Potential cost for patient	4 (5.5)	6 (8.2)	16 (21.9)	29 (39.7)	18 (24.7)
Uncertainty regarding what services are provided by an RDN	17 (23.6)	19 (26.4)	17 (23.6)	15 (20.8)	4 (5.6)
Uncertainty of benefit of RDN services to patient	25 (34.7)	18 (25.0)	11 (15.3)	15 (20.8)	3 (4.2)
Uncertainty of how/who to connect with for RDN services	13 (18.1)	14 (19.4)	10 (13.9)	27 (37.5	8 (11.1)

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Results

Highest Frequency Themes/Reponses to the final survey question: *Is there anything else we did not ask that you believe would be useful for us to know/consider?*

Insurance/ cost (n=21)

- "Cost of services not covered by insurance "
- "Difficult for community health center to afford this service."
- "Insurance does not pay for all the ways I would like to use an RDN"
- "…lack of insurance coverage - especially for Medicaid.

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Results

Highest Frequency Themes/Reponses to the final survey question: *Is there anything else we did not ask that you believe would be useful for us to know/consider?*

Service/Preferences (n=11)

- "I would like group visit at the practice…"
- "…I would like to include cooking classes"

Finding a Quality RDN (n=8)

- The most important thing is that it's very hard to find a GOOD RDN that takes insurance."
- Sometimes I am hesitant to refer because I've had some patients report they felt "judged" and then are upset with me for referring"

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Key Points and Conclusions

• This study identified low overall access to but strong overall interest in RDN care, and some uncertainty in the benefit of RDN provided care.

• Physicians reported cost and uncertainty connecting to an RDN as barriers.

• Referral to and perceptions of RDN care centered around chronic diseases.

• Opportunities for interprofessional collaborate may address barriers to referrals, integration and/or perceived low value of RDN care.

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Overall Summary: Implications for Multidisciplinary Care, Research and Practice

- Despite recommendations physicians make referrals to RDNs for obesity treatment- our research suggests access is limited. No access= less multidisciplinary care.
- Impact of IBTO on patient outcomes was promising, however, continued research examining outcomes in "real clinical" settings is warranted.
- How might improved communication and care collaboration (multidisciplinary care) between providers improve IBTO adherence and outcomes?
- What is the take-away for the RDN?

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Questions? & Contact Info

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References

Centers for Disease Control and Prevention (CDC) Obesity Facts: https://www.cdc.gov/obesity/data/adult.html
American Heart Association: BMI https://www.heart.org/en/healthy-living/healthy-eating/losing-weight/bmi-in-adults#:~:text=Obesity%20is%20now%20recognized%20as,to%20assess%20your%20body%20composition.
LeBlanc EL, Patnode CD, Webber EM, Redmond N, Rushkin M, O'Connor EA. Behavioral and Pharmacotherapy Weight Loss Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults: An Updated Systematic Review for the U.S. Preventive Services Task Force [Internet]. Report No. 18-05239-EF-1. Rockville, MD: Agency for Healthcare Research and Quality (US), 2018.
Google Scholar
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (NVVDPHP). Chronic Diseases in America. https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm (accessed on 11 August 2019).
Centers for Medicare and Medicaid Services. Decision Memo for Intensive Behavioral Therapy for Obesity. CAG-00423N. 2011. https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253 (accessed on 28 August 2019).
Yarnall KS, Østbye T, Krause KM et al. Family physicians as team leaders: "time" to share the care. Prev Chronic Dis 2009; 6: A59.
Intensive Behavioral Therapy for Obesity: Putting It into Practice, 2nd ed. Academy of Nutrition and Dietetics, 2017. https://www.eatrightstore.org/product-type/toolkits/intensive-behavioral-therapy-for-obesity-putting-it-into-practice
Mitchell LJ, Ball LE, Ross LJ, Barnes KA, Williams LT. Effectiveness of dietetic consultations in primary health care: a systematic review of randomized controlled trials. J Acad Nutr Diet 2017; 117: 1941–62.
Treviño RP, Piña C, Fuentes JC, Nuñez M. Evaluation of Medicare's intensive behavioral therapy for obesity: the Bienestar experience. Am J Prev Med 2018; 54: 497–502.
Lv N, Azar KMJ, Rosas LG et al. Behavioral lifestyle interventions for moderate and severe obesity: a systematic review. Prev Med 2017; 100: 180–93.
Lin H, Zhang L, Zheng R, Zheng Y. The prevalence, metabolic risk and effects of lifestyle intervention for metabolically healthy obesity: a systematic review and meta-analysis: a PRISMA-compliant article. Medicine (Baltim) 2017; 96: e8838
Kolasa KM, Rickett K. Barriers to providing nutrition counseling cited by physicians: a survey of primary care practitioners. Nutr Clin Pract 2010; 25: 502–9.
Webb VL, Wadden TA. Intensive lifestyle intervention for obesity: principles, practices, and results. Gastroenterology 2017; 152: 1752–6
Expert Panel on the Identification, Treatment of Overweight, Obesity in Adults (US), National Heart, Lung, Blood Institute, National Institute of Diabetes, Digestive, and Kidney Diseases (US). Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. No. 98. National Institutes of Health, National Heart, Lung, and Blood Institute, 1998.
Kahan S, Wilson DK, Sweeney AM. The role of behavioral medicine in the treatment of obesity in primary care. Med Clin North Am 2018; 102: 125–33.
Erlandson M, Ivey LC, Seikel K. Update on office-based strategies for the management of obesity. Am Fam Phys 2016; 94: 361–8.
Warner MF, Miklos KE, Strowman SR, Ireland K, Pojednic RM. Improved access to and impact of registered dietitian nutritionist services associated with an integrated care model in a high-risk, minority population. *J Acad Nutr Diet* 2018; **118** (10**):** 1951–7.Fiscella K, Sanders MR. Racial and ethnic disparities in the quality of health care. *Annu Rev Public Health* 2016; **37**: 375–94.
Bradley DW, Murphy G, Snetselaar LG, Myers EF, Qualls LG. The incremental value of medical nutrition therapy in weight management. *Manag Care* 2013; **22** (1**):** 40–5. *Eat Right: RDNS in the New*

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Questions?

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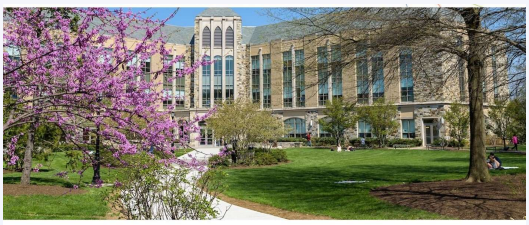

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