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# Understanding health policy to improve primary care management of obesity

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***Abstract: NPs are ideal candidates for implementing positive health changes for obese patients. Providers have medical expertise and can promote obesity reduction strategies to their patients. Increased awareness of the influence of health policy and clinical implications for obesity management are needed.***

**O**besity management for most primary care providers (PCPs) is difficult, but they are ideal candidates for making positive health changes for obese patients. PCPs have medical expertise and can promote obesity reduction by influencing patients and their families to make healthier lifestyle choices; providing patients with individualized, evidence-based health information; encouraging healthcare systems and workplaces to provide healthy environments for all stakeholders; and advocating for local, state, and national healthcare policy changes. This article reviews the clinical implications of caring

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for obese patients and how PCPs can advocate for their patients by affecting change in health policy.

### ■ Obesity

Adult obesity is defined as a body mass index (BMI) 30 kg/m<sup>2</sup> or greater; obesity in children and adolescents is a BMI in the 95th percentile or greater for the same age and gender.<sup>1</sup> Obesity is multifactorial, encompassing genetic, physical, environmental, and psychological components and transcends region, race, and gender.<sup>1</sup> In the United States, obesity affects approximately 17% (12.7 million) of children ages 2 to 19 years and 35.7% (80 million) of adults.<sup>2,3</sup> Obesity prevalence is higher among adults ages 40 to 59 (39.5%), followed by adults age 60 and over (35.4%) and younger adults between ages 20 and 39 (30.3%).<sup>1</sup>

Obesity is a global disease with many costly, chronic, comorbid conditions, including type 2 diabetes mellitus (T2DM), hypertension, gallbladder disease, osteoarthritis, dyslipidemia, coronary heart disease, and some cancers.<sup>4</sup> Obese individuals currently have improved access to obesity management, and PCPs have more reimbursement options.<sup>5,6</sup> Unfortunately, continuation of coverage for this costly disease is now uncertain.

### ■ Cost of obesity

Obesity is associated with increases in healthcare costs, and therefore has a negative influence on the economy. Approximately 34.4% of uninsured adults in the United States who are eligible for Medicaid are obese and require healthcare interventions.<sup>7</sup> The probable annual impact of obesity on the global economy is \$2 trillion, which accounts for 2.8% of the global gross domestic product.<sup>8</sup> The oldest baby boomers reached age 65 in 2011. Healthcare expenses of this large cohort, which is expected to live longer than previous generations, account for 66% of the U.S. healthcare budget.<sup>9</sup>

If current obesity trends continue, approximately half of all adults will be obese by 2030.<sup>8</sup> Medicare and Medicaid cover an estimated 40% of the annual obesity-related healthcare costs (\$60 billion) in the United States, and current investigations suggest that a 5% reduction in the obesity rate would yield a healthcare savings of approximately \$29 billion.<sup>3</sup> Similarly, childhood obesity is costly. In the United States, an obese

10-year-old child would have an estimated lifetime medical cost of \$19,000 compared to a normal weight counterpart.<sup>10</sup> Specifically, if the lifetime medical cost of \$19,000 were multiplied by the number of obese 10-year-old children, the results would be approximately \$14 billion.<sup>10</sup>

However, if no incremental, lifetime adjustments for medical costs are made for children of normal weight (who may potentially gain weight during adulthood), the estimated costs for obesity treatment will range from \$16,310 to \$39,080 per person.<sup>10</sup> The financial implications of reducing obesity prevalence are huge, so addressing barriers to obesity reduction with a multidimensional approach, which encompasses environmental factors, is essential.

### ■ Obesogenic environment

The concept of the “obesogenic environment” first emerged in the 1990s.<sup>11</sup> The obesogenic environment is a group of diverse community features that increase an individual’s risk for obesity and its related complications.<sup>12</sup> Research suggests a link between obesity and “built environments” where people live, work, and play.<sup>12,13</sup> The built environment can negatively affect physical activity and health outcomes. For example, a healthy built environment is a neighborhood with good aesthetics (more green space), sidewalks, safe traffic conditions, and convenient full-service grocery stores.

This environment facilitates healthy lifestyle behaviors needed to reduce obesity.<sup>14-16</sup> Understanding the

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possible association of a sedentary lifestyle paired with unhealthful eating behaviors within the built environment provides a framework for developing strategies aimed at reducing or eliminating the obesogenic environment.

Equally important are other external factors in the built environment.<sup>15</sup> According to the World Health Organization, walking is a primary mode of exercise for adults.<sup>16,17</sup> Walkability (sidewalks, parks, or recreation centers) and playability (yards and playgrounds) of a neighborhood are associated with physical activity in adults and children, respectively.<sup>18,19</sup> Environments

that are not conducive to physical activity may increase the risk of obesity. Therefore, the need exists for healthcare policies based on science and the population's values to create built environments that promote an active lifestyle in all communities, and thus, eliminate or reduce obesogenic environments.

Research also suggests that Black Americans and low-income individuals are more likely to live in obesogenic environments, with limited access to neighborhood supermarkets and healthy food choices.<sup>20</sup> A qualitative study of 34 obese minorities revealed perceived discrepancies between the cost of healthy and unhealthy foods in their neighborhood supermarkets.<sup>21</sup> These findings emphasized the perceived or actual barriers faced by vulnerable populations to achieve healthy eating behaviors.

### ■ Policy influence on obesity

Health policy is an official statement or process that summarizes priorities and restrictions for actions addressing health needs, identifies available resources, and responds to a systemic process or administrative pressures.<sup>17</sup> Specifically, health policy is needed to establish a consensus and outline transparent, future direction of health outcomes for health systems, PCPs, and the general public.<sup>17</sup> Policies may help create strategies and built environments that promote healthy lifestyles and prevent obesity.

PCPs, especially pediatric providers, have a unique and important role in promoting policy change and environments that support obesity reduction because early childhood is a crucial time for healthy lifestyle development.<sup>22</sup> During the first 2 years of life, PCPs have multiple opportunities during well-child visits to educate parents about maintaining healthy lifestyle behaviors and referring families to community resources to aid in obesity reduction.<sup>22</sup>

To ensure that healthcare outcomes and policies related to obesity are applicable, PCPs and scientists from appropriate disciplines must evaluate current obesity research findings along with expert position papers from organizations such as the Academy of Nutrition and Dietetics and the National Academy of Medicine.<sup>23,24</sup> Because of the national urgency to provide preventive and proactive healthcare to individuals diagnosed with obesity, PCPs need to be present in all levels of governmental decision-making committees associated with redesigning obesity healthcare and policy development.<sup>25,26</sup>

PCP expertise complements that of policy makers who rarely have the medical experience necessary to develop policies that address current obesity issues. Specifically, PCPs are poised to fill in the gap to advocate for health policy changes to help vulnerable populations and to suggest appropriate changes in the delivery of healthcare for obese patients.<sup>26</sup>

### ■ Obesity guidelines

New and revised clinical practice guidelines are a promising approach to encourage and advocate for health policy changes.<sup>27,28</sup> Currently, published clinical practice guidelines identify obesity, metabolic syndrome, T2DM, and heart disease as chronic, interrelated conditions.<sup>29</sup> Preventing these chronic diseases must encompass ongoing assessment of the patient's BMI, waist circumference, and willingness to adhere to healthier lifestyle behaviors. Research consistently suggests that prevention of these problems should begin with early childhood screening and promotion of a healthy lifestyle by PCPs.<sup>30</sup>

With decreasing numbers of PCPs and increasing numbers of newly insured obese patients due to the Patient Protection and Affordable Care Act (ACA), the demand on PCPs to manage these patients will be overwhelming.<sup>31</sup> However, if all PCPs use clinical guidelines to manage and treat obesity, the continuity of care for this patient population may improve, which may lead to reductions in obesity prevalence. For example, clinical guidelines should include therapeutic conversations with obese patients regarding healthier lifestyles to reduce obesogenic environmental influences and when to refer these patients to an obesity specialist.<sup>32</sup>

### ■ PCP influence on obesity healthcare policy

PCPs recognize the priorities and issues that accompany treating obese and overweight individuals, such as sufficient time for educating and counseling patients. PCPs need a minimum of 20 to 30 minutes to spend with obese patients—especially those with multiple comorbidities—as opposed to the usual 10 to 15 minutes for an office visit.<sup>33</sup> Practice guidelines suggest specific interventions for this population require more time (even for follow-up visits).<sup>34</sup> However, the PCP must comprehensively document the visit based on the insurer's reimbursement standards in order to receive payment.

As a result, primary prevention is often no more than a caution that overweight and obesity are present and

patients should “get more exercise and watch their diet.” This is seldom effective without specificity. Specialty clinics are available for some, and referrals are common but often not used until serious comorbidities have developed. Communication between PCPs and specialty providers is problematic with delays in both referrals and in receiving specialty reports/recommendations. Specialty providers sometimes think that in some instances, more timely consults could have prevented problems or made some treatment options appropriate.<sup>25</sup>

Existing health policies at all levels of government have identified that obesity is a major health concern, but there is a lack of influence toward a sufficient resolution to this complex issue. For example, obese Medicare clients are allowed enough primary care visits to recommend changes, set goals, and evaluate outcomes. PCPs must be cognizant of current health policies and should advocate for their patients by highlighting the barriers to individualized care. In the community, PCPs and professional organizations can help identify common problems and organize support for providing quality health services and a safe environment for all. PCPs and organizations can seek support and assistance from governmental policy makers and legislators to influence policy development at local, state, and national levels; they may also pursue appointments to committees and elections to public office that may offer opportunities to change policies.

#### ■ Clinical goals for obesity management

One of the Healthy People 2020 objectives is to increase the percentage of PCPs who evaluate their patients' BMI levels during each visit.<sup>35</sup> In 2011, Medicare announced a coverage decision describing the criteria for intensive behavioral counseling and therapy for beneficiaries classified as obese.<sup>36</sup> Furthermore, primary care experts recommend offering and referring all obese patients for obesity treatment interventions, including setting weight-loss reduction and self-monitoring goals, assessing facilitators and barriers to change, and planning how to achieve and maintain lifestyle changes.<sup>34</sup>

Unfortunately, many inconsistencies in healthcare plans exist related to the amount of primary care coverage provided for obesity treatment.<sup>37</sup> Research

suggests obese children are more likely to become obese adults. The U.S. Preventive Services Task Force (USPSTF) recommends that PCPs screen children age 6 years and older for obesity and provide thorough behavioral strategies to promote a healthy weight.<sup>34</sup>

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Adults should also be referred for multicomponent behavioral programs, including nutritional and physical lifestyle behavioral counseling that is more likely to result in weight reduction.<sup>34,38</sup> However, all PCPs should follow a standard protocol to ensure continuity of care for all overweight and obese patients for screening to be effective (see *Clinical protocol for obesity management*).

#### ■ Health policy implications

Recommendations from the USPSTF encourage PCPs to provide intensive, multidimensional behavioral strategies to all obese patients.<sup>34</sup> Strategies include behavioral management activities, such as:

- identifying weight-loss goals
- improving diet or nutrition
- increasing physical activity
- addressing barriers to change
- self-monitoring/sustainability of lifestyle change
- participating in weight-loss interventions that include 12 to 26 sessions a year and provide a variety of approaches to aid in successful weight reduction.<sup>34</sup>

Policies that address obesogenic environmental factors impacting a patient's quality of life and health outcomes are needed.<sup>42</sup> For example, an individual with limited access to safe housing compared with his or her counterpart living in a nice, comfortable home within a safe community may have poorer quality of life, which can directly affect health status.<sup>42</sup> Specifically, PCPs are cognizant of the effects of socioeconomic status on one's health and adept in educating patients, peers, and policy makers on the effects of social inequalities among vulnerable populations.<sup>43</sup> Therefore, PCPs are equipped to encourage, persuade, and petition for policy changes to reduce obesogenic environments, which may subsequently lead to reductions in obesity rates.

PCPs can advocate for policies supporting obesity prevention across the lifespan, such as increased activity and healthier food options in schools and in the workplace (specifically, policies that focus on providing access to healthy, affordable food and more safe spaces to promote physical activity in all communities).<sup>44</sup> Another example of how PCPs can influence policy is to engage insurance companies. Insurer policies frequently do not cover obesity or counseling for overweight or obese patients beyond their annual well visit. The ACA, if not appealed or underfunded, provides added support for annual visits.

PCPs can advocate for better policies to fund, such activities as gym subscriptions for patients or rewards for weight loss and other health outcome goals. Prior to the ACA, preventive screening and education were either not covered or inadequately covered to compensate for the extensive counseling required. Insurers mainly covered treatment for morbid obesity with other comorbid conditions, which

included surgery in some cases while overweight or moderately obese patients were encouraged to “exercise and eat less.”

PCPs are positioned to advocate for legislation, professional organizations, and insurance companies to focus on policies that relieve or remove major healthcare barriers to managing obesity. Specifically, emphasis should focus on obesity prevention and access to obesity healthcare for all individuals at risk.<sup>39,40,45</sup> Encouraging more PCPs to become politically active may be an underused strategy to reduce obesity prevalence through policy.

Systematic reviews of evidence are particularly useful in evaluating existing health policies and health outcomes. For example, a systematic review of obesity-related policy and environmental interventions were published for consideration of economic outcomes.<sup>44</sup> Such documents provide a template for PCPs to promote health policies addressing the difficulties associated with obesity, metabolic syndrome, and

#### Clinical protocol for obesity management<sup>39-41</sup>


Procedural steps	Actions to take	Subactions
<b>Subjective:</b>	<b>Assess:</b> medical history, family history for obesity, patients’ review of systems	Assess readiness for change and motivation level, self-awareness of obesity status, and current activity level
<b>Objective:</b>	<b>Evaluate:</b> degree of obesity	<ul style="list-style-type: none"> <li>• Vital signs, complete physical exam, height, weight, BMI, and waist circumference</li> <li>• Labs: complete metabolic panel, thyroid-stimulating hormone, cholesterol panel, glycated hemoglobin test</li> <li>• Presence of comorbidities (coronary heart disease, hypertension, T2DM, sleep apnea)</li> </ul>
<b>Treatment:</b>		
Step 1	Determine and contract mutual goals with patient	Prevent further weight gain, reduce body weight, maintain weight loss
Step 2	Develop SMART goals with patient	For success, goals must be Specific, Measurable, Attainable, Realistic, and Timely
Step 3	Generate lifestyle strategies to achieve SMART goals	Create charts with specific goals/timelines for mental, physical activity, and nutritional behaviors
Step 4	Provide assistance to achieve goals	<ul style="list-style-type: none"> <li>• Make referrals to dietitians, exercise trainers, counselors, psychologists, pulmonologists as needed</li> <li>• Provide self-management tools such as websites that help manage/track food intake and activity level</li> <li>• Order activity tracking devices</li> </ul>
Step 5	Frequent follow-up	Schedule follow-up every 2–3 months for reevaluation of facilitators and barriers and adjustments as needed
Step 6	Consider pharmacotherapy	Use short-term as adjunct therapy to improve nutrition and physical activity lifestyle changes
Step 7	Explore bariatric surgery	Recommend this option for morbidly obese patients who have several comorbidities and have been repeatedly unsuccessful with weight loss attempts

other comorbidities among individuals, communities, states, and the nation.

The WellRx Toolkit is an 11-item self-report screening tool that allows PCPs to identify and address social needs experienced by community-dwelling patients.<sup>43</sup> Researchers used this tool to screen over 3,000 patients from three primary care sites. Findings revealed that 46% of patients screened positive for at least one social need, and 63% of those had multiple needs. If PCPs use this tool with their patients, addressing social barriers may improve overall patient health-care outcomes.

Another approach PCPs may use is laypeople or community partners, such as community health workers (CHWs), to assess peers for barriers to chronic care management, such as obesity treatment. CHWs have a unique set of skills to help patients navigate health-care system processes.<sup>43</sup> For example, a CHW can assist a patient with filling out paperwork for subsidies related to a diagnosed chronic disease.

## Conclusion

Ultimately, PCPs need to become politically active at all governmental levels in order to improve obesity management and treatment by reducing the influence of obesogenic environments. Future studies examining relationships between the obesogenic environment, health policy, health outcomes, and obesity may inform policy decision makers of needed changes in healthcare policies at all levels of government. Researchers need to be cognizant of the obesogenic environment when developing tailored interventions for vulnerable populations across the lifespan. 

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