Overcoming Challenges to Obesity Counseling: Suggestions for the Primary Care Provider

Kristina H. Lewis, MD, MPH, SM, and Kimberly A. Gudzune, MD, MPH

ABSTRACT

• **Objective:** To review challenges to obesity counseling in the primary care setting and suggest potential solutions.

• **Methods:** Review of the literature.

• **Results:** There are many challenges to obesity counseling in the primary care setting, including lack of primary care provider (PCP) training, provider weight bias, lack of reimbursement, lack of time during outpatient encounters, and limited ability to refer patients to structured weight loss support programs. However, there are potential solutions to overcome these challenges. By seeking continuing medical education on weight management and communication skills, PCPs can address any training gaps and establish rapport with patients when delivering obesity counseling. Recent policy changes including Medicare coverage of obesity counseling visits may reduce PCPs’ concern about lack of reimbursement and time, and the rise of new models of care delivery and reimbursement, such as patient-centered medical homes or accountable care organizations, may facilitate referrals to ancillary providers like registered dietitians or multicomponent weight loss programs.

• **Conclusion:** Although providers face several challenges in delivering effective obesity counseling, PCPs may overcome these obstacles by pursuing continuing medical education in this area and taking advantage of new health care benefits coverage and care delivery models.

Over one-third of U.S. adults are now obese [1] and the prevalence of obesity is rising globally (2). In 2003 and 2012, the U.S. Preventive Services Task Force (USPSTF) issued a recommendation that health care providers screen all patients for obesity and offer intensive, multicomponent behavioral interventions to obese patients [3,4]. Screening for obesity typically involves assessment and classification of a patient’s body mass index (BMI). In the primary care setting, weight management may include a range of therapeutic options such as intensive behavioral counseling, prescription anti-obesity medications, and referral to bariatric surgery. Behavioral interventions typically include activities such as goal setting, diet and exercise change, and self-monitoring. A recent systematic review showed that primary care–based behavioral interventions could result in modest weight losses of 3 kg over a 12-month period, and prevent the development of diabetes and hypertension in at-risk patients [5].

While primary care–based weight management interventions can successfully achieve modest weight loss, many obese patients do not receive the recommended treatment. Studies have found that the percentage of obese patients who received weight loss counseling from their primary care provider (PCP) varies from 20% to 40% [6–8]. Most recent estimates suggest that only 18% of obese patients receive counseling for weight reduction, 25% for dietary change, and 21% on exercise [8]. Obese patients have not reported increased rates of weight loss counseling since the USPSTF guidelines were first released in 2003 [9]. We have identified several challenges that may contribute to PCPs low rates of obesity counseling, as well as potential solutions to overcome these barriers (Table 1).

PCP Concern: “I never learned about weight management during my training”

One of the most common barriers to providing the recommended counseling reported by health care providers from the Kaiser Permanente Center for Health Research Southeast, Atlanta, GA (Dr. Lewis) and the Division of General Internal Medicine, Johns Hopkins University School of Medicine, Baltimore, MD (Dr. Gudzune).
is inadequate training in nutrition, exercise, and weight loss counseling [10–12]. Many providers have knowledge deficiencies in basic weight management [13,14]. In addition, few PCPs who have received obesity-related training rate that training as good quality during medical school (23%) and residency (35%) [15].

**Pursuing Additional Training in Weight Management**

Providers could address their lack of training in weight management by participating in an obesity curriculum. When surveyed, PCPs have identified that additional training in nutrition counseling (93%) and exercise counseling (92%) would help them improve the care for obese patients, and many (60%) reported receiving good continuing medical education (CME) on this topic [15]. Much research in this area has examined the impact of such training on residents’ provision of obesity counseling. Residents who completed training improved the quality of obesity care that they provided [16], and those who learned appropriate obesity screening and counseling practices were more likely to report discussing lifestyle changes with their patients [17]. The vast majority of surveyed PCPs (86%) also felt that motivational interviewing [15], a technique that can effectively promote weight loss, would help them improve obesity care [18,19]. Patients demonstrated greater confidence in their ability to change their diet when their PCP used motivational interviewing–consistent techniques during counseling [20]; however, few PCPs utilize motivational interviewing techniques [20,21]. Offering CME opportunities for practicing PCPs to obtain skills in nutrition, exercise, and motivational interviewing would likely improve the quality of obesity care and weight loss counseling that are being delivered. PCPs could also consider attending an in-depth weight management and obesity counseling training such as those offered by the Obesity Society, Harvard Medical School Department of Continuing Education (eg, Blackburn Course in Obesity Medicine), and the Cleveland Clinic Center for Continuing Education (eg, Annual Obesity Summit). (See Appendix for contact information.)

**Applying a Universal Behavior Change Approach to Obesity and Other Behaviors**

Another option may be encouraging PCPs to use a universal approach to behavioral counseling across multiple domains [22]. Using a single technique may lend familiarity and efficiency to the health care providers’ counseling [23]. The 5A’s—Assess, Advise, Agree, Assist, Arrange—has been proposed as a possible “universal” strategy that has demonstrated efficacy in both smoking cessation [24] and weight loss [25,26]. Using the 5A’s has been associated with increased motivation to lose weight [25] and increased weight loss [26]. Many physicians are familiar with the 5A’s; however, few physicians use the complete technique. PCPs have been found to most frequently “assess” and “advise” when using the 5A’s technique for weight loss counseling [26,27], although assisting and arranging are the components that have been associated with dietary change and weight loss [26]. PCPs could incorporate these A’s into their counseling routine by ensuring that they “assist” the patient by establishing appropriate lifestyle changes (eg, calorie tracking to achieve a 500 to 1000

### Table 1. Overview of Primary Care Provider Concerns and Suggested Strategies to Address

<table>
<thead>
<tr>
<th>PCP Concern</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>“I never learned about weight management during my training”</td>
<td>• Pursuing additional training in weight management</td>
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<tr>
<td>“Weight gain reflects the patient’s lack of will power and laziness”</td>
<td>• Applying a universal behavior change approach to obesity and other behaviors</td>
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<td>“I may not get reimbursed for weight management services”</td>
<td>• Cultural influences on weight management</td>
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<td>“I don’t have time to discuss weight loss during outpatient visits”</td>
<td>• Assessing implicit and explicit weight bias</td>
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<tr>
<td>“I don’t know where to refer patients for weight management”</td>
<td>• Pursuing additional training in communication skills</td>
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<td>• Benefits coverage for obesity screening and counseling</td>
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<td>• Obesity screening and counseling quality metrics</td>
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<td>• Brief counseling interventions in the primary care setting</td>
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<td>• Longitudinal nature of PCP relationship as an opportunity for repeated counseling interactions</td>
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<td>• Weight management resources in the community</td>
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Cultural Influences on Weight Management

A final weight management training consideration relates to cultural awareness for patients who are from different racial or ethnic backgrounds than the PCP. In the United States, racial and ethnic minority groups are disproportionately burdened by obesity. Nearly 60% of non-Hispanic black women and 41% of Hispanic women are obese, compared with 33% of non-Hispanic whites [28]. Despite this fact, obese non-Hispanic black and Hispanic patients are more likely than white patients to perceive themselves as “slightly overweight” and to rate their health as good to excellent despite their obesity [29,30]. As a result, they may be less likely to seek out weight loss strategies on their own or ask for weight control advice from their providers [31]. Additionally, racial and ethnic disparities in access to healthy foods [32,33], safe areas for engaging in physical activity [34], and lack of social support for healthy behaviors may make it much more difficult for some minority patients to act on their PCP’s advice.

Because of different cultures, social influences, and norms, what an individual patient perceives as obese or unhealthy may differ dramatically from what his or her physician views as obese or unhealthy [35–38]. Therefore, it is important that PCPs have a discussion with their patients about their subjective weight and health perceptions before beginning any prescriptive weight management strategies or discussions of “normal BMI” [39,40]. If an obese patient views herself as being at a normal weight for her culture, she is unlikely to respond well to being told by her doctor that she needs to lose 40 pounds to get to a healthy weight. Recent research suggests that alternative goals, such as encouraging weight maintenance for non-Hispanic black women, may be a successful alternative to the traditional pathway of encouraging weight loss [41].

In addition to understanding cultural context during weight status discussions, it is also important to give behavior change advice that is sensitive to the culture, race, and ethnicity of the patient. Dietary recommendations should take into account the patient’s culture. For example, Lindbergh et al have noted that cooking in traditional Hispanic culture does not rely as much on measurements as does cooking for non-Hispanic whites [42]. Therefore, measurement-based dietary advice (the cornerstone of portion control) may be a more problematic concept for these patients to incorporate into their home cooking styles [42]. Physical activity recommendations should also be given in context of cultural acceptability. A recent study by Hall and others concluded that some African-American women may be reluctant to follow exercise advice for fear that sweating will ruin their hairstyles [43]. Although providers need not be experts on the cultural norms of all of their patients, they should be open to discussing them, and to asking about the patient’s goals, ideal body type, comfort with physical activity, diet advice and other issues that will make individualized counseling much more effective.

PCP Concern: “Weight gain reflects the patient’s lack of will power and laziness”

Bias towards obese patients has been documented among healthcare providers [44,45]. Studies have shown that some providers have less respect for obese patients [46], perceive obese patients as nonadherent to medications [47], and associate obesity with “laziness,” “stupidity,” and “worthlessness” [48]. Furthermore, obese patients identify physicians as a primary source of stigma [49] and many report stigmatizing experiences during interactions with the healthcare system [44,45]. In one study, a considerable proportion of obese patients reported ever experiencing stigma from a doctor (69%) or a nurse (46%) [49]. As a result of these negative experiences, obese patients have reported avoiding or delaying medical services such as gynecological cancer screening [50]. A recent study by Guzdune et al found that obese patients had significantly greater odds of “doctor shopping,” where individuals saw 5 or more primary care providers in a 2-year period [51]. This doctor shopping behavior may also be motivated by dissatisfaction with care, as focus groups of obese women have reported doctor shopping until they find a health care provider who is comfortable, experienced, and skilled in treating obese patients [50].

Assessing Implicit and Explicit Weight Bias

In addition to explicit negative attitudes, health care providers may also hold implicit biases towards obese
Overcoming challenges to obesity counseling

patients [52]. A recent study found that over half of medical students held an implicit anti-fat bias [53]. These implicit attitudes may manifest more subtly during patient encounters. PCPs engage in less emotional rapport building during visits with overweight and obese patients as compared to normal weight patients [54], which include behaviors such as expressing empathy, concern, reassurance, and partnership. The lack of rapport building could negatively influence the patient-provider relationship and decrease the effectiveness of weight loss counseling. PCPs may need to consider undergoing self-assessment to determine whether or not they hold negative implicit and/or explicit attitudes towards obese patients. PCPs can complete the Weight Implicit Association Test (IAT) for free online at https://implicit.harvard.edu/implicit/demo/. To determine whether they hold negative explicit attitudes, PCPs can download and complete assessments offered by the Yale Rudd Center for Food Policy and Obesity (www.yaleruddcenter.org/resources/bias_toolkit/index.html).

Pursuing Additional Training in Communication Skills

If weight bias is indeed present, PCPs may benefit from additional training in communication skills as well as specific guidance on how to discuss weight loss with overweight and obese patients. For example, an observational study found that patients lost more weight when they had weight loss counseling visits with physicians who used motivational interviewing strategies [20,21]. Additional PCP training in this area would benefit the patient-provider relationship, as research has shown that such patient-centered communication strategies lead to greater patient satisfaction [55,56], improvement in some clinical outcomes [57,58], and less physician burnout [59]. In fact, some medical schools address student weight bias during their obesity curricula [60]. Building communication skills helps improve PCPs’ capacity to show concern and empathy for patients’ struggles, avoid judgment and criticism, and give emotional support and encouragement, which may all improve PCPs’ ability to execute more sensitive weight loss discussions. For providers who are more interested in CME opportunities, the American Academy on Communication in Healthcare offers an online interactive learning program in this area called “Doc Com” (http://doccom.aachonline.org/dnn/Home.aspx).

PCP Concern: “I may not get reimbursed for weight management services”

Traditional metrics for how doctors are reimbursed and how the quality of their care is measured have not promoted weight loss counseling by PCPs. Prior to 2012, physicians could not bill Medicare for obesity-specific counseling visits [61]. Given that many private insurers follow the lead of the Centers for Medicare and Medicaid Services (CMS) for patterns of reimbursement, this issue has been pervasive in U.S. medical practice for a number of years, with considerable variability between plans on which obesity-related services are covered [62]. A recent study of U.S. health plans indicated that most would reject a claim for an office visit where obesity was the only coded diagnosis [62]. Additionally, the quality improvement movement has only recently begun to focus on issues of obesity. In 2009, the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) added 2 new measures pertaining to the documentation of a patient’s BMI status. Prior to this time, even the simple act of acknowledging obesity was routinely underperformed and quite variable across health plans in the United States [63].

Obesity Screening and Counseling Benefits Coverage

In 2012, CMS made a major coverage change decision when they agreed to reimburse providers for delivering intensive behavioral interventions for obesity [61]. Namely, CMS will now cover a 6-month series of visits for Medicare patients (weekly for month 1, every other week for months 2–6), followed by monthly visits for an additional 6 months in patients who have been able to lose 3 kg. For PCPs and other providers who have long hoped for more opportunity to discuss nutrition, weight, and physical activity with their Medicare patients, these policy changes are exciting. Hopefully, this move by CMS will stimulate similar changes in the private insurance market.

Greater reimbursement of obesity-related care is also more likely given the overall trend of the U.S. health care system—with the focus shifting away from traditional fee-for-service models that have de-emphasized preventive care and counseling and toward a model that rewards well care [64]. Large employer groups, who represent an important voice in any discussion of health insurance and reimbursement, are also increas-
ingly interested in the use of wellness programs and weight loss to decrease their own health care costs. This trend could further stimulate insurers to cover programs that allow providers to engage in weight counseling as a way of attracting or retaining large employer groups as customers [62].

**Obesity Screening and Counseling Quality Metrics**

A parallel movement in the quality of care realm would serve to bolster any forthcoming changes in reimbursement. For example, an expansion of the HEDIS “wellness and health promotion” measures, or going beyond “BMI assessment” to include a brief assessment of key dietary factors or physical activity level as a routine quality measure, would go a long way toward emphasizing to payers and providers the need for more routine obesity counseling. Professional provider organizations have been increasingly engaged in this area as well. The recent recognition by the American Medical Association of obesity as a disease may also influence organizations such as the NCQA and payers who may be considering how to encourage providers to better address this important issue.

**PCP Concern: “I don’t have time to discuss weight loss during outpatient visits”**

The average continuity visit for an adult patient in the United States is about 20 minutes in duration, with a mean of 6 to 7 clinical items to be addressed during that time-period [65]. This leaves little time for providers to perform the necessary history and physical portions of the visit, educate patients on various topics, and write out prescriptions or referrals. Not surprisingly, such extreme time pressure leads many PCPs to feel overwhelmed and burned out [66], and the idea of adding another “to-do” to office visits may be resisted. For obese patients, many of whom are likely to have multiple chronic conditions, PCPs are faced with the task of both discussing active issues such as hypertension, diabetes, and sleep apnea, and also potentially discussing the patient’s weight status in a very brief amount of time. Under such time pressures, PCPs often adopt a “putting out fires” mentality and therefore tackle what they see as the most pressing issues—eg, deal with out of control blood pressure by adding a new medication, or lowering hemoglobin A1c by upping the insulin dose, rather than dealing with the 20-lb weight gain that might be leading to the high pressures and hyperglycemia.

Compounding this problem is the fact that well-delivered preventive health advice can be time-consuming, and with so many topics to choose from, it may be difficult for providers to know which issues make the most sense to prioritize [67]. A recent study estimated that PCPs routinely under-counsel patients about nutrition (an advice topic that earns a “B” rating from the USPSTF), while they over-counsel them on exercise and PSA testing (topics that earn an “I” rating from the USPSTF) [68]. Topics of discussion and the time spent on them may reflect patient priorities or PCP comfort with various issues, but it is clear that some improvements could be made to better utilize available time with patients.

In the face of time and resource pressures, many PCPs may not be ideally suited to deliver the kind of intensive behavioral weight loss interventions that are supported by the best scientific evidence [69]. In fact, there is little evidence to support even brief weight counseling sessions by PCPs [70]. However, for busy providers, there are several brief and potentially impactful tasks that could enable them to better support their obese patients.

**Brief Counseling Interventions in the Primary Care Setting**

First, primary care providers should routinely measure and discuss their patients BMIs as they would any other vital sign. In addition, other brief measures such as “Exercise as a Vital Sign” [71] can be incorporated into the visit, so that behaviors linked to weight can inform the strategy adopted and monitored over time. After a brief discussion is initiated, a referral can be placed for patients who wish to pursue more intense therapy for weight loss—this may be to behavioral health, nutrition, bariatric surgery or a comprehensive weight management clinic. Practices can support their providers by streamlining this referral process and educating providers and patients on available resources. PCPs also may be able to engage their patients in self-monitoring (eg, calorie tracking, exercise tracking, self weighing) so that most of the work and learning takes place outside of the primary care office. For example, PCPs can promote the use of a food diary, a practice that has been shown to improve weight loss success [72]. Review of the diary could take place at a separate visit with the PCP or in follow-up with a weight loss specialist or dietitian.

A major strength of the primary care setting is its longitudinal nature. Even if available time at individual visits is short, advice and support can be given repeatedly over a longer period of time than may often be achieved.
with a specialist consultant. For patients who are in the maintenance phase of weight loss, having long-term frequent contacts with a provider has been shown to prevent weight regain [73]. The use of group visits and physician extenders (RNs, NPs, PAs) for delivering obesity-related behavioral advice might offer another way to relieve some of the time pressures faced by PCPs in the one-on-one chronic disease management visit [69,74].

**PCP Concern: “I don’t know where to refer patients for weight management”**

Surveys of obese patients and their doctors indicate that PCPs may not often enough refer patients to structured weight loss programs or registered dietitians [75,76]. Furthermore, PCPs are often isolated from other providers who might be important in a team-based model of obesity care, such as pharmacists, registered dietitians, endocrinologists, and bariatric surgeons. The implementation of the Affordable Care Act, including payment reform and the rise of accountable care organizations, should begin changing the relative isolation of the PCP. If more practices attempt to conform to medical home models, the interconnectedness of PCPs to other health care team members may increase, thus facilitating a more team-based approach to obesity care and easier referrals to specialized team members [77].

**Weight Management Resources**

Aside from some academic centers and large private health care institutions, many primary care practices lack access to structured obesity care clinics that can help manage the challenges of guiding patients through their weight loss options. For providers who practice in areas that do not afford them easy access to obesity care clinics, it is worth seeking out available resources in the nonmedical community that might provide a structured support system for patients. One low-cost community-based program, Take Off Pounds Sensibly (TOPS; www[tops.org]), can achieve and sustain a 6% weight loss for active members [78]. Groups such as Overeaters Anonymous are found in most U.S. cities, and have helpful websites including podcasts that patients can access even in the absence of a local branch (www[oa.org]). Organizations like the YMCA, which have good penetration into most areas of the country, offer affordable access to physical activity and health programs including coaching that can promote all around healthier living and improved dietary habits (www[ymca.net]).

A final consideration could be referral to a commercial weight loss program. A 2005 review of the major U.S. commercial weight loss programs concluded that there was suboptimal evidence for or against these programs’ efficacy [79]. A recent randomized controlled trial showed that patients referred by their PCP to a commercial weight loss program (Weight Watchers) lost significantly more weight (2.3 kg) at 12 months as compared to patients who only received weight loss advice from their PCP [80]. However, it is important to keep in mind that not all commercial programs are the same and some programs can be ineffective or even dangerous for some patients. The PCP may need to take an active role monitoring their patient’s health and safety when using these programs.

**A Strategy to Incorporate Weight Management into Current Practice**

While seeking additional training is a good option, PCPs can incorporate some strategies into their current routines with obese patients as outlined in Table 2, which integrates aspects of motivational interviewing with the 5A's strategy discussed above into a practical framework. Many of these elements are grounded in psychological theory and supported by evidence [81,82]. First, PCPs should plan to specifically discuss weight loss and dedicate time to discuss this issue with their obese patients. This task may be more easily accomplished during the patient’s annual physical where providers typically allocate longer time for the appointment and patients may be more likely to anticipate a discussion of preventive health issues. However, if the patient raises the issue, providers need to be prepared to address weight loss or at least schedule a time to discuss weight loss at a later date. Sometimes PCPs can miss these opportunities [83]. When a patient’s chief complaint is not related to obesity, then providers should minimize or avoid discussions of obesity. Obese patients may misconstrue such discussions as being motivated by negative provider judgment [84]. Second, providers should inquire about the patient’s belief about their weight and interest in weight loss. For patients interested in a weight discussion, providers should not be afraid to use the term “obese” or “obesity.” A recent study showed that obese patients actual prefer that PCPs use the term “obese” rather than another euphemism, as it suggested to patients that the problem had more serious consequences [85]. PCPs should also emphasize the collaborative nature of creating a weight loss plan and the autonomy of the patient, as well as evoke or draw out the patient’s own reasons for...
change. These techniques are essential features of motivational interviewing [86]. If acceptable, the PCP can then begin to negotiate lifestyle changes and set goals with the patient, consider weight loss medications or bariatric sur-

### Table 2. Strategies to Implement During Different Clinical Scenarios

**During the annual physical...**

- **Before entering the exam room:**
  - Measure height and weight to calculate body mass index (BMI)
    → Plan to discuss weight loss if BMI ≥ 30 kg/m²
  - Review patient’s obesity-related comorbidities

- **After entering the exam room:**
  - Use a neutral statement to inquire about the patient’s perception of their weight
    → “Would it be alright if we discussed your weight?”
    → “What do you think about your weight?”
    → “How has your weight changed over the last 10 years?”
  - If the patient is amenable to discussing their weight, then plan to discuss their BMI and medical conditions linked to obesity you identified before entering the room
    → “Based on your height and weight, your body mass index or BMI is 36, which falls into the obese category”
    → “Obesity has health risks, in fact, your weight can be contributing to your high blood pressure and high cholesterol. However, weight loss, even small amounts of weight loss, can help improve those conditions.”
  - Ask about the patient’s interest in losing weight—emphasize collaboration, autonomy, evocation
    → “Are you interested in talking about weight loss and working together to make a plan?”
    → “Whether you pursue weight loss, is entirely up to you. I am here to support your healthy changes.”
    → “What is motivating your interest in losing weight?”
  - If the patient is amenable to working on weight loss, then inquire about what strategies the patient has considered to lose weight
    → “Are there any habits that you have thought about changing that you would want to work on first?”
    → “What strategies have you considered to lose weight? What have you tried before?”
  - Incorporate patient-desired changes with evidenced-based lifestyle changes such as reducing calories by 500-1000 daily and self-monitoring with calorie tracking and weekly weights into a concrete plan with specific goals. For patients without a clear first goal, can consider smaller changes.
    → “I think that increasing your protein would be a good first step. Have you ever used a food-tracking app for your smartphone? This can help you make sure you achieve your goal of increasing your protein intake, as well as track your calories each day. It’s important to know where you’re starting from before we make any changes, so I suggest that you track your food intake for one week to establish your average daily protein intake and calories. Then, try increasing your protein by 10g and reduce your calories by 500 from this baseline.”
    → “A common source of extra calories is a sweetened beverage like soda, sweet tea, energy drinks, fancy coffees or juices. Do you drink these? On average, how many do you drink each day? What do you think about cutting back on these drinks and replacing them with water or other no- or low-calorie drinks like Crystal Light or brewed unsweetened tea?”

- **PCPs can consider weight loss medications or bariatric surgery, in eligible patients**
- **PCPs can consider referral to local weight management resources (if available) or community programs**
  → “In addition to our discussions, there is also a weight management clinic at our organization who can work with you in-depth on weight loss. Would you be interested in participating in this program? I am happy to refer you.”
- **The visit should conclude with setting up a short-term follow up to discuss changes and address challenges**
  → “I would like to see you back in 4 weeks to find out how you have been doing on making the changes we discussed. Make sure you bring in your food diaries, so that we can review them together.”

**After the visit ends:**

- **If possible, the PCP should touch base with the patient via letter, call, or email within a week that restates the goals set during the appointment using a positive tone**

*(Table continues on next page)*
surgery if appropriate, or refer to a local weight management or community program. Finally, PCPs should schedule a short-term follow-up with all patients to assess their success and challenges with implementing the agreed upon changes.

Summary
Given the obesity epidemic, PCPs will need to begin addressing weight loss as a part of their normal practice; however, providers face several challenges in implementing weight management services. Many PCPs report receiving inadequate training in weight management during their training; however, many CME opportunities exist for providers to reduce their knowledge and skills deficit. Depending upon the prevalence of obesity in their practice and interest in offering weight management services, PCPs may need to consider more intensive weight management training or even pursue certification as an obesity medicine provider through the American Board of Obesity Medicine. For providers with a more general interest in obesity counseling, applying a consistent counseling approach like the 5A’s to several behaviors (e.g., obesity, smoking cessation) may facilitate such counseling as a regular part of the outpatient encounter. PCPs should also be aware of different cultural considerations with respect to obesity including different body image perceptions and cooking styles. Obesity bias is pervasive in our society; therefore, PCPs may similarly hold negative explicit or implicit attitudes towards these patients. Providers can engage in online self-assessment about their explicit and implicit biases in order to understand whether they hold any negative attitudes towards obese patients. Additional training in communication skills and empathy may improve these patient-provider relationships and translate into more effective behavioral counseling. PCPs may be concerned about a lack of reimbursement for weight management services or a lack of time to perform counseling during outpatient encounters. With the new obesity counseling benefits coverage by CMS, PCPs should be reimbursed for obesity counseling services and provide additional time through dedicated weight management visits for Medicare patients. The new primary care practice models including the patient-centered medical home
may facilitate PCP referrals to other weight management providers such as registered dieticians and health coaches, which could offset the PCP’s time pressures. Finally, PCPs can consider referrals to community resources, such as programs like Overeaters Anonymous, TOPS or the YMCA, to help provide patients group support for behavior change. In summary, PCPs may need to consider additional training to be prepared to deliver high quality obesity care in collaboration with other local partners and weight management specialists.

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