

Improving Obesity Management in Primary Care and Community Health Centers

**Authored by the STOP Obesity Alliance Research Team at
The George Washington University School of Public Health
and Health Services**

Department of Health Policy

Christine Ferguson, JD, Stephanie David, JD,
Jennifer Leonard, JD, MPH, Lucas Divine, and Anna Stoto

THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF PUBLIC HEALTH
AND HEALTH SERVICES

STOP
STRATEGIES TO
OVERCOME & PREVENT **OBESITY**
ALLIANCE

Table of Contents

Executive Summary, Key Findings and Key Recommendations	3
Primary Care and Community Health Centers.....	4
What’s Happening in Primary Care?	5
Barriers to Effective Primary Care in the Treatment and Prevention of Obesity	7
What’s Happening in Community Health Centers?.....	8
Highlights from a Literature Review of Existing Obesity and Chronic Disease Management Programs.....	9
A Closer Look: Case Studies from the Literature Review	10
Best Practices from the Case Studies	13
Highlights from the Symposium	14
Barriers to Obesity Efforts in Community Health Centers	16
Conclusion: What Primary Care Providers in Community Health Centers and Private Practice Can Learn from One Another	17
References	18

Executive Summary

Nearly two-thirds of the population is overweight or obese, and if the current trajectory continues, 50 percent of the population will be obese by 2030. Primary care providers and community health centers (CHC) are at the frontlines of this epidemic. The Affordable Care Act (ACA) seeks to curb rising health care expenditures through an emphasis on preventive care and treating chronic diseases and conditions, such as obesity and diabetes. Primary care providers and CHCs can expect to be increasingly relied on to provide weight-related medical care. To better understand the challenges and propose solutions to this shift, the The Strategies to Overcome and Prevent (STOP) Obesity Alliance and The George Washington University's Geiger Gibson Program in Community Health Policy conducted a literature review of a variety of CHC programs across the country. They also co-sponsored a symposium at the National Association of Community Health Centers' (NACHC) annual Policy and Issues Forum in March 2011, which convened a range of stakeholders to discuss and explore the preparedness of the primary care and CHC workforce to effectively prevent and treat obesity. The following is a brief summary of our findings and key recommendations for improving obesity management in CHC and primary care settings.

Key Findings

The literature demonstrates CHCs are already addressing obesity and chronic disease through targeted, innovative programming. Many lessons can be learned from CHCs—from how they are embracing an integrated care model using the patient-centered medical home model as a treatment model to the effective use of community health workers, members of local communities who work either for pay or as volunteers in association with the local health care system and typically share ethnicity, language, socioeconomic status and life experiences with the community members they serve.

CHCs are also partnering with other organizations in the community to provide auxiliary obesity-related services to their patients, such as access to exercise classes and equipment at the YMCA to aid patients in their weight loss and health goals.

This paper provides a description of several community-oriented chronic disease and obesity management programs.

Key Recommendations

The following are our recommendations, based on the key themes from the discussion at the symposium and our literature review, on how to continue to increase the effectiveness of obesity prevention and treatment in the primary care setting, by learning from and working with CHCs.

1. Increase Integration and Care Coordination

The patient-centered medical home (PCMH) model has been successful in providing highly integrated and comprehensive care without imposing logistical barriers. Importantly, a number of primary care and support and coordination services can be delivered by non-physicians, and/or physician extenders.

2. Create Culturally and Linguistically Appropriate Programming

Patients are more likely to achieve a meaningful weight loss of 5-10 percent when programming is provided in a culturally and linguistically appropriate manner.

3. Partner with Community Organizations

Partnering with community organizations fosters a sense of patient “buy-in,” encouraging the patient to continue seeking medical care around weight-related issues and increasing their probability of achieving meaningful weight loss.

4. Reduce Barriers to Address Obesity in CHC and Primary Care

Barriers to adequately addressing obesity and related comorbidities in primary care and community health centers include a severe primary care workforce shortage and a lack of knowledge of how to adequately advise patients on weight loss. Providers need to be well-trained and comfortable in their ability to treat weight. Additionally, providers need to be trained on viewing weight primarily as a health, and not cosmetic, issue. Community health workers are also an important part of the extension of the primary care workforce and the primary care community must advocate for ACA community health worker grants to be appropriated and awarded to realize this promising addition to the primary care.

The members of the STOP Obesity Alliance research team at The George Washington University would like to extend their warm thanks and gratitude to the following participants of the Obesity and Health Centers Panel Discussion held during the National Association of Community Health Centers’ Policy and Issues Forum on March 26, 2011 in Washington, D.C.: Angela Blackwell, JD, PolicyLink; Jay Breines, Unity Health Care; Amanda Cash, DrPh, Health Resources and Services Administration, Office of Planning, Analysis and Evaluation, Research and Data Policy Group; Matthew Burke, MD, Health Resources and Services Administration, Bureau of Primary Health Care; Jessica Wallace, PA, Unity Health Care.

White Paper release date: November 8, 2011

Primary Care and Community Health Centers

There is an alarming trend toward overweight and obesity in America. Nearly two-thirds of the population is overweight, with 34 percent considered medically obese.¹ At the front lines of this epidemic are primary care providers and CHCs that see a great number of patients who are obese and have obesity-related conditions such as diabetes, obstructive sleep apnea, hypertension and other heart diseases.

Effective and innovative treatment practices in the primary care setting should be an essential piece of addressing obesity. Furthermore, as the primary medical providers for underserved and disadvantaged populations that are disproportionately affected by obesity, community health centers (CHCs) play a pivotal role in helping these individuals receive necessary health care. *Just how well-equipped are primary care providers and CHCs, which are bound to become even more called upon with the influx of newly insured patients entering the health care system under the Affordable Care Act (ACA), to deal with the issues surrounding obesity? How can they prepare to meet patients' needs?*

In March 2011, the Alliance and The George Washington University co-sponsored a symposium at the National Association of Community Health Centers' annual Policy and Issues Forum (the "Symposium") to bring together experts and stakeholders to provide insight on this set of issues and to discuss CHCs' readiness to address obesity.

This effort built on the Alliance's previous work on overweight and obesity in the primary care setting, discussed below. The goal of the Symposium was to ascertain what programs to address obesity are already in place, how these programs differ from those provided in other primary care settings, and what resources and information are needed to further improve the delivery of obesity and weight-related services in CHCs.

This paper, based on discussion at the Symposium, describes some of the lessons learned from the Alliance's research on obesity and primary care. The paper also provides details on some of the unique and successful programs CHCs have implemented to address obesity that could be applied in other CHC and primary care settings.

What's Happening in Primary Care?

The ACA of 2010 promises many things: increased coverage, higher quality health care, and increased accessibility to health care services—all at a lower cost. Given that primary care is the key point-of-contact with the health care system for most patients, it should be the front line in the screening, treatment, and delivery of obesity management services.

The Alliance has conducted a number of projects to better understand the role of primary care in addressing obesity. In August 2009, the Alliance hosted a roundtable on adult primary care treatment and management of obesity at The George Washington University. Attendees included leading health experts, researchers, and primary care providers from a cross-section of organizations.

To complement the roundtable discussion, the Alliance research team reviewed existing literature on obesity management in primary care, including issues regarding patient-physician relationships and potential solutions to common problems. Following the roundtable, the Alliance released a paper entitled, *“Improving Obesity Management in Adult Primary Care”* based on the literature review, expert roundtable discussion, and in-depth interviews with health care providers. The findings from the roundtable and resulting paper highlight five themes of particular relevance to improving obesity and weight-related disease management in primary care settings:

1. *Monitoring Weight, Health Indicators and Risk*

Although basic counseling about healthy behaviors takes less than five minutes, providers often do not incorporate this counseling into a visit.^{2, 3} Most studies show that screening is not occurring regularly during primary care office visits. Recent literature indicates that during approximately 50 percent of physician visits, height and weight data necessary to calculate BMI is not recorded.⁴ Furthermore, for clinically obese patients (BMI \geq 30), 70 percent do not receive a diagnosis of obesity and 63 percent do not receive counseling from their physician.⁵ Because the odds of receiving weight-loss counseling are best when a patient's obesity is documented, consistent tracking of BMI may initiate productive patient-provider conversations. Finally, focusing on health indicators such as blood pressure, glucose, and cholesterol levels may also be an effective way for providers to discuss and motivate their patients to lose weight.⁶

2. *Assessing Patient Motivation*

Successfully motivating patients to lose weight is a fundamental challenge for physicians. While both roundtable participants and provider interviews discussed the concept of “readiness for change,” the overall discussion frequently turned to the importance of the provider-patient relationship in both assessing and creating readiness for change. Providers agreed that patient willingness to attempt small lifestyle changes, such as not drinking sugar-sweetened beverages, was a stronger indication of patient readiness than a positive finding from a formal assessment tool, such as a questionnaire. Finally, family-centered changes, along with accounting for ethnic and cultural differences, play a significant role in patient motivation, highlighting the need for culturally appropriate programming.⁷

3. *Defining Success*

Defining success in realistic and achievable terms is an important component of maintaining patient motivation. According to the National Heart Lung and Blood Institute, a modest weight loss of 5-10 percent of total body weight significantly

improves health outcomes, including reducing the risk of developing Type 2 diabetes, dyslipidemia, hypertension, and cardiovascular disease. Concentrating on the benefits of modest weight loss may motivate both providers and patients to think about obesity management in terms of health rather than appearance.⁸

4. *Increasing Integration and Care Coordination*

Since there is no “one solution fits all” answer to treating obesity, patients are often more successfully treated by coordinated, simultaneous interventions from health professionals across multiple fields or disciplines. There are benefits to treating obesity in clinically-integrated systems of care due to the availability of multi-specialty resources involved in treatment of patients with obesity. Such practices could include physicians, nurse practitioners, psychologists or other mental health professionals, dietitians, physical therapists, and bariatric surgeons. In areas of the United States where clinically integrated systems are not accessible or feasible, alternative models should be considered. One such approach is the medical home model, where a primary care physician coordinates care among a group of specialists who are consulted as needed. Alternatively, in the more informal setting, primary care providers refer patients to community-based resources, obesity specialty practices, or technological resources such as on-line or telephonic programs.⁹ These highly integrated and coordinated models may reduce costs, enhance quality of care, increase access, and improve record-keeping.¹⁰

5. *Implementing Electronic Medical Records*

Health Information Technology (HIT) and Electronic Medical Records (EMRs) have the potential to improve collection and documentation of patients’ information, and thus improve treatment consistency and potential for success. EMRs have the potential to improve the consistency of information gathering, BMI calculation, and trend information for individual patients. Additionally, they allow the aggregation of patient data to examine treatment effectiveness for the patient population for an individual physician or across the practice as a whole, as well as enable all physicians across an integrated practice to see the entire picture of that person’s health.¹¹

Barriers to Effective Primary Care in the Treatment and Prevention of Obesity

In March 2010, the Alliance released the results of its *Provider/Patient Survey on Obesity in the Primary Care Setting*, a survey that examined the rates of diagnosis of obesity, weight loss recommendations, and dialogue between patients and providers, among other things.¹² The survey supports existing literature, finding that only 64 percent of patients told by a health provider that they had obesity actually discussed methods of achieving or maintaining a healthier weight with their provider. The Alliance's survey also reinforces the literature demonstrating that even for patients with moderate to severe obesity (BMI \geq 35), physicians only discuss weight 65 percent of the time, recommend exercise 62 percent of the time, and refer patients for nutritional counseling 25 percent of the time.¹³ These low levels of counseling and referral indicate that multiple barriers to effective obesity-related primary care exist.

Physicians' views on both obesity and the effectiveness of counseling impact how often they provide weight loss counseling to their patients.¹⁴ Physicians cite lack of effective treatments, appropriate reimbursement¹⁵, the belief that patients would not succeed, and opinions about the origin and responsibility for obesity as factors influencing their decision not to initiate weight-related discussions.^{16,17} Physicians also tend to give low ratings to their ability to treat obesity because they might lack confidence in their weight management skills. In one study, 44 percent of physicians did not feel qualified to treat obesity.¹⁸ This finding is not surprising given that the Alliance's survey showed that 72 percent of providers had not, nor had anyone in their practice, been trained to deal with weight issues. All of these factors contribute to "clinical inertia," a situation where physicians do not counsel for weight because they feel there is nothing they can do to address the problem or that available treatments are ineffective.¹⁹

Another major barrier to effective obesity management in primary care is stigma, where physicians' negative attitude toward overweight and obese patients or perception that obesity is a lifestyle and behavioral issue as opposed to a medical one, affects the likelihood and success of counseling for weight loss. A perceived lack of understanding of the difficulty of weight loss may present yet another barrier to effective primary care—patients may think that physicians do not understand how difficult weight loss is to achieve or may be offended when the provider attributes their medical problems to their weight, even if there is a weight connection. These factors, combined with the difficulty of finding and recommending evidence-based programs, contribute to a sense of futility when it comes to weight loss in the primary care setting.

Though there is a long way to go in preparing the primary care community to adequately address the obesity epidemic, there are several promising developments in treating obesity, including signs of increased integration and care coordination in the primary care setting.

What's Happening in Community Health Centers?

CHCs are community-based and patient-directed organizations that serve as the primary medical providers for medically underserved and disadvantaged populations. CHC patients include low-income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.²⁰

As of 2009, 1,100 CHCs provided care for nearly 19 million patients, 71 percent of whom have family incomes below the federal poverty line.²¹ CHCs are increasingly relied on as safety net providers. Between 2000 and 2009, CHCs expanded the number of patients served by 67 percent, with the largest growth in Medicaid beneficiaries and the uninsured.²² Additionally, new CHCs and CHC sites are likely to be funded under the ACA, further expanding patients' access to health center services.²³

Health centers function as medical homes that provide regular care and a personal relationship with clinicians who ensure the delivery of preventive care and the appropriate management of complex conditions, coordinate care provided inside and outside the medical home, help patients understand their conditions and coach them on healthy behaviors.²⁴ As such, CHCs are uniquely situated to—and in some cases already do—play a pivotal role in helping patients obtain medical services to address their weight and co-morbid chronic conditions, in addition to providing counseling, education, and other opportunities to help patients achieve healthier lifestyles.

With the expansion of the Medicaid-eligible population under the ACA, CHCs are expected to experience an unprecedented influx of adult patients and will need to expand to serve approximately 40 million patients by 2015.²⁵ Roughly 46 percent of these patients will be Medicaid beneficiaries.²⁶ CHCs will need to have obesity-related services in place to address the needs of this expanding population. Similar to physicians in other primary care settings, providers in CHCs currently have few tools at their disposal to address weight and have limited training in this area.

Highlights from a Literature Review of Existing Obesity and Chronic Disease Management Programs

The literature review of obesity management and chronic disease management programs within CHCs conducted in advance of the March 2011 Symposium reinforced that CHCs already provide services for other chronic diseases, such as diabetes, hypertension, and asthma. CHCs generally compare favorably with care provided in other disease management settings and meet or exceed national rates on clinical quality of care measures for conditions such as diabetes.^{27,28,29,30} Many CHCs have chosen to approach chronic disease management by adopting integrated team-based approaches that can facilitate improved care coordination.³¹

One such model is the medical home model, which has produced positive results through on-site comprehensive care and by utilizing an obesity team management strategy including clinicians, case managers, dietitians, behavioral counselors, exercise instructors, family members and community partners.³²

Similar to other efforts, CHCs have traditionally focused obesity programming on child and adolescent populations. Importantly, however, CHC programs typically include integrated child and adult components within their obesity programs in order to address the impact that parental variables have on the efficacy of child weight loss programs.^{33,34} Recent literature has pointed to the potential positive impact of adult obesity programming on child weight status, irrespective of an integrated approach.³⁵

Considering that many CHC patients are racial and ethnic minorities, CHCs have responded by tailoring their programming to meet the cultural and linguistic needs of program participants.³⁶ This has been done through a variety of mechanisms including interactive patient groups, providing programming in languages other than English and partnering with local community organizations.

One promising approach for extending the reach of CHCs is the use of community health workers (CHWs). CHWs are members of local communities who work either for pay or as volunteers in association with the local health care system and typically share ethnicity, language, socioeconomic status, and life experiences with the community members they serve.³⁷ In particular, CHWs are responsible for educating and guiding other members of the community regarding the promotion of health behaviors and enrollment in insurance programs, among other things. Given that obesity is a highly stigmatized condition, CHWs can help bridge linguistic, cultural, and socio-economic gaps between patients and providers.

CHWs complement the roles of medical professionals and social workers and are often found in settings utilizing the medical home model or other integrated team-based chronic disease management models used for other chronic diseases such as diabetes and heart disease. The ACA acknowledges the role of CHWs and includes a provision to support and train CHWs to promote positive health behaviors and outcomes in medically underserved areas.³⁸

A Closer Look: Case Studies from the Literature Review

The STOP Obesity Alliance staff also performed a literature review, including a comprehensive Internet search of current obesity and disease management programs utilized within CHCs. The literature review revealed a number of initiatives that may serve as models for adult services and programming, including those designed for children, but which may be adaptable to adults. Of those identified, five programs were selected as promising models and are described below.

Whittier Street Health Center: Healthy Weight Clinic^{39,40,41} **Boston, MA**

Population: Children & Adults

Model: Medical Home

The Healthy Weight Clinic was established in 2006 at the Whittier Street Health Center in Boston. Under what the clinic terms its "Healthy Weight Initiative," it has expanded the program to seven additional Massachusetts CHCs in urban and rural areas. The clinics serve predominantly minority patients and approximately 32-47 percent of their pediatric patients are overweight or obese.

The Center's Healthy Weight Clinic model has three key components: 1) designated disease specific visits that allow for more time than standard primary care visits; 2) multidisciplinary, team-based care; and 3) specialized knowledge and training within a primary care team. Care is provided by a team consisting of a physician, a dietician, and a case manager, and typically consists of six visits. The clinician is responsible for medical assessment of obesity and related conditions, the dietician reviews weekly diets and provides nutrition advice and, the case manager assesses sedentary and physical activities. The team also works with each family to develop a culturally-appropriate self-management plan targeted at behavior modification. The program has developed and uses several health IT resources specific to obesity to improve quality and data reporting.

The teams report that they attribute higher quality obesity care compared to their usual primary care interaction with families to the designated clinic sessions, specialized obesity training, multidisciplinary approach, and collaboration with other CHCs that use the Healthy Weight Clinic model.

The program is funded through a not-for-profit foundation. Although case management services are not reimbursable, health center staff explains that billable medical and nutrition visits provide enough revenue to sustain the cost of the program.

A preliminary study of the Healthy Weight Clinic childhood obesity program showed that 50 percent of child participants experienced a decreased BMI, while almost 80 percent reported at least one lifestyle change, such as increased physical activity, increased fruit and vegetable consumption, or a decrease in sweetened beverage consumption.

Unity Health Care, Inc.'s: We Can Program

Washington, DC

Population: Children and Families

Model: Medical Home

Upper Cardozo Clinic, a site in Unity Health Care, Inc.'s CHC network, is a comprehensive primary care clinic in Washington, DC. Upper Cardozo is located in an underserved area of Washington, DC and serves a predominantly Hispanic and African American patient population. To address the climbing obesity rates among Upper Cardozo's child and adult patients, CHC staff developed a family-based nutrition and physical activity education intervention modeled after the National Heart Lung and Blood Institute's Ways to Enhance Children's Activity and Nutrition (We Can) program. As part of its medical home model of care, Upper Cardozo's program consists of weekly healthy family dinners for program participants with nutrition education and physical activities for adults and children held after each dinner. Physical activities for children participants are provided by local YMCA staff and a group of non-profit yoga instructors through a partnership with Unity.

Like other medical home models of obesity care, Upper Cardozo's comprehensive weight management services allow patients to obtain medical care for their weight and other health conditions while learning about nutrition and exercise. The active participation of CHC providers and staff plays a crucial role in the program's success, both in recruiting patients to participate and in building knowledge regarding obesity interventions among practitioners.

Wishard Health Services System: Take Charge Lite^{42,43}

Indianapolis, IN

Population: Adults

Model: In-clinic behavioral counseling with nutrition and physical exercise classes

Take Charge Lite, implemented at multiple Wishard Health Services System sites, is a weight management support network that utilizes wellness coaches trained in motivational interviewing to assist people wanting to live a healthier lifestyle. The program does not prescribe to any specific diet plan, but instead uses coaching, group support, and motivation to supplement a physician's clinical care. The program began at a single urban CHC in 2006 and has since expanded to five additional Indianapolis health centers, serving more than 5,000 patients.

The program is open to Wishard patients 18 years and older with a BMI of 30 or greater, or 25 or greater for people with certain risk factors. Once program staff determines a patient meets the criteria for program participation, the patient's physician discusses certain recommended health changes and then the patient schedules an appointment with a wellness coach. In addition to opportunities to work one-on-one with the wellness coach, Wishard provides support groups, fitness classes, walking clubs, regular weigh-ins and healthy nutrition and cooking education.

Canyon Ranch Institute Life Enhancement Program^{46,47}

Four Program Sites (South Bronx, NY; Cleveland, OH; Milan, MO; Tucson, AZ)

Population: Adults

Model: Patient-Centered Medical Home

The Canyon Ranch Life Enhancement Program (CRI LEP) takes an integrated health approach to helping adults from low-income communities overcome and prevent obesity and address chronic diseases that can be impacted by lifestyle choices. The first CRI LEP was established in partnership with Urban Health Plan, Inc. (UHP), a federally qualified community health center (FQHC) network, at UHP's South Bronx, NY site. The CRI LEP also is offered in partnerships with another FQHC in Tucson, AZ; with a county hospital in rural Missouri; and with The Cleveland Clinic in Cleveland, OH.

CRI trains health professionals at partner sites on the principles, curriculum, process and evaluation of the program, and works with each partner site to ensure that the programming is culturally and linguistically appropriate to the community that is being served by that site. The CRI LEP is free and open to individuals who are referred by a primary care professional. Participants must agree to attend all program sessions and show a potential to want to make and sustain healthy changes.

Program sessions cover a variety of topics, including physical activity, social support, nutrition and sense of purpose. CRI LEP sites vary in program length from 6-12 weeks, but do not vary in content. In addition to the group sessions facilitated by health professionals, each participant meets individually for one hour each with a physician, nutritionist, exercise specialist, behavioral health specialist, and medications professional. At UHP, the program provides access to exercise equipment and space for meditation, relaxation and yoga. UHP encourages and supports continued use of the facilities after the program ends. Sites vary in their available facilities and make adjustments to accommodate program requirements.

Data are collected from all participants pre- and post-program and one year later. Based on the data available, statistically and clinically significant changes have been found in many individual measures of health status, knowledge and healthy behaviors. Of the participants at the UHP identified as obese or overweight, BMI changes were statistically significant, as was waist measurement for all. While not statistically significant for all participants, the evaluation data demonstrates healthy changes for the groups in HbA1c, total cholesterol, triglycerides, blood pressure, amount of strenuous exercise per week, dietary fat intake, eating healthier foods, resting heart rate, and the number of sit-ups participants are capable of performing.

Qualitatively, analysis of comments from participants identified themes related to gains in health literacy, changes in attitudes and behaviors, weight loss, improvements in nutrition, improvements in perceived health and well-being and increased awareness of the integrative aspects of health.

Diabetes Prevention Program

Nationwide

Population: Adults

Model: Lifestyle and behavior counseling targeted at nutrition and physical activity

The National Institutes of Health sponsored Diabetes Prevention Program (DPP) was a major clinical study that demonstrated that engaging in certain lifestyle changes, such as healthy eating, physical activity, and receiving intensive counseling and education on diet and exercise-related behavior modifications was effective at reducing the risk of developing diabetes compared to standard pharmaceutical interventions. Specifically, the study showed that individuals with pre-diabetes can reduce their risk of going on to develop diabetes by 58 percent with a modest 5-7 percent weight loss. Since the completion of this study in 2002, various organizations, such as CHCs and private insurers, have tailored the DPP model to serve their patient communities.

Although not officially affiliated with any single CHC, United Healthcare (a private insurer) coordinates a Diabetes Prevention Program through a partnership with local YMCAs, which are also frequent partners for CHCs around the country. United Healthcare covers services provided through the DPP at no charge to participants enrolled in employer-based health insurance plans. The YMCA has become an important partner for several group model DPP programs, including programs supported by United Healthcare. Under the YMCA DPP model, the YMCA provides 16 classes that discuss intervention goals, physical activity, diet, and psychological, social and motivational challenges to maintaining healthy lifestyles. Participants also take part in a four-week exercise program at the YMCA. Following the completion of the curriculum and exercise program, participants are encouraged to continue ongoing exercise classes and attend monthly group sessions that focus on maintaining healthy lifestyles.

By way of example, the Fair Haven Community Health Center in Connecticut provides a DPP-based program to its patients, known as the Diabetes Prevention Lifestyle Intervention (DPLI). The DPLI is a 12-week intensive counseling program run by the Fair Haven Community Health Center structured to meet the needs of its predominantly Hispanic population in New Haven, Connecticut, where it was discovered that 40 percent of Latina women have pre-diabetes.

DPLI participants and their families attend three exercise classes and one nutrition session per week. Participants also can own shares in a community garden. Transportation, childcare and meals are provided for participants free of charge. According to the Center, participants have achieved an average weight loss of 6.5 pounds (4 percent of body weight) and have documented an increase in physical activity, despite the fact that roughly 90 percent of the population lives below the federal poverty level and fresh produce is not readily available. The DPLI program has its own blog and Facebook page, allowing community partners to continually engage in the DPLI process.

Robert Wood Johnson Foundation: Healthy Kids, Healthy Communities

Nationwide

Population: Children

Model: Multiple

Healthy Kids, Healthy Communities is a national program of the Robert Wood Johnson Foundation whose primary goal is to implement healthy eating and active living policy and environmental change initiatives that can support healthier communities for children and families across the United States. Healthy Kids, Healthy Communities places special emphasis on reaching children who are at highest risk for obesity on the basis of race, ethnicity, income and/or geographic location.

While not specifically geared toward CHC-based programming, the activities of the 50 communities participating in the Healthy Kids, Healthy Communities initiative provide examples of partnership possibilities, such as those with the local YMCA, restaurants, and corner stores, as well as nutrition and physical activity-based initiatives, such as cooking and exercise classes, that CHCs may consider modeling in their centers and in collaboration with community partners.

Best Practices from the Case Studies

Obesity-management program models within CHCs range from comprehensive medical home-based services to basic group nutrition counseling and exercise classes. An important component of most programs is the collaboration between CHCs and community partners, such as the YMCA, to provide obesity-related services to patients that CHC staff and resources would not otherwise be able to support. These community partnerships often facilitate the integration of an exercise component to obesity programming at CHCs, which can range from utilizing a local school's track for group walking exercise to facilitator-led exercise classes.

One such example is the Unity Health Care *We Can* program discussed above, which partnered with a local yoga studio to provide tailored family-oriented yoga classes for participants. Such collaborations are not only beneficial to patients but also help CHCs meet the Bureau of Primary Health Care's requirements for community partnerships, as well as allowing CHCs to offer more comprehensive care.

In addition, with the support of community partners, many CHCs are providing their obesity and wellness services on-site so that patients do not have to travel to additional locations to obtain the care they need. This "one-stop-shopping" model is important for ensuring continuity of care, as studies have noted various potential problems associated with referrals to outside specialists, including long wait times to see the limited number of clinicians who specialize in obesity, the fragmentation of care resulting from separating weight-loss interventions from the medical home and community, problems with insurance reimbursement and ability to obtain care as a Medicaid beneficiary, and the time, distance, cultural, and linguistic barriers that patients encounter in seeking outside care.^{44,45}

Several CHC obesity programs are also taking advantage of new social media opportunities to connect with their respective communities and patients. In addition to program information and weight-loss tools provided on CHC websites, some CHCs are using blogs, Facebook, text messages, and Twitter as part of their communication and outreach strategies.

The practices utilized within these programs helped initiate the discussion on potential CHC obesity best practices at the Symposium held at the National Association of Community Health Centers' Policy and Issues Forum.

Highlights from the Symposium

In addition to emphasizing the importance of defining success, Symposium participants identified three themes with regard to promising treatment practices for obesity in CHCs. These are the need to 1) Increase integration and care coordination; 2) Create culturally and linguistically appropriate programming and 3) Partner with community organizations.

1. Increase Integration and Care Coordination

Symposium participants agreed that there are benefits to the treatment of obesity in clinically integrated systems of care due to the often complex, multi-specialty resources involved in treatment of patients who have obesity. Participants highlighted the promise and current successes of team-based approaches to obesity management in health centers, including combinations of physicians, nurse practitioners, psychologists, or other mental health professionals, dietitians, and physical therapists. Participants also pointed to the fact that most CHCs already utilize and are unique in their ability to provide, multidisciplinary, integrated practitioner groups and to facilitate care coordination.

One such example highlighted at the Symposium was the Holyoke Health Center in Holyoke, MA, where the Healthy Weight program pulls in resources from all sectors of the community. In addition to learning about healthy menu planning and exercise, the women involved in the program learn how to restructure their lives around healthier habits and to develop skills to allow them to identify healthy foods at a grocery store. Also discussed was Unity Health Care's program, We Can, cooking demonstration and Special Supplemental Nutrition Program for Women, Infants and Children assistance office in the clinical setting to help create a cohesive, integrated program.

2. Create Culturally and Linguistically Appropriate Programming

As a large portion of CHC patients are racial and ethnic minorities, integrating culturally and linguistically appropriate approaches can improve the efficacy of CHC programming. Symposium participants acknowledged the role of culturally and linguistically appropriate programming in effectively treating patient populations and maintaining patient motivation.

The Holyoke Healthy Weight program highlighted at the Symposium incorporates this idea. Given the largely Latino program's population, a key facet of the program is the use of promotoras who are previous graduates of the program. The promotoras create linkages to community support, in addition to providing peer mentorship to participants. Promotoras also help to increase patient knowledge and self-efficacy and assist with goal setting and problem solving.

3. Partner with Community Organizations

Multiple Symposium participants noted that many obesity-related CHC programs have partnered with local community organizations such as the YMCA and local schools and emphasized the importance of such partnerships. This partnership approach allows CHCs to provide more comprehensive care, including physical activity interventions, which would not otherwise be feasible in current CHC settings. Symposium participants acknowledged the efficacy of such approaches and highlighted that this approach moves financial burden from the CHC to the organization or community.

For example, Symposium participants discussed the collaborative efforts of Unity's We Can, which, along with the program elements discussed above, works with several community organizations, including Washington DC's Department of Parks and Recreation and local yoga instructors, to provide increased opportunities for physical activity and exercise for the entire family. CHCs may also follow the lead of several community organizations participating in the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities program by implementing joint use agreements to provide community access to school playgrounds, pools, and gymnasiums during non-school hours.⁴⁶

Barriers to Obesity Efforts in Community Health Centers

Despite the important role that CHCs can and do play in assisting patients with obesity management, multiple barriers exist that hamper CHC efforts at effective patient prevention and treatment of overweight and obesity.

First, numerous articles and news sources have noted that the United States is likely to face a severe shortage of primary care providers, with some estimating there will need to be an additional 150,000 physicians trained in the next fifteen years.⁴⁷ CHCs are especially affected by primary care provider shortages⁴⁸ because primary care services comprise 98.2 percent of all care provided by most CHCs.⁴⁹ Because of this, CHCs will need adequate staffing to handle the large influx of patients under the ACA. Recent estimates predict a shortage of nearly 30,000 primary care providers by 2015 and more than double that figure by 2025.⁵⁰

Further, CHCs face additional challenges in their ability to adequately expand to serve the influx of new Medicaid beneficiaries under the ACA. Recent federal budget cuts of \$600 million in CHC funding have restricted CHCs' ability to expand to meet growing demand.⁵¹ CHCs also are explicitly excluded from the funding and collaboration opportunities afforded to the new accountable care organizations (ACOs) being formed in accordance with the ACA's provisions. This is true despite the fact that as many as 200 CHCs already meet the National Committee of Quality Assurance certification standards for patient-centered primary medical homes, which will be relevant for ACO formation.⁵² Because the co-morbidities associated with obesity are likely to be a focus of many of the ACOs,⁵³ this will hinder CHCs' and their community partners' ability to fully realize the potential in this area.

Moreover, despite the promising role that community health workers (CHWs) can provide in assisting CHC patients with obtaining obesity-related services, funding to support CHWs is limited, leaving CHCs to forego the use of CHWs or rely on volunteers. While the ACA does establish a grants program to help CHCs support the use of CHWs within their facilities, legislators have not yet appropriated funds for this effort, leaving CHCs to question whether such future assistance will ever become available.⁵⁴

The continued stigmatization of obesity presents yet another challenge for CHCs. Similar to other provider settings, under-diagnosis of obesity remains commonplace in CHCs.⁵⁵ Obesity continues to be misunderstood by many, and some physicians feel that addressing obesity is outside the scope of their position, viewing weight management as a cosmetic rather than a health concern.

Finally, the lack of a well-defined and realistic definition of success, both in obesity management and with respect to programmatic success (particularly when coupled with limited resources), may lead CHCs to abandon programs that yield seemingly small weight-loss results but that in reality lead to substantial increases in health benefits for participants. Providing ongoing and improved education about the significant health improvements a 5- 10 percent reduction in weight can yield would be beneficial to CHC and primary care providers alike. Lastly, a "successful" program within a CHC may be one that provides additional access to or knowledge about healthy foods, opportunities for fitness and exercise, or a healthier community, which may not be measurable with scales or BMI tracking.

Conclusion: What Primary Care Providers in Community Health Centers and Private Practice Can Learn from One Another

As nearly all care provided by CHCs is primary care, primary care providers and CHCs have closely aligned objectives, with a number of mutually shared practices. However, both CHCs and primary care providers working in other settings can further build off the experiences of, and practices utilized within, the other's health care setting.

Health reform provides an opportunity to prioritize primary care and the patient-centered medical home. CHCs can be leaders in this effort, through development of comprehensive community-based approaches. Though the issues surrounding obesity are complex, certain practices are promising and are resulting in marked health improvements. Nearly all of the successful interventions identified within CHCs and other primary care settings involve addressing multiple components of the obesogenic environment.

Strong community partnerships are important in both CHCs and other private primary care settings, as is the recognition and incorporation of the idea that even modest weight loss leads to improved health. In addition to publishing results of successful programs, CHCs can use social media to increase community awareness and participation in community partnerships and other methods of fostering patient buy-in. Focusing on the entire family is an important concept in all primary care settings. Recognizing the impact that parental habits have on children can help to improve health outcomes for both groups.

However, there is much room for improvement in primary care. Most primary care providers work in practices where no one has received training in weight-related issues.⁵⁶ It is essential that providers become well-trained and are comfortable treating obesity in the primary care setting. It's also important that providers view obesity as a serious health condition that demands medical attention and can be treated and prevented successfully through a variety of clinically-supported interventions, rather than as a cosmetic condition where responsibility lies entirely with the patient.

Importantly, CHCs teach us that there are many aspects of primary care that can be delivered by non-physicians. Rather than placing the emphasis solely on physicians, primary care visits should be redefined to include less time with the doctor and more time with other providers, such as nurse practitioners and physician assistants. Here, CHCs provide a good example of how such integrated primary care can be provided. Further, medical homes provide an opportunity for patients to be connected with experts who are trained to assist in developing and maintaining skills and behaviors associated with achieving a healthier weight. By focusing on numerous factors that shape a patient's health, and addressing the obesogenic environment, CHCs are uniquely situated and have significant potential to impact the obesity epidemic.

References

- ¹ Flegal, K.M., Carroll, M.D., Ogden, C.L., Curtin, L.R. Prevalence and trends in obesity among US adults, 1999-2008. *JAMA* 2010;303(3):235-241. Available at: <http://jama.ama-assn.org/cgi/content/full/2009,2014>.
- ² Albright, C.L., Cohen, S., Gibbons, L., et al. Incorporating physical activity advice into primary care: physician-delivered advice within the activity counseling trial. *Am J Prev Med*. 2000;18:225-234.
- ³ Stange, K.C., Woolf, S.H., Gjeltema, K. One minute for prevention: the power of leveraging to fulfill the promise of health behavior counseling. *Am J Prev Med*. 2002;22: 320-323.
- ⁴ Ma, J., Xiao, L., Stafford, R.S. Adult obesity and office-based quality of care in the United States. *Obesity*. 2009;17(5):1077-1085. Available at: <http://www.nature.com/oby/journal/v17/n5/abs/oby2008653a.html>.
- ⁵ Ma, J., Xiao, L., Stafford, R.S. Adult obesity and office-based quality of care in the United States. *Obesity*. 2009;17(5):1077-1085. Available at: <http://www.nature.com/oby/journal/v17/n5/abs/oby2008653a.html>.
- ⁶ Ferguson, Christine et al. Improving Obesity Management in Adult Primary Care [White paper]. (2010). Available at: <http://www.stopobesityalliance.org/wp-content/assets/2010/03/STOP-Obesity-Alliance-Primary-Care-Paper-FINAL.pdf>.
- ⁷ Ferguson, Christine et al. Improving Obesity Management in Adult Primary Care [White paper]. (2010). Available at: <http://www.stopobesityalliance.org/wp-content/assets/2010/03/STOP-Obesity-Alliance-Primary-Care-Paper-FINAL.pdf>.
- ⁸ Ferguson, Christine et al. Improving Obesity Management in Adult Primary Care [White paper]. (2010). Available at: <http://www.stopobesityalliance.org/wp-content/assets/2010/03/STOP-Obesity-Alliance-Primary-Care-Paper-FINAL.pdf>.
- ⁹ Ferguson, Christine et al. Improving Obesity Management in Adult Primary Care [White paper]. (2010). Available at: <http://www.stopobesityalliance.org/wp-content/assets/2010/03/STOP-Obesity-Alliance-Primary-Care-Paper-FINAL.pdf>.
- ¹⁰ Rosenthal, T.C. The medical home: growing evidence to support a new approach to primary care. *JABFM*. 2008;21(5):427-440. Available at: <http://www.jabfm.com/cgi/content/full/21/5/427>.
- ¹¹ Ferguson, Christine et al. Improving Obesity Management in Adult Primary Care [White paper]. (2010). Available at: <http://www.stopobesityalliance.org/wp-content/assets/2010/03/STOP-Obesity-Alliance-Primary-Care-Paper-FINAL.pdf>.
- ¹² STOP Obesity Alliance. Provider/Patient Survey on Obesity in the Primary Care Setting. Available at: <http://www.stopobesityalliance.org/research-and-policy/research-center/survey-results/>.
- ¹³ Waring, M.E., Robert, M.B., Parker, D.R., Eaton, C.B. Documentation and management of overweight and obesity in primary care. *JABFM*. 2009;22(5):544-552. Available at: <http://www.jabfm.org/cgi/content/abstract/22/5/544>.
- ¹⁴ Sussman, A.L., Williams, R.L., Leverence, R., Gloyd, P.W., Crabtree, B.F. The art and complexity of primary care clinicians' preventive counseling decisions: obesity as a case study. *Ann Fam Med*. 2006;4(4):327-333.
- ¹⁵ Foster, G.D., Wadden, T.A., Makris, A.P., et al. Primary care physicians' attitudes about obesity and its treatment. *Obes Res*. 2003;11:1168-1177.
- ¹⁶ Sussman, A.L., Williams, R.L., Leverence, R., Gloyd, P.W., Crabtree, B.F. The art and complexity of primary care clinicians' preventive counseling decisions: obesity as a case study. *Ann Fam Med*. 2006;4(4):327-333.
- ¹⁷ Rippe, J.M., McInnis, K.J., Melanson, K.J. Physician involvement in the management of obesity as a primary medical condition. *Obesity*, 2001;9:s302-s311. Available at: <http://www.nature.com/oby/journal/v9/n11s/full/oby2001135a.html>.
- ¹⁸ Jay, M., Kalet, A., Ark., T., McMacken, M., Messito, M.J., Richter, R. Physicians' attitudes about obesity and their associations with competency and specialty: A cross-sectional study. *BMC Health Services Research*. 2009;9(106). Available at: <http://www.biomedcentral.com/1472-6963/9/106>.
- ¹⁹ Phillips, L.S., Branch, W.T., Cook, C.B., Doyle, J.P., El-Kebbi, I.M., Barnes C.S. Clinical inertia. *Ann Intern Med*. 2001;135(9):825-834. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11694107>.
- ²⁰ U.S. Department of Health and Human Services, Bureau of Primary Health Care. What is a Health Center? Available at: <http://bphc.hrsa.gov/about/> (accessed March 14, 2011).
- ²¹ In 2009-10, approximately 98 million people had incomes less 200 percent of the federal poverty level. U.S. Census.
- ²² NACHC. A Sketch of Community Health Centers: Chart Book 2009. <http://www.nachc.com/state-healthcare-data-list.cfm>
- ²³ HRSA Press Release, "HHS Awards Affordable Care Act funds to Expand Access to Health Care" (August 9, 2011)(access August 11, 2011).
- ²⁴ NACHC, Robert Graham Center. Access Denied: A Look At America's Medically Disenfranchised. March 2007. www.nachc.com/access-reports.cfm.

- ²⁵ D. M. Herrick. Critical Condition: Primary Care Physician Shortages. (May 25, 2010), National Center for Policy Analysis, available at <www.ncpa.org/pub/ba706> (accessed April 26, 2011).
- ²⁶ NACHC. Community Health Centers Lead the Primary Care Revolution. August 2010.
- ²⁷ Shin P, Markus A, and Rosenbaum S. Measuring Health Centers against Standard Indicators of High Quality Performance: Early Results from a Multi-Site Demonstration Project. Interim Report. Prepared for the United Health Foundation, August 2006.
www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/United_Health_Foundation_report_082106.pdf
- ²⁸ Hicks LS, et al. The Quality of Chronic Disease Care in US Community Health Centers. November/December 2006 *Health Affairs* 25(6):1713-1723.
- ²⁹ Ulmer, C et al. Assessing Primary Care Content: Four Conditions Common in Community Health Center Practice. *Journal of Ambulatory Care Management*. 23(1):23-38, 2000, Jan.
- ³⁰ Hicks, L., O'Malley, J., et al. The quality of chronic disease care in US community health centers. *Health Affairs*. 25(6): 1712-1723, 2006.
- ³¹ Ndumele, C., Russell, B., Ayanian, J., Landon, B. Strategies to improve chronic disease management in seven metro Boston community health centers. *Progress in Community Health Partnerships: Research, Education, and Action* 3(3):203-211. 2009.
- ³² McClaskey, E. A childhood obesity program in federally qualified community health centers. *Journal of Health Care for the Poor and Underserved*. 21(3):774-779. 2010.
- ³³ Epsetin, L. H., Wing, R. R., Valoski, A., McCurley, J. Ten-year follow-up of behavioral, family-based treatment for obese children. *JAMA*. 55:91-95. 1990
- ³⁴ White, M., et al. Mediators of weight loss in a family-based intervention presented over the internet. *Obesity Research*. 12:1050-1059.
- ³⁵ Boutelle, KN, Cafri, G, Crow, SJ. Parent-only treatment for childhood obesity: a randomized controlled trial. *Obesity*. 19(3):574-580. 2011
- ³⁶ Betancourt, J., Green, A., Carrillo, E., Park, E. Cultural competence and health care disparities: key perspectives and trends. *Health Affairs*. 24(2):499-505. 2005.
- ³⁷ Spencer, M., Gunter, K., Palmisano, G. Community Health Workers and Their Value to Social Work. *Social Work*. 55(2):169-180. 2010.
- ³⁸ The Patient Protection and Affordable Care Act, Pub. L. 111-148 (2009), as amended by the Health Care and Education Affordability Reconciliation Act, Pub. L. 111-152 (2010), collectively known as the Affordable Care Act (ACA). Section 5313.
- ³⁹ Anand SG, Adams WG, & Zukerman BS. (2010). Specialized Care of Overweight Children in Community Health Centers. *Health Affairs*. 29:4
- ⁴⁰ Whittier Street Health Center. Specialized Clinics. Available at: http://www.wshc.org/specialized_clinics.html (accessed March 14, 2011).
- ⁴¹ Weintraub K. A weight-loss win: How one program changes the way kids drop pounds and gain self-esteem. The Boston Globe, April 5, 2010. Available at: http://www.boston.com/community/moms/articles/2010/04/05/a_weight_loss_win/ (accessed March 14, 2011).
- ⁴² Clark D, Chrysler L, & Perkins A et al. (2010). Screening, Referral, and Participation in a Weight Management Program Implemented in Five CHCs. *Journal of Health Care for the Poor and Underserved*. 21(2010); 617-628.
- ⁴³ Wishard Health Services. Take Charge Lite (TCL) Wellness Program. Available at: <http://www.wishard.edu/TakeChargeLite.html> (accessed March 14, 2011).
- ⁴⁴ Anand SG, Adams WG, & Zukerman BS. (2010). Specialized Care of Overweight Children in Community Health Centers. *Health Affairs*. 29:4
- ⁴⁵ McClaskey, E. A childhood obesity program in federally qualified community health centers. *Journal of Health Care for the Poor and Underserved*. 21(3):774-779. 2010.
- ⁴⁶ Robert Wood Johnson Foundation. HKHC Case Examples: Joint Use Agreements. Available at: <http://www.healthykidshealthycommunities.org/node/672> (accessed August 11, 2011).
- ⁴⁷ See e.g., *Primary Care Shortage May Undermine Health Reform Efforts*, Hasley, A., Washington Post, June 20, 2009; *Physician Shortages to Worsen without Increases in Residency Training*, American Academy of Medical Colleges, available at: https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf; *Medical Schools Can't Keep Up As Ranks of Insured Expand, Nation Faces Shortage of 150,000 Doctors*; Sataline, S. and Wang, S., The Wall Street Journal, April 12, 2010.
- ⁴⁸ *Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion*, Rosenblatt, R. et al., *JAMA*. 2006;295(9):1042-1049.
- ⁴⁹ Geiger Gibson/RCHN Community Health Foundation. 2011. Rosenbaum, S., Shin, P. Medicare's Accountable Care Organization Regulations. Retrieved from: http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_6EFAAA15-5056-9D20-3DBE579D20C06F05.pdf

How Will Medicare Beneficiaries who Reside in Medically Underserved Communities Fare?.

⁵⁰ AAMC Center for Workforce Studies, June 2010 Analysis

⁵¹ Marcy, Jessica. Community Health Centers To 'Turn The Promise Of Coverage' Into Better Care—The KHN Interview. *Kaiser Health News* May.04 (2011). <<http://www.kaiserhealthnews.org/Stories/2011/May/05/Hawkins-Q-and-A-Community-Health-Centers.aspx>>.

⁵² Kaiser Health News. Available at: <http://www.kaiserhealthnews.org/Stories/2011/May/05/Hawkins-Q-and-A-Community-Health-Centers.aspx>

⁵³ *Bending the Cost Curve: A Critical Component of Health Care Reform*, Shortell, S., JAMA. 2009;302(11):1223-1224

⁵⁴ The Patient Protection and Affordable Care Act, Pub. L. 111-148 (2009), as amended by the Health Care and Education Affordability Reconciliation Act, Pub. L. 111-152 (2010), collectively known as the Affordable Care Act (ACA). Section 5313

⁵⁵ Lemay, C. (2003) Underdiagnosis of Obesity at a Community Health Center. *The Journal of the American Board of Family Practice*. 16:14-21

⁵⁶ STOP Obesity Alliance. Provider/Patient Survey on Obesity in the Primary Care Setting. Available at: <http://www.stopobesityalliance.org/research-and-policy/research-center/survey-results/>.